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
- 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

[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.

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.

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.

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:** (1) Kiki Ferrari (2) Dr. Brian Klar
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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? (1000 words)

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

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

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

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

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

Maximum word count: 1000

Alignment

Alignment between the population/service area the Brampton/Etobicoke and Area OHT ("the OHT") proposed during the Self-Assessment and the OHT's attributed population is moderate.

The population included in the Self-Assessment was based on residential geography and included residents of the Brampton, Bramalea, and North Etobicoke, Malton and West Woodbridge (NEMWW) Sub-regions. The attributed population is not based on residence, but

[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.

reflects networks formed by primary, acute, and specialist care utilization patterns. The size, age ranges, and gender of the attributed population are similar to the residential population in the OHT's catchment area, whereas the area of residence is not, as outlined in Appendix 1.

Population Health Approach

OHT partners have experience implementing a population health management approach, but previous experience focused on initiatives by area of residence. For the attributed population, the OHT will require additional information about health characteristics of the population (socio-demographics, general health, risk factors and prevention) to ensure an effective population health approach based on shared needs.

The OHT will build on population health management experience to segment the attributed population effectively, implement in-reach and out-reach services, and reduce inequalities in health status between population groups. The following initiatives demonstrate population health management approaches by OHT partners:

- Central West Local Health Integration Network (LHIN) Sub-region Initiatives: Sub-region initiatives segment the population based on health and socio-demographic data to develop interventions targeted to the needs of the segmented population.
- Multidisciplinary Tuberculosis Clinic: Peel Public Health collaborated with William Osler Health System (Osler) in 2010 to open Peel Region's first multidisciplinary tuberculosis clinic, to provide integrated client care, shared accountability and improve population health outcomes.
- Health Links Central Intake: The Central West LHIN developed a central intake model for identification of patients with complex care needs. Inclusion criteria for patients with complex care needs reflects a broader definition of health, including the social determinants of health.
- Healthy Communities Initiative (HCI): The Central West LHIN, Region of Peel and Osler, with the City of Brampton and other community partners, are addressing population health through the HCI by creating environments and opportunities to achieve better health and wellness.
- Region of Peel Seniors Health and Wellness Village/Peel Integrated Care: The Region of Peel is currently developing in-reach services for the senior's population. Services are offered as part of an integrated hub providing robust care coordination.
- Family Health Team (FHT) Interdisciplinary Care Program Expansion: Interdisciplinary programs have been developed to address the needs of target populations including those with dementia, mild to moderate mental health conditions, pre and post-natal needs, and diabetes.
- Rexdale Community Health Centre and WellFort Community Health Services: Provide group sessions for vulnerable seniors including exercise, congregate dining, education, case management and other supports.
- Osler and the Woodbine FHT COPD clinic: The clinic has been established at 135 Queens Plate Drive in Etobicoke.

Opportunities

Given the overlap in the anticipated and attributed population in Brampton, much of the OHT's knowledge about its health characteristics will be useful, and the OHT can make use of existing partnerships among providers in this area.

Challenges

Attributed Population versus Residential Population

While the attributed population approach will help to preserve existing care relationships, it may pose challenges when preserving care relationships with other sectors, such as home and community care. The attributed population for the OHT whose place of residence has been identified mostly live in a geography centred on Brampton, and bound by Barrie, Markham, Hamilton, and Kitchener. The OHT is confident that by working with the partners and collaborating with neighbouring OHTs, it will provide seamless care to this population.

Per Capita Funding

Many patients attributed to the OHT receive care outside of the OHT's networks and fees associated with these patients were billed from other networks, including:

- 22% of GP physician fees;
- 48% of acute care fees; and
- 51% of physician specialist fees.

This outflow presents a risk as the receipt of care outside the OHT could result in inadequate funding if a proposed funding envelope follows primary care attachment.

Chronicity and Complexity

In the three Sub-regions included in the OHT's Self-Assessment, there are approximately 37,710 residents (5%) who meet the Ministry's definition of complex (four or more chronic conditions). The top three health conditions for the attributed population are the same as for Ontario. Chronic conditions that the OHT has chosen to focus on in its early years include:

- Diabetes
    - There is no significant difference between the self-reported prevalence of diabetes in the residential population of the OHT catchment area versus the population of the province of Ontario. However, based on administrative data, NEMWW has the sixth highest prevalence of diabetes in the province, and Bramalea has the eighth highest.
    - Diabetes/hypoglycemia without significant comorbidities is the third highest health profile group in terms of population costing, and accounts for the largest number of patients in the top 10 health profile groups.
- Respiratory Disease
    - Acute and other respiratory diseases and disorders is the fourth highest ranked health condition for the OHT population, two higher than it is for the province.
    - Respiratory failure with heart failure accounts for the highest cost per OHT patient of the top 10 health profile groups.

Other Health Conditions

The population of the OHT's catchment area has troubling results in perinatal measures. All three Sub-regions are among the 10% of Sub-regions with the highest low birth weight rates

in Ontario, with Brampton having the highest low birth weight rate, and NEMWW having the highest “small for gestational age” rate. Bramalea and Brampton are tied for the third highest pre-term birth rate in the province, and Brampton has the third highest stillbirth rate. For potential years of life lost for perinatal conditions, which is not measured at the Sub-region level, the Central West LHIN had the highest rate in Ontario. For the attributed population, obstetrics is the seventh highest health profile group in terms of population costing.

1.2. Who will you focus on Year 1? (1000 words)

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 OHT submission is based on the co-design of a comprehensive population health model which will serve the OHT's attributed population through an Integrated Care Hub (ICH), which is based on equity (described in detail in section 3.2).

In Year 1, the OHT will focus on serving rostered patients of primary care providers (PCPs) who are members of the OHT (which is reflective of the population proposed in the Self-Assessment). The total number of patients is estimated to be 200,000. The OHT recognizes that this is a large population, but the degree of services and intensity of resources required to serve this population will be stratified and scaled over time. The ICH will provide a basic level of service to all patients referred by member PCPs, but a particular focus for Year 1 is the development of a diabetes care pathway for complex patients of rostered member PCPs with diabetes. In addition, all complex patients with diabetes who are discharged from William Osler Health System will be referred to the ICH to ensure warm handoffs. While the OHT is not proposing to change the Ministry's clinical definition of complexity, it will adopt the Central West Local Health Integration Network's (LHIN) Health Links Central Intake model for the identification of patients with complex care needs as criteria for target population identification which reflects a broader definition of health, including the social determinants of health. The utilization of this inclusion criteria will allow the OHT to identify a greater number of patients rostered to member PCPs who would benefit from the diabetes care pathway.

Rationale for Year 1 Population

<u>PCP Rosters</u>

Generally, population health based models that have demonstrated success internationally have been those where primary care is a central focus. The creation of OHT is based upon networks rooted in primary care which are expected to provide fully integrated and

coordinated care for an entire attributed population at maturity. Primary care data for the OHTs attributed population and geographic region shows that:

- 22.6% of the OHT's attributed population is not enrolled in a physician enrollment model (PEM) as per Ministry data;
- 30% of primary care visits are made outside of an enrolling group as per Ministry data; and
- 85% of PCPs have minimal system and allied health supports (Central West LHIN Integrated Health Service Plan 5 Environmental Scan).

This data suggests that there is a significant opportunity to improve the availability of comprehensive primary care services to meet the OHT's goal of providing better coordinated, integrated health care that is easier to navigate. By using rosters from all primary care models in the OHT's Year 1 population, the OHT will be able to provide equitable access to integrated care services across a more general population with diverse needs.

Diabetes

In addition to focusing on comprehensive primary care for PCP rostered patients, the OHT will target interventions towards patients with complex care needs with diabetes. A central intake process and standardized pathway will be implemented as a proof of concept to address the needs of patients living with complex chronic conditions where social determinants (e.g. food access, income, housing, etc.) play a significant role in health outcomes.

Over 65% of the OHT's attributed population reside in the Region of Peel, and 50.8% of residents in the Region of Peel are of South-Asian descent (Peel Data Centre, 2016). Diabetes was chosen as a Year 1 focus as this population is known to be predisposed to the development of diabetes, with diabetes often being a precursor to multiple comorbidities:

The rising prevalence of diabetes in South Asians has significant health and economic implications. South Asians are predisposed to the development of diabetes due to biologic causes which are exacerbated by lifestyle and environmental factors. Furthermore, they experience significant morbidity and mortality from complications of diabetes, most notably coronary artery disease, cerebrovascular disease, and chronic kidney disease. Therefore, understanding the pathophysiology and genetics of diabetes risk factors and its associated complications in South Asians is paramount to curbing the diabetes epidemic. With this understanding, the appropriate screening, preventative and therapeutic strategies can be implemented and further developed. (Shah, A. & Kanaya, A.M. Curr Cardiol Rep (2014) 16: 476. https://doi.org/10.1007/s11886-014-0476-5)

The OHT area is also home to large populations with African, Arab and Hispanic roots, which are also known to be predisposed to diabetes according to Diabetes Canada.

In 2017/18, the OHT's attributed population included approximately 6,200 people who had diabetes with other conditions as their most complex and clinically relevant health condition. According to the data package provided by the Ministry, these patients accounted for total health costs of $85,386,318 during 2017/18.

In addition to diabetes having a large impact on the OHT's population, focusing on diabetes for Year 1 will be a proof of concept for the ICH to scale and spread.

By focusing on these two approaches for Year 1, the OHT will implement and improve integrated care for a larger number of patients included in the attributed population and implement targeted interventions for a smaller subset of patients with specialized needs that can be applied to other complex populations in the future.

1.3. Are there specific equity considerations within your population? (1000 words)

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

Maximum word count: 1000

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

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

The OHT's approach to regional equity addresses a high and growing number of recent immigrants, a high percentage of residents who speak neither of Canada's official languages, and low socio-economic status.

Indigenous Populations

The OHT geography traverses both the Credit and Humber Rivers as well as Etobicoke Creek, significant historical travel routes for Anishnaabe, Huron-Wendat, Haudenosaunee, Petun, and Mississaugas of the New Credit nations. While no First Nations are within the region, about 1% of the population identifies as Indigenous and/or Métis. Affiliated with Métis Nation of Ontario, the Credit River Métis Council represents its local constituency. A range of holistic, culturally-appropriate services are offered by the Métis Nation of Ontario office in Brampton and by the Peel Aboriginal Network/Indigenous Friendship Centre close to the Mississauga-Brampton border.

Epidemiological studies, health status profiles, and community narratives of Indigenous health all point to diabetes as a significant and even devastating population health challenge. Data released by Métis Nation of Ontario and ICES (2012) indicate:

- Prevalence of diabetes among registered Métis in Ontario was 26% higher than the general population, and incidence was 24% higher; and
- Métis people with diabetes were 18% less likely to receive care from a diabetes specialist, and 86% were more likely to be hospitalized due to a heart attack or pre-heart attack.

[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.

While not specific to Peel Region, *Our Health Counts*, a ground-breaking research project led by Well Living House (St. Michael's Hospital) and Seven Generations Midwives, is generating new evidence (released 2016) on urban Indigenous health in Toronto:

- 65% of Indigenous adults reported having one or more chronic condition;
- 38% of Indigenous adults experience multiple chronic health conditions, compared to 15% of the general population; and
- Twice the prevalence of diabetes compared to the general adult population.

The OHT's Year 1 focus on diabetes and overall population health focus aligns with chronic disease evidence, patterns and risks prevalent in Métis/urban Indigenous communities. The model embeds health equity principles that improved care, more integrated prevention and management, and culturally-appropriate services can help close the Indigenous health gap. See section 3.7.1 for details of how the OHT will engage Indigenous populations.

Francophone Populations

The OHT is located within the Regional Municipality of Peel, one of the 26 designated French Language Services (FLS) regions in Ontario. There are 12,095 Francophones living in the OHT area, or about 2% of the total population. Nearly half of Francophones living in this region were not born in Canada (*Office of Francophone Affairs, 2016*). Research shows that 39.1% of Francophone immigrants come from Europe and 26.9% from Africa. Additionally, one in two Francophones identifies as a visible minority (*Office of Francophone Affairs, 2016*).

Health considerations include:

- 73.7% of the Francophones living in the OHT catchment area self-perceived to be healthy and 85.1% reported access to a regular doctor (*Selected Health Indicators for Francophone vs. Non-Francophone (Inclusive Definition of Francophone), Percent by LHIN & Ontario, CCHS, 2013-2014*);
- 248 Francophones in the OHT's catchment area (0.03% of the OHT population) seek primary care in other geographical regions, such as at the Centre Francophone de Toronto (*Centre Francophone de Toronto, Client Mapping by region, 2019*); and
- 41.1% of Francophones have at least one chronic condition compared to the general population (32.4%) and 60.7% have two or more risk factors for chronic conditions, which is similar to the general population (*Selected Health Indicators for Francophone vs. Non-Francophone (Inclusive Definition of Francophone), Percent by LHIN & Ontario, CCHS, 2013-2014*).

There are currently no FLS designated health service providers in the region; however, LHIN-funded partners have provided services to 558 Francophones in 2018/19 (*Reflet Salvéo: OZI Report, 2019*). Based on the same report, 43% of Francophones received services at a hospital and 41% received services from a community health centre (CHC).

Other Equity Considerations

The OHT is located in one of the most diverse regions in the province with Brampton, Bramalea and North Etobicoke having among the highest immigrant and visible minority populations in Ontario. More than 50% of the residents of all three Sub-regions are immigrants. Of Ontario's 76 sub-regions, North Etobicoke, Malton, West Woodbridge (NEMWW) has the seventh highest percentage of residents who are immigrants and who are first generation Canadian. NEMWW and Bramalea are in the top 10% of Sub-regions for

recent immigrants (residents who immigrated within the past five years). NEMWW and Bramalea are also both in the 10% of Sub-regions with the highest percentage of residents who report no knowledge of English or French. This lack of language ability in a substantial proportion of the OHT's population can lead to barriers to access. More than 65% of the residents in the OHT identify as visible minorities, with Bramalea, at 77.9%, being the second highest in the province. In the 2016 census, more than 73% of Brampton residents reported belonging to a visible minority group, with South Asian (60.4%), Black (18.9%), and Filipino (4.6%) being the most commonly identified groups (Statistics Canada, Census of Canada 2016). Research highlights that health disparities (differences in health status) widen when recent immigrants and marginalized or disadvantaged groups face barriers to receiving the care they need, like access to primary care, mental health or community supports. Studies examining cardiovascular health profiles in Ontario suggests that there two-fold higher risk of diabetes among South Asian and Black groups than among Caucasian and Chinese groups (Chiu M et. al. CMAJ, 2010).

Socio-economic factors are also a barrier to access in NEMWW sub-region which include:

- 19% of residents living below the low income measure;
- proportion of households in the lowest income quartile is 27%;
- the sixth highest percentage of children under six living in low-income households; and
- the eighth highest percentage of children under 18 living in low-income households.

There is a consistent spatial relationship between prevalence rates of diabetes and lower socio-economic status (SES) in all three sub-regions (Institute for Clinical Evaluative Sciences, 2005).

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

[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 2.1.1. If you are unsure of where to list an organization, please contact the MOH.

Name of Physician or Physician Group	Practice Model[4]	Number of Physicians	Number of Physician FTEs	Practice Size	Other

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

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)*

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

[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

2.2. How did you identify and decide the members of your team? (500 words)

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.

Maximum word count: 500

The OHT engaged all sectors pertaining to the social determinants of health in a process to build relationships, trust and a common understanding of the collective community's needs.

To develop the Self-Assessment, an open invitation was created for health care and related services to provide input on how integrated care could be improved in the region. Over 70 cross-sector partners continued to meet biweekly to develop the OHT vision. The inclusive approach to planning allowed meaningful participation from community support/social services, home and community care, specialists and digital partners to be engaged from the outset. As the vision was defined, partners identified their own level of commitment and involvement in the Full Application, in addition to identifying other partners who should be included.

Engaging primary care providers (PCPs) was a priority and was led by PCP volunteers from Queen Square Family Health Team (FHT), Castlemore Family Health Group (FHG), Claireville FHG, West Vaughan Family Health Organization (FHO), Brameast FHO, Woodbine FHT and others through information sessions, office visits and surveys. Physicians committed to the OHT by signing a declaration of intent to signal their interest in being involved. Endorsement of this approach by the Ontario Medical Association helped to provide reassurance to PCP partners.

Challenges

While the current OHT membership is strong, the OHT anticipates an evolution in membership over time. Some partners intend to participate fully in the operations of the OHT, but are uncertain about the level of legal commitment (member versus affiliate). This is especially true for PCPs who have not participated in accountability agreements with government in the past, and for community services partners serving large geographies. Further information on these agreements will enable the OHT to expand and cement membership.

Year 1 Population

The OHT is confident that it can deliver care to the Year 1 population, as this population is a subset of the rostered patients of member PCPs, and services are already being delivered to these patients. Some strategic advantages related to the health needs of the OHT's attributed population at Year 1 and maturity include:

- Cross-sectoral partners including social, community support, rehabilitation and clinical services;

- Diverse areas of expertise including ethics, community engagement, patient and family engagement, quality improvement, analytics capacity, enterprise risk, etc.;
- Patients, caregivers and community members guiding development;
- Multiple primary care practice models (Community Health Centres, FHTs, FHGs, FHOs, solo practitioners) representing diversity in practices and guiding design and implementation;
- Specialists in primary care, endocrinology, nephrology, internal medicine, radiology and psychiatry developing the primary care specialist access model and diabetes care pathway;
- Digital and education partners creating innovative ways to approach digital health, training and workforce development to respond to new integrated care delivery systems;
- Region of Peel/Peel Public Health providing population health and municipal expertise; and
- Deliberate outreach to regional partners with diabetes expertise (e.g. Lifestyle Management Clinic Healthcare).

In the future, additional retail partners (grocery chains, pharmacies etc.), digital partners and labs may be needed to advance the OHT towards maturity based on examples in other jurisdictions.

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)*

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

2.4. How have members of your team worked together previously? (2000 words)

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.

Maximum word count: 2000

OHT partners have both formal and informal working relationships and are comfortable in formalized partnership relationships.

Partners have worked together through the development of shared clinical pathways and patient care, Health Links, bundled care, shared back-office and administration support, joint procurement and targeted initiatives to improve health on a population-level scale/reducing health disparities. Examples include:

1. Development of shared clinical pathways or shared patient care
    - <u>In-STED (In Short-Term Emergency Department Diversion)</u>
      Team Members: Canadian Mental Health Association Peel Dufferin (CMHAPD), Supportive Housing in Peel, and Punjabi Community Health Services, William Osler Health System (Osler)
      Length of Partnership: Established 2015/16
      Scale and Scope: Emergency Department (ED) diversion program where individuals with mental health and/or addictions concerns are offered additional services. Hospital staff refer to In-STED, where CMHAPD staff, using their knowledge of community-based services such as emergency housing/community case management/social support/addiction services, complete assessments and develop plans for immediate individualized care. In addition, the In-STED team offers short-term crisis planning for individuals being discharged from the ED with next day telephone follow-up and access to short-term case management provided by partnering community agencies. The combined knowledge and services offered by In-STED collaborative services effectively supports individuals needing immediate community-based services and has resulted in a significant reduction in unplanned repeat visits to the ED.

Intended Outcomes: In 2015/16 there was a 61% decrease in repeat ED visits once In-STED was involved (comparing pre and post 30 day ED visits). By the end of 2017/18 there was a 65% reduction in the rate of ED visits. The driving factor behind the success of the program is the ability of the hospital and community to work collaboratively as partners to jointly support clients/patients and their families seeking help in an emergency situation.

- Transitional Care Program
  Team Members: Central West Local Health Integration Network (LHIN) Home and Community Care, Osler and Headwaters Health Care Centre
  Length of Partnership: January-August 2019
  Scale and Scope: 68 patients designated alternative level of care (ALC) or at risk of being designated ALC.
  Results: 94% success rate for preventing hospital readmission and an average of 27 days of length of stay in the program.

- Group Mental Health Workshops
  Team Members: Central Brampton Family Health Team (CBFHT), CMHAPD
  Length of Partnership: Established Q1 2019/20
  Scale and Scope: Quarterly workshops for reaching CBFHT patients, BramEast Family Health Organization (FHO) patients and community members dealing with mild to moderate anxiety and depression, looking for more support. Workshops include interactive sessions that help patients understand their feelings, thoughts and behaviours, and what to do about them. CMHAPD manages the intake and registration with CBFHT as the host site. The CBFHT location removes stigma and has no cost for parking, which provides ease of access to attend workshops.
  Intended Outcomes: To equip participants with coping skills to help reduce feelings of anxiety and depression.
  Results: The first session had full attendance throughout the 8 weeks.

- Support for Caregivers of Patients with Dementia
  Team Members: CBFHT, Alzheimer Society Peel (ASP)
  Length of Partnership: Established 2017/18
  Scale and Scope: Collaboration to provide caregiver events started with ASP when it was recognized that caregiver support was not being held in the Brampton area. CBFHT offered space to host and help recruit caregivers to provide much needed support. Caregiver education and events provided by ASP.
  Intended Outcomes: The purpose is to provide to patients and community members who provide care for someone with a diagnosis of dementia. Multiple topics are discussed which have intended outcomes of reducing caregiver burnout, informing on dementia trajectory, and improving communication between patients, caregivers, and health care providers.
  Results: Size of groups have steadily increased to be at maximum capacity (due to the size of the program room, the size of the group is limited to 15).

- Chronic Pain Self-Management Program
  Team Members: CBFHT, WOHS
  Length of Partnership: Established Q1 2019/20
  Scale and Scope: Self-management programs facilitated by Osler at CBFHT open to patients and community members. CBFHT had a pre-existing relationship with Osler for this specific program, but the partnership was revisited in Q1 of 2019/20 to provide the Chronic Pain Self-Management Program outside of Osler to allow for increased access and free parking. The hope is to offer a self-management program on a quarterly basis and alternate between the pain and chronic disease management programs.
  Intended Outcomes: Provide attendees with the skills necessary to manage their condition and improve quality of life.
  Results: The pain management session held in Q2 had three participants. The low number can be attributed to a short recruitment period. The goal is to have at least eight participants going forward. The goal is to increase awareness of the importance of self-management and understanding chronic diseases.

- The Gift of Motherhood eLearning Prenatal Program
  Team Members: Region of Peel, Osler
  Length of Partnership: From 2015 to 2018
  Scale and Scope: Peel Public Health on-line prenatal education program; Peel Postpartum Mood Disorder Program is a community collaborative which aims to build community capacity to respond to families at risk for, or experiencing, postpartum depression; Peel Public Health is supporting Osler in their efforts towards Baby Friendly designation and have implemented a Healthy Babies Healthy Children Letter of Agreement to book home visits that facilitate new parents to transition home.
  Intended Outcomes: To increase access and reach of free eLearning prenatal education program to pregnant families in Peel, Peel partnered with William Osler Health System in 2015 to December 2018.
  Results: Since 2015, 5,777 individuals have participated in the the Gift of Motherhood eLearning Prenatal program.

- Bridging to Addictions Program
  Team Members: Peel Addiction Assessment and Referral Centre (PAARC), Osler, Punjabi Community Health Services and CMHAPD
  Length of Partnership: Established in 2015
  Scale/Scope/Intended Outcomes: Support clients/patients from withdrawal management and Health Links who require further treatment. Clients/patients who are identified as having comorbidities are seamlessly referred to PAARC and partners for coordinated care planning.
  Results: Results show that clients/patients (n=60) received seamless access to addictions support from Osler's Withdrawal Management Centre. All clients, including those who are mandated from DTC, Probation and Parole and/or CAS, receive addictions counselling with little to no wait for service.

- Prevention of Error-Based Transfers (PoET)
  Team Members: Osler, Long-Term Care homes in Central West LHIN
  Length of Partnership: Established 2011
  Scale and Scope: PoET helps to prevent unnecessary or unwanted

transitions between long-term care homes and hospitals. It is based on an ethical obligation to provide treatment that long-term care residents in end-of-life care want, and can benefit from.
Intended Outcomes: Reduction of error-based transfers across a variety of care settings.
Results: To date, there has been a 59% reduction in repeated end-of-life transitions for long-term care residents between care settings in the Central West LHIN. The initiative received a $1.5 Million grant from Health Canada as part of the PoET Southwest Spread Project.

- <u>William Osler ProResp (ProResp) Joint Venture</u>
  Team Members: ProResp, Central West LHIN, Osler
  Length of Partnership: Approximately 20 years
  Scale/Scope/Intended Outcomes: William Osler ProResp is a joint venture partnership to accomplish seamless transitions of care from hospital to home for respiratory compromised patients, including the very technically complex respiratory patients with support from the LHIN.

- <u>Other</u>
  - Central West LHIN care coordinators and primary care providers (Queen Square FHT and other FHTs) have collaborated to ensure patients receiving home and community care services stay connected to primary care, including patient care planning and review of service needs to keep patients out of hospital.
  - Right at Home has developed shared patient care mechanisms with CBI Home Health (sub-contracted relationship) and Indian Rainbow.
  - WeCare Health Services has worked collaboratively with partner home care organizations and hospitals to create clinical guidelines and pathways to conduct interprofessional education to support safe and effective care when transitioning patients home from the hospital and when caring for patients in the community.

3. Participation in Health Links
   - Many partners have participated in Health Links with the aim of working better together to support patients with complex care needs through greater collaboration and the development of Coordinated Care Plans (CCPs). These include:
     i. CBFHT
     ii. Rexdale Community Health Centre (CHC)
     iii. WellFort Community Health Services
     iv. Central West LHIN Home and Community Care
     v. 1to1 Rehab Group
     vi. CANES Community Care
     vii. Brameast FHO
     viii. Queen Square FHT and FHO
     ix. Closing the Gap Healthcare Group
     x. Punjabi Community Health Services
     xi. WeCare Health Services

xii. Woodbine FHT
xiii. Saint Elizabeth (SE) Health
xiv. CMHAPD
xv. HeartHouse Hospice
xvi. Peel Senior Link
xvii. The Regional Municipality of Peel
xviii. PAARC

4. Bundled Care

- Hospital2Home (H2H) is an innovative model of care starting in 2016 between Osler, the Central West LHIN, Headwaters Health Care Centre and Ontario Telemedicine Network (OTN) that helps improve clinical handoffs and information-sharing when patients leave hospital. Patients receive short-term nursing from H2H staff who are able to seamlessly access patients' health records. The use of OTN has strengthened quality of care and overall communication among health care providers. Within a year of launch, in 2016, 740 patients received 6,500 in-home nursing visits though the program.
- West Park Healthcare Centre has implemented bundled care related to stroke and bilateral joints which supports timely access to rehabilitation services for the Etobicoke population.
- Closing the Gap Healthcare Group has worked with Osler through the hip and knee bundled care program where they serve Osler post-hip and knee patients in Community Physiotherapy Clinics.
- Osler has participated in a bundled care and funding pilot for unilateral hip and knee surgeries in collaboration with Central West LHIN Home and community care and various other community physiotherapy providers in the community. The pilot was completed successfully and Osler continues to provide oversight along the continuum of care as a bundle holder for these services.

5. Shared Back Office
   - Osler, Headwaters Health Care Centre and the former Central West Community Care Access Centre (CCAC) completed a formal integration relating to back-office support in 2013. This collaboration was dissolved as part of the merger of the CCACs into the LHINs in 2017.
   - Peel Senior Link collaborated with CANES and ESS on a voluntary joint venture concentrating on shared back-office support and joint procurement from 2011-2015. The intended outcomes of the partnership included enhanced service capacity and back-office support (common banking institution, group benefits program, CM software, Accreditation Canada approvals, pre-qual with the Ontario Association for CCACs for contracts, and shared legal and consulting services). Through this venture, Peel Senior Link expanded assisted living service capacity by 60 clients. The joint venture received Voluntary Integration Designation by the Central West and Mississauga Halton LHINs.

6. Joint Procurement
   - CANES has participated in joint procurement as described above.

7. Targeted Initiatives to Improve the Health of a Population
    - Queen Square FHT has developed targeted programs based on the Health Links population including diabetes, geriatrics, palliative and mental health.
    - Healthy Communities Initiative (HCI): the Central West LHIN, Region of Peel and Osler – in collaboration with the City of Brampton, local school boards and a diverse group of community partners – have been working to address population health through the HCI. HCI's vision is a healthy community in which all residents have the environments and opportunities to achieve better health and wellness. HCI is informed by a simple and internationally-recognized prescription for promoting and maintaining population health (5-2-1-0).
    - Rexdale CHC and WellFort Community Health Services conduct community needs assessments and interventions including: food security initiatives, Pharmacy Program, Healthy Kids Community Challenge to address childhood obesity, a social prescription program, public education, and preventative health/screening activities (e.g mass diabetes screening, blood pressure screening, influenza immunization and public awareness activities).

Many primary care provider members have also have working relationships with each other and with non-physician members of the OHT. These relationships will be strengthened during Year 1 and beyond.

2.5. How well does your team's membership align to patient/provider referral networks? (500 words)

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?

Maximum word count: 500

Alignment between the OHT's current membership and the provider networks identified by the Ministry is **moderate**.

A significant reason for this level of alignment is that in the region, almost a third of patients use walk-in clinics and a significant number have fee for service physicians who are in solo practices. The data packages provided by the Ministry do not yet include details about solo practitioners and specialists. As such, it is difficult to gain a complete view of the alignment. Currently, the OHT has three solo practitioners who do not belong to any patient enrollment models as members.

The OHT's membership consists of providers who deliver services in the Brampton and Etobicoke areas, to residents of Brampton, Bramalea, and North Etobicoke, Malton and West Woodbridge (NEMWW) Sub-regions. Many of the PEMs identified in the Ministry's data set do not operate in this geography, and in some cases, were previously thought to be affiliated with other prospective OHTs.

Primary Care

There are 18 PEMs listed in the Ministry's data package with patients in a network that aligns with a different OHT. Of these, the OHT is engaged with only three, which suggests that those care providers may have thought themselves more closely aligned with a different prospective OHT. Of the remaining 41 Ministry-identified PEMs, the OHT has partnered with 17 as members. The OHT is open to engaging with the primary care providers (PCPs) that are not currently members, and collaborating with neighbouring OHTs about patients who seek care across networks. Given the provided data, a primary care engagement strategy has been developed to engage the PCPs identified by the Ministry. Since the Self-Assessment, a number of PCPs have been added as members by indicating their willingness to participate through a declaration of intent.

Acute Care

William Osler Health System is the only acute care organization in the OHT. Patients included in the data package provided by the Ministry were also discharged from Holland Bloorview

Rehabilitation Kids Hospital, and the OHT will engage with Holland Bloorview Rehabilitation Kids Hospital to ensure continuity of care for shared patients.

Specialist Care

A number of specialist groups have indicated interest in providing services to the OHT, specifically for complex patients with diabetes and more generally for other services. The OHT has not received information about specialists in the network and it is difficult to comment on the degree of alignment.

Shared Populations

The data provided on the OHT's attributed population show that other prospective OHTs share some patients. The OHT has contacted these OHTs (Mississauga, North Toronto, and University Health Network) to explore how to best provide seamless care to these patients. Patients requiring certain community support, rehabilitation, tertiary and quaternary health care services (e.g. cardiology) are likely to continue to cross OHT boundaries as part of their care journey.

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 2.5.1.

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)

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

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)*

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

2.7. What is your team's integrated care delivery capacity in Year 1? (500 words)

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.

Maximum word count: 500

Year 1 Integrated Care Population Estimate

System Navigation

It is anticipated that the OHT's Year 1 population will receive an initial level of system navigation via the Integrated Care Hub (ICH), elaborated further in Section 3.3.2.

Existing Integrated Care

The OHT's Year 1 population totals approximately 200,000 patients, as defined by the rosters of member primary care providers. Of this amount, approximately 79,250 patients belong to Family Health Teams (FHTs), where they receive integrated care that is actively coordinated across many aspects of the care continuum. The FHTs have been highly engaged in the design and development of the OHT, and are willing to champion the evolution of integrated care delivery models within the OHT to ensure patients continue to receive integrated care.

The approximately 120,750 remaining patients are part of Family Health Organizations (FHOs), Family Health Groups (FHGs), and solo fee-for-service practices that may not have readily available access to integrated care resources. The ICH will help to improve integrated care for these patients.

Fully and Actively Coordinated Integrated Care

In Year 1, complex patients with diabetes and other chronic conditions will receive fully and actively coordinated care across the continuum. According to the Ministry data package, there are 41,874 people attributed to the OHT whose most significant medical condition is diabetes. Of these, 6,236 have diabetes with other disease or with significant comorbidities. The Year 1 complex diabetes population will be a subset of these.

Actions to Support Year 1 Population Patients

In Year 1, the OHT will work towards creating an ICH to serve as a central access point for care coordination and navigation services. This will build off of the central intake lead agency model that the Central West Local Health Integration Network (LHIN) has developed. For complex patients with diabetes who require fully integrated care in Year 1, the ICH will act as a "quarterback" for their care, ensuring they receive appropriate services based on their needs. The ICH will also be the central point of access for primary care to refer their complex patients with diabetes.

For other patients, primary care providers will have access to the SCOPE model (elaborated further in Section 3.2) through the ICH, which will provide patients with more comprehensive services as required.

The following actions will be taken in Year 1 to develop the ICH to serve this care coordination function:

- Complete an inventory of organizations that have embedded coordinated care functions like home and community care, community support service providers, and transition coordination (currently in progress);
- Repurpose Central West LHIN central call-in number for the ICH;
- Stratify/segment population by levels of risk and resource intensity ; and
- Working closely with primary care, community care, home care, and acute care, local Lifestyle Management Clinics (LMCs), as well as local endocrinologists and nephrologists, will develop robust care pathways for complex patients with diabetes to ensure that pathways capture preventative as well as responsive care.

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.)*
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)				

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.)*
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)				

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

2.9. How will you expand your membership and services over time? (500 words)

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.

Maximum word count: 500 words

In Year 1, the OHT will build a "proof of concept" Integrated Care Hub (ICH) that meets the needs of rostered patients of member primary care providers (PCPs).The concept of the ICH is patient and primary care focused, and is a catalyst for future elements of home and community care.

In Year 2, the OHT will focus on the same population, but serve additional patients from PCPs attributed to the OHT who have not signed on as members and expand the diabetes care pathway to include further levels of risk stratification. The following members, collaborators/affiliates and services will be added:

- Additional PCP members for the attributed population (Patient Enrollment Models (PEMs) and solo practitioners) will provide access to the ICH for their patients. The goal is to have 50% of the attributed PEMs connected to the OHT in Year 2;
- Additional specialty and community services for diabetes as additional pathways are identified that require rehabilitation services (e.g. West Park Healthcare Centre), palliative care (hospice services), and paediatric, cardiology, nephrology and psychiatry services; and
- Additional specialist consults available for PCPs as part of the SCOPE model, as defined by the needs of PCPs.

In Year 3, the OHT plans to build on the Health Links philosophy of care and expand the central intake proof of concept to all patients with chronic conditions included in the OHT's attributed population. This expansion will require partnerships with specialist and community support services who are skilled at managing complex conditions in the community. In addition, the OHT will seek to include additional PCPs from the OHT's attributed population who will connect their patients to the ICH and access primary care support resources through SCOPE. Prioritization of these services will take into consideration the population data for the OHT's attributed population. For example, dementia, palliative care and respiratory failure with heart failure represent some of the most costly conditions (either total or per patient cost), with low birth weight and pre-term birth rates presenting higher in the OHT's attributed population compared to the province.

At maturity, the OHT anticipates providing care from birth to death for its attributed population, with an emphasis on upstream, preventative care. The OHT anticipates entering into partnerships with additional health, social and community support service providers as the

model expands and improves, including local pharmacies, walk-in clinics, schools, dentists, etc.

The major challenges associated with expanding membership beyond Year 2 is providing adequate resources through the ICH to meet patient/primary care demand. According to the SCOPE model experience in Toronto, one nurse navigator can provide service to approximately 200 physicians. It may be possible to resource the SCOPE service through the ICH for attributed PEMs, but the added demand from patients will require close monitoring to scale the ICH appropriately due to the OHT's large attributed population. The inclusion of home care providers is also important in the model, requiring significant and meaningful engagement of these providers. Clarity on how home care regulations will evolve will be welcomed.

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.

Maximum word count: 500 words

Through a dedicated primary care engagement strategy, the OHT has had a significant and comprehensive focus on primary care and physician engagement as it is believed the OHT must be rooted in primary and community care. The efforts made to date to engage primary care providers (PCP) include:

- Multiple physician information sessions, created and delivered by primary care physicians;
- Primary care physicians as members of the OHT's Planning Committee who are informing primary care engagement approach;
- Outreach to all physician offices directly by primary care physicians (who are volunteering their time), creating brochures and information packages regarding the benefits of the OHT;
- Creation of SCOPE model (primary care access to urgent specialist and navigation services) designed by PCPs in partnership with acute care, specialists, community partners and informed by PCP survey; and
- In addition to current efforts to engage PCPs, the OHT will continue to expand primary care partnerships through:
    - Creating and marketing the SCOPE model to help attract additional PCPs to participate in the OHT – there is a requirement to become a member of the OHT to access services;
    - Ongoing outreach, clinic visits, information sessions with PCPs with OHT physician leadership; and
    - Creation of a primary care governance structure, including a community Medical Advisory Committee, to conduct active communications and outreach and ensure balanced representation of primary care in decision-making.

Since receiving the list of primary care practices that are part of the OHT's attributed population, the OHT has arranged in-person office visits with PCPs that have not been involved in OHT discussions to date to build relationships and provide education about the OHT and Integrated Care Hub and to discuss possible future partnerships. At least one

patient enrollment model (PEM) that was not an existing partner has expressed interest in collaborating with the OHT.

2.10. How did you develop your Full Application Submission? (1000 words)

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.

Maximum word count: 1000

The process used to develop the Full Application submission was a participatory process involving all partners and reflects consensus across the entire membership. No third parties were involved in the completion of the submission. To achieve consensus across the entire membership, the following working group structure was created:

The **OHT Partner Meeting** is a forum of all partners that came together every two weeks (or weekly as needed) to brainstorm, review, approve and provide feedback on submission components through table top discussions, speaker presentations, question and answer sessions, and voting where required.

Supporting the OHT Partner Meeting were various working groups that comprised up to 20 members including clients/patients and community members, primary care physicians and nurse practitioners, specialist physicians, and leaders from many sectors including home and community care, community support services, social services, acute care, specialty care, and more (see diagram of groups in Appendix 2).

The **Governance and Foundations Working Group** developed the transitional oversight and management structure for the OHT in Year 1, including considerations for funding, decision-making, dispute resolution, and common branding.

The **Digital Infrastructure and Operations Working Group** developed the digital health strategy for the OHT and functional and structural requirements to develop and implement the Integrated Care Hub (ICH). The digital group held regular meetings where input was collected from each member, discussed and consolidated.

The **Care Management: Primary Care Provider Access to the Hub Working Group** developed the specialist access model for primary care providers (i.e. SCOPE model) and featured many primary care providers and specialists in the group. Surveys were conducted with broader primary care sector partners to understand the needs of primary care providers to further design the model.

The **Care Management: Diabetes Care Pathway Working Group** developed the model for the diabetes care pathway through the ICH, considering the Year 1 target population. Clients/patients, organizations with diabetes services, and specialists (e.g. endocrinologists and nephrologists) participated in the working group to design the model.

The **Care Management: People Access to the Hub Working Group** developed the ICH model further, taking into consideration direct feedback from clients/patients, PCPs, home and community care providers, specialist physicians, and community support services who were all members of the group.

The **Planning Committee** served as the secretariat for the development of the application. With 15-20 members from across all sectors, this group supported the planning process and writing of the Full Application.

In addition to having clients/patients as working group members and OHT Partner Meeting participants, in-person Patient and Community Engagement events were held at the Central West Local Health Integration Network (LHIN) and Rexdale Community Health Centre (CHC) and an online survey was distributed to all partner Patient and Family Advisory Councils (PFACs), Resident Councils, and other structured committees for client/patient feedback. Surveys were also printed and distributed across waiting rooms and other venues by partner organizations. Nearly 400 individuals from the community provided feedback through the survey and the in-person event (Appendix 3). The Patient and Community Engagement event and surveys were translated into Hindi, Punjabi, and French and responses received in these languages were translated back into English and incorporated into the design of the various OHT components by the working groups. Examples of where feedback was incorporated include how the ICH supports transitions from hospital to the community, self-management resources for patients as part of the diabetes care pathway, and the changes proposed to home and community care.

The Central West LHIN PFACs featured a Francophone representative, who participated in various working groups to design the ICH and other aspects of the OHT. The OHT has also partnered with Les Centres d'Accueil Héritage on the *Leadership Training on Active Offer* to gain a greater understanding of the importance of French Language Health Services as part of the Ministry's transformational agenda to provide a connected health care system centred around patients, families and caregivers, including Francophones. A session on *Leadership Training on Active Offer* was held on October 2nd, 2019 for the OHT Planning Committee.

Additionally, online surveys have been distributed by Reflet Salvéo during the month of September 2019 to receive feedback from the Francophone population, and Francophone representatives have been asked to participate in the co-design of care pathways as part of the working group. Their feedback on active offer of French Language Services (FLS) and identification of language of care will be incorporated in the design of all the OHT's functions. The OHT will continue to include the Francophone lens to ensure care coordination and navigation are available in French and to promote active offer of French Language Services by partnering with designated French Language Services providers as appropriate. Through the Central West LHIN, the OHT will continue to pursue collaboration and engagement with Reflet Salvéo, the local French Language Planning Entity.

Finally, the Regional Municipality of Peel supports this application as a signatory member.

The process of having cross-sectoral working groups that designed elements of the OHT with meaningful client/patient and community input, and validating ideas at broader OHT Partner Meetings, helped to create consensus and meaningful engagement for all members involved. Two information sessions for governors of all partners were organized by the Governance and Foundations Working Group where collaborative governance models and education on legal, regulatory and other considerations were addressed.

The catchment area of the OHT does not overlap with any First Nation communities. However, engagement activities will be undertaken to understand the specific care needs of these communities and will be reflected in the OHT's planning processes.

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? (1000 words)

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.

Maximum word count: 1000

The OHT partners co-created First Principles for achieving integrated care that serves as a guiding vision. Highlights include:

1. Working towards accessible, cost-effective and integrated care that puts people at the centre;
2. Acting as one team sharing information and resources to optimize outcomes for clients/patients, families and caregivers; and
3. Building on members' strengths to improve health care in the region.

To achieve these, the OHT envisions redesigning care by:

- Creating a central Integrated Care Hub (ICH) to provide 24/7 care coordination and system navigation services for clients/patients/caregivers. Together with front line delivery practices, the ICH will expand virtual-care offerings and increase the availability of patients' digital access to their own health information;
- Developing/testing a system-wide diabetes strategy through the ICH to stratify the diabetic population based on social, behavioural and medical risk and standardizing a care pathway for complex patients that includes self-management and health literacy supports; family and caregiver education; and
- Creating a central service for primary care providers (i.e. SCOPE) to access specialists and system navigation services through the ICH.

Improvement opportunities identified for Year 1 were based on:

- The Quadruple Aim;
- The services/interventions mentioned above; and
- A pragmatic assessment of the OHT's capabilities/resources in Year 1, including identifying opportunities for early successes.

With these in mind, the most important performance improvement opportunities for the OHT are:

- Timely access to primary care;
- Avoidable emergency department (ED) visits (ED visit rate for conditions best managed elsewhere);
- Rate of hospitalization for ambulatory care sensitive conditions (ACSC);
- 7-day physician follow up post-discharge; and

- 30-day inpatient readmission rate.

The Quadruple Aim guided the OHT's prioritization of improvement opportunities by taking the following into consideration:

Informing The OHT's Approach

Clients/patients/caregivers and the broader community were engaged to provide input on what integrated care means to them. Nearly 400 survey responses were received virtually and in-person, along with feedback from in-person community engagement sessions and client/patient advisors on OHT working groups. Key themes included:

- Improved System Navigation and Care Coordination: clients/patients need assistance with navigating through the system, and would value help to avoid feeling lost;
- Collaboration between Providers: clients/patients are frustrated with how disconnected the system is and want providers to be coordinated;
- Clients/Patients as Individuals: all clients/patients are unique, and want their care to reflect their own needs including health and social needs;
- Reduced Steps: clients/patients have experienced issues with the number of steps in the system and an overall lack of understanding about what the next step is in their care;
- Caregiver Support: caregivers are an important part of client/patient care and clients/patients want better support for caregivers, including housekeeping and respite services;
- Access to Their Own Records: clients/patients want to be able to access their own record and share it so they do not have to repeat their story; and
- Equity Across the Region: clients/patients should receive the same, high quality of care regardless of where they receive it.

The Diabetes Focus

The top 10 Health Profile Groups for the attributed population show uncomplicated diabetes accounted for the largest number of clients/patients (35,000+). Additionally, over 6,236 of clients/patients have diabetes with significant comorbidities. Given these numbers and that diabetes is a precursor to many comorbidities, OHT partners recognized the opportunity to improve care for this segment of the population in Year 1.

The costs for diabetes-related conditions in the OHT's attributed population totaled over $107M in 2017/18. OHT partners recognize the opportunity to improve care for this population and reinvest savings to provide the most effective care within available resources.

The OHT does not expect any of the performance measures to shift for the entire attributed population (871,852 patients) in Year 1. However, the OHT does expect a shift for the Year 1 population - complex patients with diabetes. Diabetes is explicitly included in the ACSC and inpatient readmissions indicators, and the OHT anticipates that the diabetes care pathway will have a measurable impact for this population. The OHT further anticipates that the 24/7 care coordination and system navigation services provided by the ICH will assist with access to primary care both from the community and from the hospital, as well as avoidable ED visits.

The OHT also hopes to provide the most effective care within available resources for the Year 1 target population.

Provider Experience

Primary Care Providers from all payment models, and health and related services from across the region identified the following priorities for the OHT:

- Support primary care as the first point of contact in the system;
- Create a central intake for all health and related services to enable better coordination and a “one stop shop” for providers;
- Improve data collection to better understand the complexity level and needs of the entire population in order to plan and deliver upstream services;
- Ensure readily available access to specialists and navigation services to keep people healthy in the community and navigate to the right resources; and
- Create one ‘source of truth’ electronic record with all pertinent information to provide seamless care.

Based on the Ministry’s data package, the OHT identified the following performance measures to focus on in Year 1, as outlined in Appendix 4.

These metrics represent opportunities to set stretch targets and achieve early successes based on the Quadruple Aim and capabilities/resources in Year 1, leading to increased momentum and stronger partnerships. As the ICH is scaled, additional integrated care indicators are expected to improve.

3.2. How do you plan to redesign care and change practice? (2000 words)

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.

Maximum word count: 2000

Many partners of the OHT have been working together to improve care for years. The OHT has presented a significant opportunity for partners to come together in a different way to create a new collective vision. To that end, the OHT intends to continue:

1. Co-creating with OHT partners, physicians, clients/patients/caregivers and the community the Integrated Care Hub (ICH) structure, services and functionality, the SCOPE model, and complex care pathways (initially diabetes).
2. To build and refine the joint performance and process measures.
3. To build on OHT partners' existing cross-sectoral quality improvement plans.
4. Better understanding the OHT's collective attributed populations through shared data analysis and alignment of measures and strategies; and
5. To test, analyze and refine new pathways, models and care transitions.

The process of developing this application has already been an exercise in working together. Participants from across all sectors have been devoting their time and expertise to draft, test, and revise the substance of the plan. This process has been exciting, and laid a solid foundation for future collaboration in the delivery of health and related services to the attributed population.

OHT members have substantial resources already in place within their organizations, and share significant knowledge and experience partnering together and reviewing together the health needs and services in the region. The OHT's Year 1 plan is to create synergies by standardizing and co-locating some of the services provided by the OHT partners, and reducing duplication where possible.

To date, OHT partners have been coming together regularly (weekly, bi-weekly and more often) as part of various cross-sectoral working groups (approximately 15-20 members each) to design the OHT. Working group and project teams are expected to be formed following the submission of this application to meet implementation needs. Within the first 12 months, OHT partners will work together to redesign care and change current practices through three primary interventions:

1. Integrated Care Hub (ICH)

The ICH will act as a "one stop shop" providing 24/7 care coordination and system navigation services for clients/patients and their caregivers (see diagram of the ICH in Appendix 5). The OHT partners will work together in Year 1 to:

- Identify the Central West Local Health Integration Network (LHIN) Home and Community Care office as the first physical location for the central ICH;
- Utilize staff from OHT members to be co-located at the ICH and work as a unified team, employing existing skill sets to provide 24/7 intake, referral management, and access to coordinated care across the full continuum for the Year 1 target population;
- Consolidate resources focused on diabetes care;
- Develop and implement standardized processes to ensure consistency of service, including:
    - Operationalizing consistent care coordination functions among all providers to ensure alignment on the full continuum of care;
    - Identify an inclusion criteria in addition to medical complexity so that the target population is larger and includes patients with varied medical and socio-economic complexities and diabetes; and
    - Create collective risk stratification tools for diabetes care and Home and Community Care to test with target populations.
- Work with primary care provider (PCP) members to allow ICH staff to schedule appointments for Year 1 target population patients;
- Develop and execute information sharing agreements allowing for patient information to be shared across the circle of care;
- Expand virtual care offerings and increase the availability of clients'/patients' digital access to their own health information; and
- Identify neighbourhood hub locations and associated principles (e.g. equitable access, etc.), including but not limited to:
    - The Peel Integrated Care project at Peel Manor;
    - Community health centres;
    - Family health team members; and
    - Nursing clinics.

Members who will provide staff and/or other resources to the ICH include:

- Region of Peel;
- William Osler Health System;
- Central West LHIN; and
- Other partners to be defined in Year 1.

2. SCOPE Model

The University Health Network (UHN) describes SCOPE as *a virtual interprofessional health team that supports primary care providers through a single point of access. Family physicians and nurse practitioners registered with SCOPE can connect to local specialists, imaging, and community services, to serve their patients with complex care needs*. A function of the ICH will be to scale the UHN SCOPE model to the OHT to provide PCPs with access to specialists and system navigation services (see diagram of SCOPE model in Appendix 6). Substantial cooperation is required among the hospital, where the specialists are based, PCPs, who will be accessing the services, and ICH staff, who will be making the connections between these two groups, as well as providing other supportive

services to clients/patients. From day zero, the OHT will continue having PCP members leading the development of the specialist access model to ensure they are engaged and have the right services available to them in Year 1. The services that have been identified to date via PCP surveys are:

- Navigation;
- Care coordination;
- Internal Medicine;
- Mental Health; and
- Radiology.

3. Complex Care Pathway (Diabetes)

OHT members will work together to improve the care and experience of the complex clients/patients with diabetes (see diagram of the pathway in Appendix 7) in the following ways:

- Implementing a standardized complex care pathway that focuses on diabetes for the Year 1 population. Members have been collaborating on the development of this pathway for several months, and will continue to work together to refine it over Year 1, using current resources, strengthening collaboration among all partners, and seeking out and exploiting opportunities for innovative approaches;
- Developing and launching diabetes management hub(s) located in different areas within the OHT geography and available at times that are responsive to client/patient and caregiver needs;
- Developing standardized tools, including a common referral form, resource inventory map by area, a comprehensive database that will be maintained and up-to-date, and improved monitoring of persons with diabetes by developing automated mechanisms for patients with diabetes to follow up with their primary care providers;
- Enhancing collaboration models through team based access to care, enhanced system navigation roles, introducing the shared medical appointments (SMA) model with PCPs, and allied care providers, and improved screening, outreach and equation for patients living with diabetes; and
- Specific performance measures processes will be implemented to measure the outcomes of the diabetes pathway for the Year 1 population (for example an integrated quality improvement (QI) plan, implementation of clinical standards and best evidence, accurate reporting, central learning collaboration, and QI integrated initiatives).

Proposed Targets and Outcomes

Because many of these services are new, certain process measures will be useful to track progress on their development and implementation, including:

- Number of PCPs registered for the SCOPE service;
    - Target: all PCPs who are designated as members of the OHT in Year 1;
- Number of agencies/partner organizations providing full continuum care coordination as lead coordinator for complex patients;
- HbA1c testing to prevent complications from diabetes;
- Hospitalization rates related to diabetes;
- Number of primary care provider calls to the ICH; and
- Number of client/patient/caregiver calls to the ICH.

The OHT's Year 1 target performance in the measures selected in 3.1 is as follows:

- Same day/next day access to primary care: ≥75% for patients calling in to the ICH
- Emergency department visit rate for visits best managed elsewhere: ≤ 0.5 per 1,000 Year 1 target population
- Admissions for Ambulatory Care Sensitive Conditions: ≤ 30 per 100,000 Year 1 target population
- 7-day follow-up: 75% for Year 1 target population
- Readmissions: no higher than the Health Analytics Branch (HAB) calculated evidence-based rate

The OHT recognizes that it will be difficult to measure performance for the Year 1 target population, which is based on referral to the ICH by PCP and acute care members. A proxy population measurable by Institute for Clinical Evaluative Sciences (ICES) could be a subset of the OHT's attributed population who fall into the following Health Profile Groups:

- 116. J002C: Diabetes/hypoglycemia with PVD/Oth Chronic Vasc Dx w/o sig comorbidities
- 117. J003C: Diabetes/hypoglycemia with PVD/Oth Chronic Vasc Dx w sig comorbidities
- 118. J004C: Diabetes/hypoglycemia with Chronic Kidney Dis/Failure w/o sig comorbidities
- 119. J005C: Diabetes/hypoglycemia with Chronic Kidney Dis/Failure w sig comorbidities
- 123. J033A: Diabetes/hypoglycemia w/o Chronic Kidney Dis or PVD/Chronic Vasc Dx w sig comorbidities

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? (1000 words)

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.

Maximum word count: 1000

Care coordination is a mainstay of the Integrated Care Hub (ICH) concept. The ICH will be staffed by Central West Local Health Integration Network (LHIN) and partnered community support services care coordinators who will act as a single point of contact for primary care providers, patients, and caregivers. These care coordinators have experience coordinating care across multiple providers and care settings and across health and social needs.

Clients/patients want their providers to talk to one another. Improving coordination between primary care, home care, hospital care, social services will be the outcome of the improved care coordination model.

Through the ICH, all patients in the Year 1 target population will have access to 24/7 care coordination services, and to services through referrals. Initially, access will be through the Central West LHIN's existing central intake telephone number (310-2222); additional access channels, such as via email, instant messaging, and other electronic communications vectors, will be developed over Year 1.

Care coordination models will be redefined within the OHT with a focus on exploiting the strengths, competencies, infrastructure and required outcomes to support a population health focus. The current state of care coordination within this region serves as existing readiness for an improved model of care coordination. The Central West LHIN care coordinators are currently organized within existing neighbourhoods of this OHT. Additionally, there is some maturity of care coordination alignment with primary care where existing care coordinators carry caseloads built around primary care practices. Health Links approaches to care will be embedded within the coordination workflows in order to continue to build on an integrated approach to care planning.

The transformational components of care coordination within this OHT will include a consistent model of core competencies and execution regardless of the current employment status of the staff. Coordination roles from all organizations will be working together virtually and will come together as one team based off of the work flows developed through the ICH. The focus of coordination will include initiation of home care but broader than that, access to a wide variety of social and health services will be readily available as partners and services will be better integrated in order to be more responsive.

The following activities will be in and out of scope for OHT care coordination service in Year 1:

In Scope

- Intake/screening assessments and eligibility determination
- Appropriate warm handoff to other required services (Long-term care, home care, nursing clinics, Community Support Services (CSS), Canadian Mental Health Association, rehabilitation, etc.)
- In partnership with primary care, creation of a collaborative care plan and review of medical history and the patient/family/caregiver needs and preferences
- Arrangement of service intervention with delivery partners
- Arrangement for Ontario Drug Benefit authorization
- Planning for safe and seamless transitions from one setting to another
- System navigation and referral
- Case management with appropriate intensity for all health and social needs in collaboration with other key partners in the patients care team
- Reassessments as required to maximize care delivery and identification of rising risk factors affecting the patient's care plan needs
- Referrals to Health Care Connect
- Making urgent primary care appointments

Out of Scope

- All other home and community care service delivery elements beyond Year 1 focussed population.

Within the expected role composition of care coordination, a full range of services will include system navigation, clinical care management (care pathway bundles with expected outcomes), referral management, joint care planning development, monitoring and implementation, advocacy, health and wellness/self-management education, team-based interprofessional coaching and serving as a key collaborator.

With the launch of the ICH, care coordination resources will be organized differently from how they are currently deployed.

Care coordination levels of intensity across all partner providers will be re-evaluated in Year 1 to ensure any duplication of function is reduced or eliminated. Existing alignment of community care coordination approaches to primary care within the OHT neighbourhoods will remain and the model will be strengthened from a collaboration and partnership approach. The potential to leverage professional designations and clinically specialized care coordination approach will be explored. This would consider service delivery partners such as home care nurses or therapists serving as lead coordinators for appropriate patient profiles, to maximize existing scopes of practice, utilize health human resources and support the triad of clinician, patient and primary care partnerships.

Based on current trends and the desired future state, it is anticipated that approximately 50 care coordination functional FTE's from the Central West LHIN Home and Community Care are required in Year 1. In addition, CSS, primary care and family health teams, service provider organizations and other health service partners may also serve as additional care coordination functions over Year 1.

Within the existing resources it is anticipated that approximately 30,000 unique patients per year can be supported through the transformed efficient care coordination approaches outlined above.

In addition, the SCOPE model will employ a nurse navigator who together with a community care coordinator, will be available to liaise with primary care providers for a variety of clinical and community based resource matching and care coordination needs. The physician will be able to refer new and existing clients to home and community care services and specialized clinical services from within the hospital and community specialty services and they will have awareness of the linkages and next steps to care delivery in a timely manner.

Because of existing per capita funding inequities, there are existing challenges to meet the care coordination needs of the regional population. Co-location and consolidation of care coordination resources, and standardization of processes and workflow for these resources, will increase the pooled capacity of these resources. However, this increase in efficiency will not eliminate the funding gap.

Measures of success for care coordination services will include:

- Improvement in the five identified performance measures listed in section 3.1
- Improved Patient Reported Experience Measures and Patient Reported Outcome Measures performance for the Year 1 target population once these instruments have been developed
- Increased number of patient contacts with the ICH
- Patient confidence in managing their health care

3.3.2. How will you help patients navigate the health care system? (1000 words)

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.

Maximum word count: 1000

The vision of the OHT is to evolve the way clients/patients in this region access care. In Year 1, system navigation services will be provided through the Integrated Care Hub (ICH) in three ways:

1. System Navigation for all Clients/Patients

Clients/patients need assistance with navigating through the system. They would value someone to help them do this, in addition to having a 'system navigation map' so they know what to expect and not feel lost in the system. The Central West Healthline (centralwesthealthline.ca) is an actively managed repository of information for all health and social services providers in the region. Management of this service will be assumed by the OHT for maintenance and to allow anybody to access the resource and self-navigate, including the Year 1 target population. Opportunities to expand the information provided (e.g. to include wait times, etc.) can be explored. The OHT will continue to enroll patients into the MyChart patient portal to enhance self-management, self-education and navigation.

Additionally, Health Care Connect services will be embedded in the ICH to connect clients/patients with a family doctor if they are currently unattached to primary care, thereby promoting a stronger connection with the health system through primary care.

Embedded in the ICH will be a digital command centre responsible for monitoring real time client/patient and performance data related to care transitions, accessibility and predetermined outcomes. Whether accessing centralwesthealthline.ca or speaking with a staff member in the ICH over the phone, patients, families and the community will experience a responsive and well-versed care partner who is aware of all of the available services and, at maturity, access points (including wait times) to care resources, which will support improved care navigation.

The vision is to digitize the patient flow process and develop a virtual operation centre whereby all partners can see where their clients/patients are on the continuum in real-time.

2. System Navigator for Primary Care Providers (PCPs)

The SCOPE model will employ a Nurse Navigator and Community Coordinator who will assist primary care providers (PCPs) with system navigation and referrals to specialists and resources in the community. The Nurse Navigator will have prior work experience within OHT partner organizations to ensure seamless navigation of existing services. The Community Coordinator will support real-time access to appropriate home and community care linkages and assist the physician with the administrative requirements to initiate appropriate service levels in home care delivery. In order to facilitate provider communications, a mobile secure messaging system will be introduced to providers.

3. System Navigation for Year 1 Target Population

Because the Year 1 population comprises the rosters of primary care OHT members, and their complex patients living with diabetes, it is likely that a wide array of system navigation services will be required. For any services that are provided by non-OHT members and affiliates, the system navigation service will use centralwesthealthline.ca to direct clients/patients and caregivers to the appropriate resources nearest to them.

The scope of enhanced system navigation services for the Year 1 target population will be limited to the services offered by OHT members and affiliates in Year 1, where parties will agree to share and update their service information with the ICH to ensure it is current.

Existing Central West LHIN resources will be deployed to staff the system navigation services in Year 1, building off of existing expertise. It is anticipated that a portion of current staff from the Central West LHIN will be sufficient to meet the navigation needs of the OHT in Year 1.

System navigators serving the entire population will have access to the clients'/patients' health information (for example Connecting Ontario and hospital information system, CHRIS and, at maturity, perhaps EMR access) in order to support navigation and communicate back to primary care. The same applies for the Nurse Navigators and Care Coordinators providing targeted assistance to primary care providers through the SCOPE model. System navigation services will aim to be personalized, pending the addition of client/patient level data to the Clinical Data Repository and/or ConnectingOntario.

The ICH will have one phone number to call, (310-2222) which will be marketed using a comprehensive communications strategy to the target populations via primary care practices and other means as appropriate, until it can be scaled and marketed to the broader OHT population. Additionally, the existing systems directing the public to the centralwesthealthline.ca will continue to be in place.

Measures of success for system navigation services will include:

- An increase in web traffic to the centralwesthealthline.ca;
- An increase in calls and emails to Information and Referral specialists who manage the Healthline (baseline data is available); and
- Successful/completed referrals to specialists by the Nurse Navigator.

3.3.3. How will you improve care transitions? (1000 words)

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.

Maximum word count: 1000

Based on client/patient/community feedback, transitions should feel as if they are operating from one unit, with the same information and standards of care. There is an acknowledgement that for some patient cohorts transitions are challenging so the OHT will focus on supporting those challenging transitions through communication, role clarity of all partnered team members and responsive follow up. As a result, the OHT is committed to creating “warm handoffs” for the attributed population.

Building on existing integrated funding model programs, the OHT will continue to improve care transitions between acute care and the community (i.e. Hospital to Home program).

Ensuring Smooth Transitions

Members of the OHT currently have several initiatives in place to ensure smooth transitions, including:

- Providing automatic hospital discharge summaries to primary care, community support services and care coordinators in real-time;
- Integrated care coordinator program to transition clients/patients from acute care to home;
- Utilization of Health Partner Gateway (HPG) for the electronic editing and sharing of Coordinated Care Plans (CCPs);
- eNotification for Central West Local Health Integration Network (LHIN) clients/patients admitted to William Osler Health System’s (Osler) emergency departments (EDs);
- ED Discharge Summaries support coordinating care through transitions (ED back to primary care);
- Access to virtual care approaches such as Ontario Telemedicine Network (OTN) Guest link;
- Build on Osler’s virtual operation centre to digitize the flow of clients/patients between partners (electronic client/patient transition board as referenced in Appendix 8);
- Behavioural Supports Ontario (BSO) program; and
- Post-Op patient hotline pods.

In Year 1, the OHT will build on these examples and create new methods to enable seamless transitions between providers. For example, a portion of the Year 1 target population is complex patients with diabetes discharged from the hospital. The Integrated Care Hub (ICH) will serve as a warm handoff for these patients leaving the hospital, where care coordinators will be notified of client/patient discharges, ensuring appropriate follow up care is received (including those on home care wait lists).

With the Year 1 population of complex patients with diabetes, the warm hand-off will help improve communications between different providers and access to needed services. People living with diabetes will be connected to a primary care provider via OHT partners and Health Care Connect. There will be clear and standardized criteria for inclusion and discharge, with transparent wait times. Existing tools used by care coordinators and staff in the ICH, such as the CDA flow sheet to guide care, and Coordinated Care Plans in HPG will be used to avoid duplication when possible. Smooth transitions facilitated through the ICH will ensure complex patients with diabetes will not fall through the cracks during Year 1. The ICH will help strengthen interprofessional care in the community through connecting clients/patients with the services in the ICH, and coordinating services outside of the ICH.

Finally, the integrated care coordination role situated at the acute care hospital sites will be reimagined to take advantage of the strengths of all aspects of this integrated team approach. By focusing on improved transitions in care with warm reintegration practices into the community, care coordinators will follow the patient into the community in order to stabilize all care supports required to remain independent in the community post hospitalization, and the discharge planning team members will work to a fuller scope of transitional care planning. Key resources such as Geriatric Emergency Medicine (GEM) nurses and ED team members will become more familiar with the full array of transitional resources available and will have improved relationships with dedicated transitional coordinators who bridge the gap between hospital and home. Additionally, the partnering of existing resources such as Rapid Response Nurses, Telehomecare programs and the local Hospital to Home Program will be explored as opportunities to further integrate as unified transition programs that allow for improved stratification of transitional care planning between acute care and community care.

One way to move from disjointed to seamless transitions for the client/patient is to eliminate the transition from the patient's point of view. The SCOPE model of care is a method of doing this--instead of primary care providers providing "cold handoff" referrals to specialists, clients/patients can benefit from the primary care provider having immediate access to specialists for consults or referrals. In some cases, these interactions may prevent the patient from having to be referred to the specialist at all. As the OHT transitions to maturity the ability for the SCOPE model to support patient seamless transitions will be further enhance as the OHT gains access to future versions of Health Report Manager (HRM) and/or REACH portals, once uploads to clinical data repositories are online (for OHT primary care physician's and specialist electronic medical records). The OHT expects to begin to have access to these upgraded solutions once electronic medical records (EMRs) pass the HRM certification process as there are active discussions to take advantage of early adoption opportunities and complete systems integration efforts. Improved 'unified point to point' secure messaging among care coordinators, primary care and specialist partners are also expected to be

available late in Year 1 to support coordinated communication and improved transitions for patients.

As the OHT matures, more and more services will be fully integrated into a shared set of systems, including central intake, a central resource managing each patient's referrals (both internally and externally), shared care models with primary care, and streamlined communication tools and digital platforms like those mentioned above. The vision is to achieve a comprehensive Electronic Health Record (EHR) and provide a platform where clients/patients, providers, and navigators can all interact simultaneously. A more integrated model means improved efficiencies and patient satisfaction.

Measures of success for improved transitions of care will include:

- Improved communication during transitions through the number of updated care plans;
- Improved PREMS focused on experience of transitions;
- Reports from primary care providers that there has been an improvement in the experience of transitions for them and for their patients; and
- Reports from clients/patients and caregivers regarding their experience with transitions.

3.4. How will you provide virtual care? (refer to Appendix B)

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? (500 words)

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.

Maximum word count: 500

Existing self-management programs (SMP), including peer-led, are offered by Home and Community Care, Community Health Centres, Family Health Teams (FHTs) and other OHT member/affiliate organizations separately and in partnership with one another. William Osler Health System and the Central West LHIN offer free programs for people at risk of developing chronic health conditions and their caregivers. Currently offered SMPs include:

- Getting the Most from your Health care Appointment: Teaches clients/patients what to do before, during and after a health care appointments.
- Chronic Disease SMPs: Six week peer-led programs which help individuals gain confidence in their ability to manage their own health and the symptoms associated with their chronic conditions, including diabetes.
- Powerful Tools for Caregivers: Intended to prevent caregiver burnout.
- Mindfulness Awareness Stabilization: A four week training program for people struggling with mental health issues.

These SMPs are taught by trained individuals from the community who have the condition of the topic of reference and are trained by formalized self-management models (the Stanford Model).

SMPs will continue to be offered to the OHT's attributed population in Year 1 who are living with, or at risk for developing, chronic health conditions and their caregivers in order to provide individuals with the knowledge, skills and confidence to effectively self-manage their chronic conditions and improve their health. Additionally, the following self-management and health literacy support mechanisms will be offered to complex patients with diabetes:

- Health literacy prevention and health promotion programs including those offered through the Central Brampton FHT including Heart Health, Let's Talk DM Group, grocery store tours, and mental health and diabetes education workshops.
- Falls prevention and nursing clinic services offered by the Central West LHIN where individual and group self-management approaches can be delivered.
- Through the Nurse Navigator role and by taking advantage of existing diabetes education programs (DEP), Centre for Complex Diabetes Care (CCDC), health promotion programs offer chronic disease and skill building programs and workshops.
- Individual counselling and group sessions through DEPs.

- Validate experience through the development of peer-to-peer programs (guided by Certified Diabetes Educators (CDEs) and Health Promotion teams).
- Culturally specific and educationally appropriate care, identifying what the client's/patient's understanding of their condition and facilitating an improved understanding based on this starting point. The OHT will work with multilingual organizations to provide content on strengthening basic health literacy and target newcomer centres to provide workshops dedicated to improving health literacy skills.

The support outlined above are built off of the current health literacy/self-management processes, tools, and programs offered by OHT members.

OHT members ensure that information is communicated to clients/patients in a variety of languages (including traditional and Simple Chinese, Urdu, Arabic, Punjabi, French, Polish, English, Portuguese, Italian, Spanish, Somali, Hindi, etc.) and in plain language that is easy to understand.

The OHT will adopt outreach approaches to assist with those who are hard to reach, including digital enablers such as apps that reward healthy behaviours.

3.5.2. How will you support caregivers? (500 words)

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.

Maximum word count: 500

The OHT understands the integral role caregivers play in the health care system. The nearly 400 client/patient surveys conducted provided important insights about the needs of caregivers. For example, clients/patients wanted the OHT to recognize that caregivers and family members are important members of the health care team, and want better support for them including housekeeping, personal support worker (PSW) care and respite services.

The 2018 Spotlight on Ontario's Caregivers report by the Change Foundation reported the following information about caregivers in the 905 area code and in Toronto, two of the regions with the majority of the OHT's attributed population:

- Nearly 40% of caregivers needed hands-on, written or verbal training and information by a health care provider, but did not receive any;
- The majority of these caregivers were between the ages of 45-64; and
- The health conditions of the care receiver that received the least caregiver support were related to mental/cognitive and old age conditions (41% and 42%, respectively).

Additionally, the 2019 Change Foundation report entitled "Understanding the caregiver experience: Regional insights to inform Ontario Health Teams" indicates that a high proportion (68%) of caregivers in Central West Local Health Integration Network (LHIN) want one place to go to receive support, and that one of the main challenges for caregivers is transitions. Caregivers in the OHT said that the way health care providers are organized makes receiving care difficult - they are more likely to feel that their loved ones would miss appointments if they were not available to provide caregiver support.

To help address these concerns, the OHT will implement the following measures:

- Ensure caregivers are represented in OHT Patient/Family/Caregiver/Community governance structures and engagement panels;
- Involve caregivers in the design and implementation of the Integrated Care Hub (ICH), as caregivers will be provided access to the ICH not only for the person they are caring for, but to receive support for themselves. The OHT plans to work with caregivers to determine what supports are needed through the ICH so that they have a single entity to connect with in the event they need support;
- The ICH will ensure patients experience smooth transitions with the introduction of "warm handoffs" to the ICH, which will help alleviate the burden of transitions on caregivers;
- Caregiver burden assessment tools will be used and built into the intake and system access approach. This will be improved over traditional care as collectively all team members will be better aware of at-risk caregiver issues so that caregiver support will be built into the evolving models of care delivery; and

- The Ontario Caregiver Helpline will have launched in October 2019 to provide 24/7 access to caregiver resources. The OHT will connect with this resource to determine the best way to leverage this through the ICH.

Through these initiatives, the OHT hopes to improve the experience of caregivers/care partners and improve outcomes for them and those they care for.

3.5.3 How will you provide patients with digital access to their own health information? (refer to Appendix B)

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? (500 words)

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.

Maximum word count: 500

Because of the siloed nature of the current health system, the ability to identify, track and develop sustained relationships with patients has always been challenging and is particularly frustrating for patients and their families.

Given the disparate processes, technologies and systems, the OHT will focus on understanding the barriers and enablers to break down silos, making use of Ministry tools and resources articulated in the Digital Playbook, and developing both technological and non-technological solutions to address a more seamless and integrated client/patient experience.

Empowering clients/patients with their data will help the OHT with this tracking as it's their journey and they are experiencing all elements of it. The OHT has the opportunity to work with innovation and technology partners to help create a process to track and follow clients/patients.

Alignment and standardization of clinical interventions, minimum data sets, process and performance measures and protocols will be critical to this work.

Patient identification and tracking will be centred around their health card numbers. In preparation to becoming a designated OHT, members will further advance the ability to track patients by identifying a common way of flagging targeted clients/patients within their respective electronic medical records (EMRs), so that each OHT partner is aware of the identification marker(s) and will be able to easily identify and track targeted clients/patients in order to develop sustained care relationships with these clients/patients. No matter which specialty the client/patient interacts with, the client's/patient's medical history will be available so that they can continue care and/or community support seamlessly. The care coordinators from the Integrated Care Hub (ICH) will be used to track and follow up with complex diabetes patients and will serve as support so that OHT members will know that if additional tracking help is needed, that by reaching out to the ICH, they can seamlessly enlist additional staff within the OHT to support client/patient care coordination, ensuring improved client/patient outcomes.

The Year 1 target population is made up of the following groups:

- Rostered clients/patients from OHT member primary care providers
    - Within the above population, clients/patients who are identified as complex patients with diabetes
- Complex patients with diabetes who are discharged from William Osler Health System (Osler)

As an example for the OHT's vision, as these complex patients with diabetes are discharged Osler, staff at the ICH will be sent discharge summaries. They in turn will review the patient's medical history by using their available Health Report Manager (HRM) enabled EMRs, they will reach out to and will work with these clients'/patients' family physicians to create care plans to help these patients on their journey back into the community post hospitalization. This will ensure that the desired coordination, efficiency and effectiveness of care is met and will help to minimize relapse and hospital readmissions.

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? (500 words)

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?

Maximum word count: 500

Respectful of the intersect and convergence between traditional Indigenous healing and contemporary medical practices, the OHT is mindful that the health care needs of Indigenous communities are intrinsically unique. To effectively understand and meet these needs -- from prevention and wellness to mental health, chronic disease management and palliative care perspectives -- Indigenous communities must be engaged as valued partners in the ongoing planning and management of the local health care system. Accordingly, the OHT is committed to engaging Indigenous communities to ensure their needs are understood and addressed, as well as to ensuring the provision of culturally competent care that recognizes social, cultural and linguistic needs. More specifically, the OHT will: establish a formal structure for ongoing and active Indigenous community engagement; deliver culturally-appropriate training; and develop a local health care system that ensures the delivery of culturally competent and safe care.

OHT members currently engage Indigenous peoples in numerous ways to address the needs of Indigenous clients and patients in service planning, design, delivery and evaluation. OHT members strive to ensure that care is provided in culturally safe and appropriate ways that acknowledge the potential for past trauma. For example, Closing the Gap Healthcare Group uses the listen and “LEARN” approach to engaging Indigenous peoples or to address care improvements. Saint Elizabeth (SE) Health’s programs are developed in full partnership with Indigenous communities to ensure it is relevant and culturally rich. William Osler Health System works with the Brampton office of Métis Nation of Ontario and the Peel Aboriginal Network / Indigenous Friendship Centre on a number of hospital priorities, including patient

and family experience, multi-faith and diversity days, as well as community healing and wellness initiatives.

Partners are eager to build on and strengthen relationships with Indigenous communities, people, and service providers and ensure that unique needs are embedded in the OHT model and implementation. While focused collaboration with Indigenous community organizations on OHT development has yet not been extensive, local partners recognize that they have much to learn from Indigenous communities and organizations, who offer significant expertise on integrated and holistic care and services.

In addition to deepening local Indigenous health partnerships and collaboration, the OHT will use the Health Equity Impact Assessment tool in its design and implementation to identify and respond to unintended potential health effects of its plans.

Resources available to primary care providers within the SCOPE model will be based on patient need, with patients being provided individualized, coordinated, and culturally appropriate/safe care. The Nurse Navigator and Care Coordinator employed through the OHT will play a central role in ensuring patients are connected to, and provided with, services which meet the diverse population health needs of the community. They will receive appropriate and high-quality Indigenous health and cultural safety training. OHT partners are committed to expanding supports and services to ensure the provision of culturally appropriate care for Indigenous clients, patients, caregivers and families.

3.7.2. How will you work with Francophone populations? (500 words)

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.

Maximum word count: 500

The Municipality of Peel is one of the 26 designated French Language Services (FLS) areas in Ontario (*Ministry of Francophone Affairs*). Among OHT partners, Central West Local Health Integration Network (LHIN) Home and Community Care, William Osler Health System, Canadian Mental Health Association Peel Dufferin (CMHAPD), March of Dimes, and Services and Housing in the Province are identified health service providers (HSPs); there are no currently designated HSP members.

The OHT will promote the principles of active offer and is committed to its obligations and responsibilities under the *French Language Services Act*. The OHT will ensure alignment with the *Guide to Requirements and Obligations Relating to French Language Health Services* to develop mechanisms to address the needs of local Francophone residents by improving access to linguistically and culturally appropriate services. For example, WellFort Community Health Services has a health promotion program exclusively in French that addresses issues identified by the community through partnerships with other francophone-serving agencies. Rexdale Community Health Centre (CHC) has a French Language program with French speaking program coordinator. CMHAPD plans collaborative educational opportunities to address mental health and addictions needs within the Francophone community. The Peel Addiction Assessment and Referral Centre is actively engaged in implementing active offer of FLS. Many organizations, such as the Region of Peel and CMHAPD, also conduct Health Equity Impact Assessments (HEIA) to identify the needs of Francophones.

In 2018/19, 100% of OHT partners, funded by the LHIN, had completed the Human Resource Capacity Plan section of their required FLS report and a total of 558 Francophones were identified as 'French-speaking' and received services across the HSPs. 46% of OHT HSP partners have a process in place to identify language of preference for service delivery (*Reflet Salvéo, OZi Report, 2019*). OHT partners have undergone leadership training on active offer, organized by Les Centres d'Accueil Héritage on October 2 to ensure that they are aware of the principles of active offer to support the needs and demographics of the Francophone patients in Year 1 and at maturity.

In the OHT's catchment area, 1.8% of the population meet the inclusive definition of Francophone. The OHT partners are committed to applying an FLS lens when it comes to health system service delivery, ensuring local Francophone residents are provided with a continuum of care that meets their needs. The principles of active offer and identification of Francophones will be implemented in Year 1 and at maturity to ensure that Francophones

have equitable access to health services in French, including navigation and care coordination.

The OHT will be proactive in complying with all requirements outlined in the *French Languages Services Act*, and will make use of the French Language Services Supplement of the HEIA as a vital input into the OHT's program development. The OHT is also committed to working with the Ministry, Ontario Health, Reflet Salvéo, and other partners to improve the quality of data related to the francophone population, supporting the development and use of common FLS indicators.

3.7.3. Are there any other population groups you intent to work with or support? (500 words)

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.

Maximum word count: 500

The OHT has a substantial South Asian population. Focusing on diabetes for the Year 1 population, special attention will be paid to groups with higher risk for developing diabetes: new Canadians; South Asian and Afro-Caribbean communities; those with stage 2+ obesity; and people with low income/limited access to healthy food and recreation. Improving access to affordable food, exercise and medications is paramount, as many clients living with diabetes are reliant on food banks that do not alter the foods they distribute for persons with diabetes.

Over 65% of the residents of all three Sub-regions are visible minorities with Bramalea, at 77.9%, being the second highest in Ontario. Over 50% of the residents of all three sub-regions are immigrants. Of Ontario's 76 sub-regions, Brampton, Bramalea, and North Etobicoke, Malton and West Woodbridge (NEMWW) have the seventh highest percentage of residents who are immigrants and who are first generation Canadian. NEMWW and Bramalea are in the top 10% of sub-regions for residents who immigrated within the past five years, with India being the country of origin for the largest proportion of this group.

Other issues outlined in sections 1.1 and 1.3 may be related to cultural or other socio-demographic factors. The OHT will work closely with community groups (such as Punjabi Community Health Services) and service providers to identify/meet the needs of the attributed population both at Year 1 and maturity.

OHT members currently engage with and consider the needs of specific population sub-groups in their work, and provide services in multiple languages. For instance, 1to1 Rehab provides occupational and speech language pathology services in the language of the local community, covering over 27 languages.

OHT members provide specialized services that address the needs of vulnerable or marginalized populations. Rexdale Community Health Centre and WellFort Community Health Services deliver health promotion programs designed with a health equity lends to address social determinants of health. Their seniors group addresses social isolation and brings together a vulnerable population on a frequent basis to build skills to take control of their health and well-being.

CANES Community Care operates a Community Outreach Social and Wellness program for South Asian seniors in Brampton. Canadian Mental Health Association Peel Dufferin (CMHAPD) engages in activities to address health care issues for individuals with various socio-demographics considerations, including those with mental health and addictions

challenges, recognizing that clients often have additional impacts by their social determinants of health that cause further marginalization.

In addition to meeting legislative requirements to provide services in both of Canada's official languages, additional support will be provided to patients and primary care providers to provide translation and interpretation services. With a large, multi-cultural population, the OHT has identified the need to expand these services to ensure patients understand recommendations and care plans. The Central West Local Health Integration Network (LHIN) is currently pursuing a one-year contract for real-time interpretation services that will support the Integrated Care Hub in Year 1.

3.8. How will you partner, engage, consult or otherwise involve patients, families, and caregivers in care redesign? (1000 words)

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.

Maximum word count: 1000

What the OHT has Done in the Past

OHT partners have been committed to the engagement of client/patient, family and caregivers in the planning and development of the OHT. Each OHT partner has extensive experience engaging clients/patients, families and caregivers to inform collaborative care planning, development of programs of services and improving partnerships. This work is guided by the Health Quality Ontario (HQO) Patient and Family Engagement Framework which outlines a spectrum of engagement levels ranging from information sharing to consultation and co-design across domains of point of care, program services and governance. Between 2015 and 2019, a formal Central West Local Health Integration Network (LHIN) partnership between acute and Home and Community Care utilized this framework in developing a regional approach to client/patient and family/caregiver engagement.

In addition, this evidence-based framework will continue to influence the planning and implementation of the OHT and support its intentional shift towards enhanced provider and client/patient, family/caregiver shared decision-making and co-management.

To date, the OHT has used a wide spectrum of engagement strategies:

- OHT partners have a strong history of asking what is important to clients/patients. This has occurred through either informal or formal patient experience or satisfaction surveys, focus groups, motivational interviews, suggestion boxes or real-time feedback. In addition, every OHT partner has a robust patient relations process where there is a visible and responsive process for receiving patient/client or family/caregiver complaints or compliments. Themes from this type of feedback are often valuable in highlighting quality of care as well as service delivery improvement initiatives.
- OHT partners have either formal Patient Family Advisory Councils (PFAC) or ad hoc Patient Family Advisors (PFA) whose consultation is based on areas of interest, expertise and availability. PFAC membership and PFA recruitment is skills- and 'lived experience'-based and representative of the rich diversity of the community.
- Various OHT partners have had experience with larger community engagement strategies especially when seeking feedback about broader, more systemic planning, funding or access issues. Recently, the OHT hosted a client/patient/community engagement event to engage people about what is important to them in an integrated care system. The event included questions that were co-designed with patients and families, and included a focus on elements of a positive health care experience, safe transitions, patient confidence and self-management, the value of technology, and the

importance of support and well-being of caregivers. Interpretation and translation services were available at the well-attended event

- The OHT also distributed a survey to clients/patients/caregivers focused on improving care in the region. There was an option to complete the surveys online or in person, and the survey was translated into any language as requested by the client/patient/caregiver. Nearly 400 responses from this initial survey were received.
- Various partners use virtual forums where clients/patients/caregivers can provide feedback on the care they receive. For example, William Osler Health System (Osler) has a virtual web panel where providers or teams can post customized questions and receive feedback on various topics. One of the most valuable examples has been feedback in developing a robust and community-based Patient Declaration of Values (PDoV). In addition to virtual feedback, community members have provided commentary through a survey accessed on the hospital website, posters, digital TV, patient portal and an external media campaign. Community organizations were also contacted and facilitated PDoV discussions with patient/client group members. While led by Osler, the feedback has been community-wide and open ended for feedback related to clients'/patients' hopes for respectful and compassionate communication, safety, seamless transitions, navigation and engagement across the continuum of care.

As the in-person, survey and virtual care feedback options all proved effective in receiving client/patient/caregiver feedback, the OHT will continue to host in-person events, distribute surveys and utilize virtual forums throughout the planning and implementation phases of the OHT as a means of gathering feedback from the attributed population. Client/patient insight will be especially valuable in the continued development of clinical pathways for the Year 1 target population.

What the OHT will Do in the Future

The OHT will:

- Create a community advisory committee that will include clients/patients and caregivers. Additionally, client/patient and caregiver advisors will be invited to participate in working groups tasked with redesigning care;
- Explore a collective PFAC or formal process of recruiting and engaging PFAs in preparation for building structure and processes for clients/patients and caregivers to participate further in shared decision-making and governance;
- Develop a patient relations process to collectively respond to and manage complaints/compliments and capacity across partners to share learnings as well as meet accountability for cross sector client/patient and caregiver engagement prior to, during and following quality of care reviews;
- Reference the provincial PDoV and build on the community-based PDoV initiated by Osler to create a comprehensive OHT PDoV;
- Utilize the McMaster University (2018) Public and Patient Engagement Evaluation Tool to measure levels of patient/client, caregiver and community engagement in the planning and implementation of initiatives; and additionally
- Leverage and sustain existing community partnerships and relationships that OHT partners have with various agencies.

Measures of success for patients/clients, families, and caregivers engagement will include:

- Participation of members of the community or formal PFAs on OHT committees/working groups;
- Numbers of, and feedback from additional community engagement forums or surveys;
- Incorporation of feedback from clients/patients, families, and caregivers into plan- do-study-act (PDSA) cycles for co-design of ICH operations and complex care pathways;
- Patient Satisfaction, Patient Reported Experience Measures (PREMS), Patient Activation Measures (PAMs) and Patient Reporting Outcomes Measures (PROMs); and
- McMaster University (2018) Public and Patient Engagement Evaluation results.

4. How will your team work together?

4.1. Does your team share common goals, values and practices? (500 words)

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.

Maximum word count: 500

OHT partners engaged in a series of collaborative design sessions to create a common set of values and behaviours to guide the partnership referred to as the First Principles and Rules of Engagement.

First Principles:

- The OHT is working towards accessible, cost-effective and integrated care that puts people at the centre
    - *The OHT is committed to moving away from institutional silos, removing barriers, and prioritizing seamless care transitions.*
- The OHT believes that health promotion and early interventions keeps people healthy and at home longer
    - *The OHT recognizes health equity principles across the health and social continuum.*
- OHT partners are one team sharing information and resources to optimize outcomes for clients/patients, families and caregivers
    - *The OHT commits to transparency and fiscal responsibility, and partners will share what they can.*
- The OHT will build on partners' strengths to improve health care in the region
    - *OHT partners will apply their expertise to create models for timely and efficient care.*
- The OHT embraces best practices guidelines and quality standards in delivering care
    - *The OHT values evidence in designing its models and recognizes that innovation supports quality improvement*.

Rules of Engagement:

- Commit to what is most important for the community;
- Operate with openness, transparency and regular communication;
- Collaborate towards OHT co-creation and not individual or organizational interests;
- Ensure equitable representation;
- Demonstrate respect for diverse perspectives and expertise, including front-line staff, clients/patients and families;
- Mitigate partner risks when making decisions;

- Apply best available evidence;
- Ensure safe space for discussion and decisions;
- Present options and recommended solutions when not in agreement; and
- Reach consensus whenever possible.

Furthermore, the proposed Integrated Care Hub (ICH) model was designed to address the Quadruple Aim in the following ways, demonstrating that OHT partners value working towards achieving these aims:

Better Client/Patient and Caregiver Experience: Individualized care plans, increased "warm" handoffs, access to interprofessional care regardless of location, provider or socio-demographic status, "one truth" record negates duplication of story, client/patient more in control of their own health outcomes.

Better Population Health Outcomes: Match care to level of need, greater adherence to appropriate care pathways/protocols, aggregated data and artificial intelligence (AI) to predict rising risk and promote early intervention at maturity, increased awareness and adoption of behaviours that promote health.

Better Value and Efficiency: Appropriate allocation of resources, reduction in service fragmentation and duplication, redistribution of resources to reduce duplication/overutilization of services, streamlined care pathways, improved determinants of health

Better Provider Experience: Better understanding of roster/enrolment list care needs, greater confidence in care pathways for clients/patients, access to comprehensive interprofessional services regardless of practice model, timely access to "one truth" record, ability to see more motivated clients/patients at maturity.

The oversight model proposed in Section 4.2 follows a collaborative governance approach and will facilitate partnership agreements between organizations to promote shared accountability. In cases where there are differences in values, organizational processes, etc. a dispute resolution process will be put in place to reach consensus and/or agreement as required.

4.2. What are the proposed governance and leadership structures for your team? (1500 words)

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)?***

Maximum word count: 1500

The proposed OHT model will enable partners to come together in an integrated and coordinated manner and create a seamless, easy to access continuum of care that will benefit clients/patients, families and caregivers alike. Recognizing this is a large scale transformational change, trust and collaboration will be instrumental in enhancing a successful implementation and ensuring sustainability. The expressed enthusiasm of all member partners to have the opportunity to collaboratively modernize regional health care will enhance collective and appropriate decision-making.

Proposed Governance Framework and Shared Decision Making

The collaborative work of the OHT will require shared accountability and oversight mechanisms between participating partners. As the OHT builds an oversight and accountability model, "form should follow function". There has been significant focus on broad stakeholder engagement and co-creation of the model. The OHT has ensured active participation and shared ownership amongst not only core partners, but the broader community.

Integral to the OHT's proposed approach is the ability to continue to engage broadly with community, physicians/practitioners and organizations to enhance both the quality of the model and buy-in for its approach. A significant number of organizations included in the OHT have history of working together through various partnerships over many years. Because of

this strong history, there has been a substantial regional interest in actively participating in this OHT.

The Ministry has suggested that OHTs will operate under a single accountability framework at maturity. In the interim, the proposed governance model will be focused on providing the mechanisms for shared-decision making and continuous growth and development among partner organizations (see Appendix 9 for model). The Year 1 approach will also serve as the critical foundation from which to build and foster trust between all partners.

During the first year of operations, key factors in developing an appropriate governance model will include: a collaborative leadership model; mechanisms for partner contributions and feedback; opportunities and structures that will facilitate and encourage the involvement of patients/clients from across the OHT; joint accountability and decision-making agreements and frameworks; opportunity for shared resources; measurable performance outcomes; and information sharing.

The principles of collective impact were key considerations in helping the OHT create a recommended starting point. These principles include:
● Building a culture that fosters relationships, trust, and respect across participants;
● Ensuring mechanisms are in place that will facilitate the design and implementation of initiatives with a priority placed on equity;
● Inclusion of community members and other key stakeholders in the development of the collaborative; and
● Use of data to continuously learn, adapt and improve.

In addition to the principles identified above, other planning considerations will include a balance of autonomy and collective decision-making that will advance the will of the group without compromising best interests at the organizational level. It will also include the ability to address performance and ensure alignment with the objectives of the OHT.

Although a great number of the partners already have existing relationships, building a foundation of trust will be paramount in ensuring the success of the OHT. As a starting point, the OHT has established a number of mechanisms for networking and relationship-building across the partners. Working groups consisting of a cross section of members, physicians and patient/community representatives have been engaged in a series of meetings and educational forums for the past several months. In addition, a series of joint information sessions were scheduled with the governors/executives of all partner organizations, physicians and clinicians, and client/patient and community partners.

Managing the Activities of the OHT

The OHT is committed to building a foundation that includes a shared vision, purpose, strong relationships and trust.

The OHT will create a governance framework that will achieve a shared vision and ensure its alignment with the principles of the Quadruple Aim, and will develop a decision-making body that will provide guidance and oversight for the shared work. Members of the committee will include representatives from sector organizations including, but not limited to: primary care; community support services; home and community care; mental health and addictions; and acute and long-term care. Additional support will be provided by non-affiliated (subject matter

expert) representatives and working groups (client/patient care, caregivers, digital, governance and finance). With over 100 engaged physicians/clinicians and existing Community Patient and Family Advisory Committees (CPFAC), the creation of a Community Medical Advisory Committee and Community PFAC Council will be developed. Representatives from both groups will serve as key members in the decision-making body. Structured processes to gather experiences from multiple viewpoints and backgrounds will be developed as part of the client/patient/family/caregiver engagement plan.

To formalize the activities between the multiple partners, collaboration agreements or memorandums of understanding will be created. The agreements will set out the partners' roles, responsibilities and accountability to the OHT vision. They will also include how the establishment of collaborative priorities will be made, mechanisms for decision-making, managing risk, conflict resolution, resource allocation, information sharing and terms for new partner member inductions. In addition, the agreements will identify collective performance measures and will inform how and when to engage existing and potential OHT members.

During the first year of operation, the steering committee will make shared decisions by consensus. As part of the decision-making framework, a dispute resolution process (which includes an escalation process as a last resort) will be required. Although not all disputes will end with an acceptable resolution, mechanisms will be implemented that will support the continuation of the work of the OHT as well as address the concerns of participating partners.

Terms of reference will define the scope and direct the work of the Steering Committee. In addition to the Terms of Reference, other supporting documents will be created including a code of conduct, confidentiality agreement, and an ethical decision-making framework.

To support the activities of the steering committee, a number of working groups will be instituted each with a defined scope and objectives, and will focus on areas such as client/patient care, compliance and resources, and partnerships. These groups will be comprised of individuals from the partner organizations and will assist with operationalizing new processes in order to change the way the OHT delivers care. Initial terms will be established to ensure rotation of members and greater participation of the partner organizations. The chairs of the working groups will report to the steering committee to facilitate communication and ensure alignment of work across the OHT. A key feature of this structure is flexibility to mobilize and maximize opportunities to meet emerging needs/issues. Learning and reflection from the first year will inform the OHT's evolving governance model.

To support the ongoing efforts and progress of the OHT, an extensive communications plan will be developed that will assist in streamlining messages and ensuring a common understanding and knowledge platform for all members. Mechanisms for sharing information are being considered and may include portals, bulletins, communiqués, and joint retreats.

Managing performance will evolve over time, however, during its initial stages this will be done through the various accountability agreements and cross-sectorial measures such as an Integrated Quality Improvement Plan. It is also the intent of the OHT to work collaboratively to create a joint strategic plan that will focus the group's efforts and vision for the future. Allocation of resources will be reviewed during the first year of operations. The OHT will need to develop a process that will allow relevant resources by partner organizations to be pooled

and accessed to enhance transition and care pathways, and facilitate the development of the Integrated Care Hub (ICH).

Moving forward to a new integrated care model is both challenging and complex. The journey ahead is an ambitious and exciting one. The OHT looks forward to collaboratively creating an ICH that will provide comprehensive services for people, where and when they need it most.

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? (1500 words)

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. TBD: Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

Maximum word count: 1500

Sharing Personal Health Information (PHI) within the OHT Team

There are existing examples of data sharing within the OHT that will form the foundation for the OHT's Year 1 work together. An electronic health information portal called Rapid Electronic Access to Clinical Health Information (REACH) that allows authorized clinicians access to their patients' information through a secure web browser has been in place in the Central West region for over a decade. In addition, a previous Central West Local Health Integration Network (LHIN) regionalization initiative led to the development of a clinical data repository designed to host William Osler Health System (Osler) and Central West LHIN Client Health and Related Information System (CHRIS) data. Currently, the best sources of information for providers is ConnectingOntario (cON) and REACH. Without a clear plan from Ontario Health on whether additional data sources (like primary care core data) will be added to cON, the OHT will look to employ the Clinical Data Repository (CDR) and begin working with Health Shared Services Ontario (HSSO) for CHRIS data as well as the top three electronic medical record (EMR) vendors to populate the CDR. Discussions with vendors have taken place and there is a high degree of confidence that the OHT can begin to add more content to the CDR commencing Year 1. This initiative will be resource-intensive and will require a financial investment. However, no investment at the individual provider level is required to implement the Year 1 plan.

See Appendix 10: Leveraging REACH/BBNEMWW CDR Strategy DATA Flow Chart

In parallel, the OHT have had discussions with OntarioMD and with eHealth Ontario around becoming an early adopter to have EMR core data populate the Health Integration Access Layer (HIAL) and cON. The OHT has also approached OntarioMD and Sunnybrook about further enhancing the acute care relationship and working with Ontario Health to have physician EMR core data flow from HRM to the HIAL and populate cON and also MyChart for patients to access more content to enhance their self-management capabilities. This is the

preferred option as it would not only benefit this OHT, but also other OHTs and enable moving even closer to a provincial view of patient information (albeit view only).

See Appendix 11: Early Adopter Strategy DATA Flow Chart

Note that the ultimate longer-term vision (five to seven years after the launch of this OHT) is to acquire a new modular Health Care Information System that, where possible, provides an opportunity to consolidate fragmented cross-sector systems to create a more comprehensive electronic health records (EHRs) yet it must provide interoperability capability. At maturity, the OHT plans to have a comprehensive digital system in place that will support efficient and effective communication and allow all members to share patient records securely.

See Appendix 12: EHR Vision – (Five to seven years from today) Outlook DATA Flow Chart

Actions to be taken to Mitigate Gaps

The OHT will work with vendors to integrate HRM into supported EMRs and will be prepared to use REACH as the mitigating alternative to maximize information sharing. The team will continue to notify OntarioMD of the desire to be an early adopter to get on board with any efforts they take to make the flow of patient health information from primary care EMRs bi-directional at the earliest opportunity, so it meets the needs of this OHT. Doing so will allow the team to remain in line with the Ministry's expectation to use their recommended digital solutions.

Health system resources such as cON privacy policies may offer effective practice models for data sharing and related harmonization policy/protocols across Health Information Custodians (HICs). The OHT will also look to any Ministry guidance or OHT-specific Data Sharing Agreement (DSA) templates designed to assist OHTs across the province. Adoption would ensure Ministry expectations and Digital Playbook policies are met.

A minimum data set of shared patient information will be identified, and this process will involve close engagement by patients and clients. To implement the Integrated Care Hub (ICH) and ensure privacy-protective patient information sharing, a health information network provider (HINP) structure is anticipated. Similar to DSAs, current HINP agreements will be leveraged and modified to enable OHT integration, and the OHT will look to sector best practices and Ministry resources that may be made available. At the appropriate stage, a privacy impact assessment will identify vulnerabilities along with risk and liability assessments. The ICH will have HICs in place with access to CHRIS and Community Care Information Management (CCIM).

Legal Authority to Collect Information

As HICs, OHT partner organizations currently have appropriate legal authorities under the *Personal Health Information Protection Act* (PHIPA) to collect, use and disclose patient personal health information for care and treatment. Local privacy and access requirements, such as Agent agreements, client/patient access request and correction procedures, and information safeguards such as auditing and monitoring practices are employed by HIC partners to protect patient privacy and ensure compliance. HIC partners also have appropriate authorities under PHIPA to use PHI for administrative and secondary purposes, including decision support, analytics and research. For example, Osler's Research Ethics Board (REB) ensures scientific, regulatory, and ethical standards are met, and all research

that involves patients, physicians, staff, students, volunteers or visitors, must obtain REB ethical approval, including by investigators from other institutions who may wish to engage in research on Osler premises or with its patients. Similar privacy protective research ethics models currently employed by HICs, particularly those with highly vulnerable client populations (for example mental health and addictions), may be applied by partners for the OHT. One thing to note is that not all HICs have uniform privacy processes. Taking this into account, the OHT has already begun discussions regarding the need to level-set privacy and security policies and practices.

Safeguards to Protect PHI

Osler is the HINP for the REACH portal, and also for the CCIM Integrated Assessment Record; there is Enterprise Service Providers (ESP) and HINP experience within the OHT. As part of being a HINP, Osler undergoes routine Privacy Impact Assessments (PIAs) and Threat Risk Assessments (TRAs). Osler is well versed in these practices and also engages third parties to conduct these exercises when required. Some DSAs currently exist amongst health care providers in the region. Current DSAs offer baseline standards for information safeguards and roles and responsibilities for privacy and access, and can be used as a model or modified to support care delivery within the OHT. A master DSA with amendments will be needed to enable PHI sharing. From the OHT's inventory review of information sharing agreements and DSAs, identified agreements that can be used to aid in the development of this needed DSA where amendments can be added over time.

Challenges to Information Sharing and Overcoming Them

OHT partners currently use varying patient health information systems, according to their clinical scope and available assets. For example, primary care providers use Practice Solutions, Accuro, Oscar, and various EMRs. The CHRIS system hosted by HSSO is used by the LHIN to store patient records such as Health Links coordinated care plans, assessment and eligibility information, and home care service information. Multiple community partners access CHRIS through health partner gateway (HPG) as part of their processes. Osler uses multiple systems to make up its hospital EMR, and Meditech is the primary access point for providers. Hospital systems also include Picis, used in the emergency department, operating rooms and critical care departments. Other "best in breed" solutions are employed for specified clinical needs. Various partners use cON assets and community health organizations have various client/patient record systems, with some paper-based processes still in place. The challenges to information sharing will revolve around the various systems used by partners to access medical records. Having partners exchange information over existing information systems will be the primary barrier to overcome. Until regional pilots become available, the team will deploy REACH and cON portals throughout the sites of the OHT partners as a stop gap. Most of the OHT partners' native EMRs do support integration into REACH and cON such that these portals can be launched from provider's EMRs with patient demographics details included. The OHT can provide a data sharing solution among the OHT partners with minimal disruption to their workflows.

As the OHT progresses into Year 1 and beyond, it will add enhanced functionality and make an effort to join OntarioMD and Ontario Health pilots as early adopters as these options become available. Doing so will be ideal as it will move the OHT closer to its system consolidation goal and further simplify workflows as new functionalities (like single sign on) are introduced and made available throughout the OHT.

4.3.2. How will you digitally enable information sharing across your team? (refer to Appendix B)

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? (500 words)

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.

Maximum word count: 500

All member organizations have signed an attestation (see Appendix 13 for a blank copy of the attestation form signed by members) to indicate any performance or compliance issues, and to confirm that plans are in place to address them.

Governance

No OHT members have identified any recent issues with governance.

Financial Management

William Osler Health System (Osler) has submitted a balanced position for 2019/20 and has successfully balanced its Hospital Service Accountability Agreement (HSAA) budget for the past 10 years despite undergoing three large redevelopment projects at Brampton Civic, Peel Memorial Centre for Integrated Health and Wellness and Etobicoke General Hospital. All other members with service accountability agreements (SAAs) are also projecting a balanced budget at the end of the year.

Compliance with Contractual Performance Obligations

All partners with SAAs are substantially compliant with them. Some members have had varying issues with meeting contractual performance targets in the past, largely due to increasing demand for services in the high-growth region without corresponding increases in funding. The partners anticipate that by consolidating resources through the Integrated Care Hub (ICH) and across the OHT, they will be able to meet the collective demand of clients/patients more efficiently and effectively, and in doing so will mitigate any performance issues as a collective.

Compliance with Legislation/Regulation

No members have had recent issues with legal or regulatory compliance that would impede them from participating in the OHT.

Through the operational governance structure (steering committee) that will be created, an extensive due diligence process will be conducted to ensure that the partners contribute to

the overall benefit of the OHT. Through sharing of performance, compliance information and performance dashboards that outline collective goals, partners will have visibility to any emerging issues that need to be addressed.

Moving forward, OHT partners are committed to ensuring that the following processes are put in place in Year 1:

- Performance and compliance information relevant to the operations of the OHT are shared amongst partners;
- Performance dashboards outlining common goals are created and shared to improve performance of individual OHT members and the collective;
- Sound processes related to conflict resolution and accountability to OHT partners are developed and implemented to address performance and compliance issues, particularly as it pertains to the accountability agreement(s) between partners and the Ministry of Health; and
- Support and coaching for partner organizations to address performance and compliance issues will be offered.

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 experiences does your team have with quality and performance improvement and continuous learning? (1000 words)

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.

Maximum word count: 1000

Quality and Performance Improvement across a System

OHT partners have a well-established foundation and substantive, sustained results to support the realization of breakthrough improvements at the patient population and system levels. Cross-sectoral commitment and resources are in place to drive quality across the system of care, including:

- Implementing programs, protocols and strategies to improve integrated care management;
- Managing cross-sectoral/multi-organizational improvement initiatives as a result of integrated care programs and shared programs;
- Creating Quality Improvement Task Forces and other committees to manage quality improvement internally;
- Developing quality improvement plans with performance indicators that are audited throughout the year to ensure targets are being met;
- For home care and long-term care partners, undergoing Ministry inspections; and
- Accreditation

For a comprehensive view of each OHT partner's experience with quality and performance improvement, please see attached OHT Full Application - Supplementary Excel for Teams Table 5.2. The table demonstrates each partner's experience which will help shape an OHT

Integrated Quality Improvement Plan (IQIP). Many of the OHT partners have achieved "Exemplary Standing" with Accreditation Canada and others are accredited with high standing with Commission on Accreditation of Rehabilitation Facilities (CARF).

Partners rely on metrics to make data-driven decisions. William Osler Health System (Osler) tracks patient flow at an individual and aggregate level through the stages of transfer from ED to inpatient wards. Where problems are found, weak points are identified so teams can improve workflow, improve transfer efficiencies, and reduce occurrences of hallway medicine. More examples of dashboards used to drive performance can be seen by reviewing Appendix B.2.4.

The existing IQIP, developed through partner consultation and review of current practices, will be used to support improvements at the patient population and system levels. These will serve as a templates for the Integrated Care Hub's (ICH) approach to drive quality improvement across the system.

The IQP has adopted the Quadruple Aim as its true north to achieve quality outcomes.

The IQP provides:

- A Strategic Quality Framework;
- An approach to system level integration and alignment;
- The use of Logic Models for how to improve priority populations; and
- The Institute for Healthcare Improvement (IHI) Collaborative Model for Breakthrough Improvement: An approach to planning and deployment of improvement initiatives.

Three primary frameworks and an environmental scan of the partner organizations will be used to identify, exploit and integrate current or planned initiatives within the ICH to drive Quadruple Aim improvements. These include:

- Coordinated Care Management – Access to a care team 24x7;
- Health Quality Ontario (HQO) Quality Standards- Drive evidence to improve quality outcomes; and
- Ontario Patient Engagement Framework – Engage patients at all stages of the improvement journey to create a fully patient-centered care delivery system.

A shared learning of quality and performance improvement and active client/patient/caregiver/family member/community involvement will ensure that at maturity, the OHT will provide excellence in care, meeting expectations regarding acknowledgement and resolutions of concerns – and providing best practices in integrated care.

Continuous Learning

OHT partners are committed to continuous learning and improvement, with a strong emphasis on staff/provider engagement and growth. Using feedback provided directly from staff/providers as well as from clients/patients, engagement and development strategies include meetings, lunch and learns, best practice training, personal development, quality improvement training and other forms of continuing education. For a comprehensive view of each OHT partner's experience with continuous learning and improvement, please see **attached OHT Full Application - Supplementary Excel for Teams Table 5.2.**

Humber College is an academic partner that can respond nimbly to support the learning and improvement goals of the OHT, including educating staff for new/revised roles and offering leadership education and support strategies for change management and other best practices. Additionally, Osler offers a library service to address learning needs including academic literature and resources from thought leaders to inform business and clinical processes. This can be scaled to ensure OHT partners have access to up-to-date information on best practices to advance integrated care and population health.

An integrated continuous learning and improvement plan, informed by each partner's experience and the Improvement Science, Patient Safety and Patient Experience Capability building plan developed by the Central West Local Health Integration Network (LHIN), will also drive continuous learning. The plan provides:

- A capability and capacity assessment to understand learning needs;
- A dosing matrix which identifies which roles require different levels of knowledge;
- A course syllabus of three modules: Performance and Process Improvement, Patient Safety, and Patient Experience; and
- Ability to obtain a Lean Six Sigma Yellow Belt certification by completing three supplemental courses, taught by a Lean Six Sigma Black Belt-certified instructor.

Implementing Regional Quality Tables, Quality Leaders Tables and Patient and Family Advisory Committees with representation from all partners will provide a venue for partners to coalesce around three major priorities with an intentional focus on improving the patient experience, quality improvement capacity, and capability and collaborative adoption of quality standards. These committees will help support improvement work at the ICH level.

Osler, the Region of Peel, and the Central West LHIN all have robust data analytics and decision support functions. These organizations are accustomed to working together and with provincial/national partners to gather, review and interpret data. A small group has been identified with representation from all these organizations to review the data provided by the Ministry on the OHT's attributed population. In addition, the following OHT partners have indicated their organization has moderate to high data analytics capacity:

- West Park Healthcare Centre
- Central Brampton FHT
- Sienna Senior Living
- 1to1 Rehab
- WellFort Community Health Services
- CANES Community Care
- Bayshore Healthcare Ltd.
- Nurse Next Door
- Punjabi Community Health Services
- WeCare Health Services
- Saint Elizabeth Health Care
- Etobicoke Services for Seniors
- Peel Senior Link

Based on self-assessment, the following organizations have indicated they have a low level of data analytics capacity:

- CMHA Peel Dufferin
- Right at Home
- North Peel Family Health Team
- Dorothy Ley Hospice
- Heart House Hospice
- Brameast Family Health Organization
- Queen Square Family Health Team and Family Health Organization
- Wise Elephant Family Health Team
- Closing the Gap Healthcare Group
- Woodbine Family Health Team
- Peel Addiction Assessment and Referral Centre

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement? (refer to Appendix B)

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? (500 words)

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.

Maximum word count: 500

OHT partners have well established, unique processes for collecting client/patient feedback which is embedded into strategic policy or operational aspects of care and have demonstrated an improvement in care practices.

The majority of partner organizations collect client/patient/caregiver feedback on an annual basis, including holding yearly feedback and social events (Friends of Punjabi Community Health Services event), or include open invitations to operational meetings and board meetings. Most partners have implemented practices to gather feedback on a more frequent basis – typically through surveys. The feedback collected by OHT members (including patient experience) is used to inform improvement plans, strategic planning, and operational policies and procedures. For example:

- As a result of Woodbine Family Health Team's (FHT) patient advisory group, the FHT was able to modify the content and timing for various programs to better suit the needs of their patient population; and
- At William Osler Health System (Osler), a patient expressed concerns that a specific diagnostic imaging procedure was not delivered in a complete/informative manner, and as a result, the patient recommended creating a template that was later implemented.

In addition, partners hold focus groups, attend conferences, create advisory groups, councils and committees, and include client/patient/family/caregivers in the development of newly-formed practices and care pathways. Partner organizations that have had experience working with patients to re-design care pathways include:

- West Park Healthcare Centre
- Right at Home
- Central Brampton FHT
- Sienna Seniors Living
- WellFort Community Health Services
- Rexdale Community Health Centre (CHC)

- CANES Community Care
- Bayshore Healthcare Ltd
- Punjabi Community Health Services
- Etobicoke Services for Seniors
- Peel Senior Link
- Peel Addiction Assessment and Referral Centre
- Osler

Patient relations is a priority for partners and is built into feedback processes. The data collected about patient experience helps organizations understand the needs of the population they are serving and provides guidance as to how to improve care. All partners have patient relations processes in place, which for most organizations are combined with client/patient/family/caregiver feedback processes. Some successful examples of how different partner organizations have used their patient relations processes for quality improvement and practice change include:

- WellFort Community Health Services started a quality improvement project to make services more accessible after many clients expressed challenges with the booking system;
- After holding an annual client focus group, CANES Community Care changed their pharmacy vendor and started a foot care program for diabetes after clients expressed concerns with the current pharmacy vendor and lack of diabetes programs available;
- Rexdale CHC introduced same day/next day appointment booking system to access chiropody and physiotherapy in response to client feedback;
- Canadian Mental Health Association Peel Dufferin clients expressed concern with long service wait times, which led to the introduction of various quality improvement plans that reduced wait times by improving intake and discharge processes; and
- Peel Senior Link held a community engagement session with over 150 clients, caregivers, service partners and funders, with one of the outcomes being the development of the shift exchange IDEAS project (checklist) that led to a significant reduction in third party direct service staffing.

5.4. How does your team use community input to change practice? (500 words)

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.

Maximum word count: 500

The majority of partners understand the value of community input on improving the strategic, policy, or operational aspects of care. Many of the partners use unique approaches to engage with the broader community to gather this information. Most partners have implemented community outreach strategies to increase awareness of the programs their organizations offer and gather feedback on services and programs available. Some of these organizations have direct representation from the community (clients/patients/caregivers) on their boards, or invite clients/patients/caregivers to attend board meetings on a quarterly basis. The outcomes of engagement activities influence the strategic, policy and operational aspects of care for the OHT partners. Some prominent examples of how partner organizations engage with the broader community and how the feedback collected is directly used to improve care include:

- Punjabi Community Health Services (PCHS) extends the invite to their annual "Friends of PCHS" event to all members of the community, as a way to demonstrate to the work PCHS provides to;
- William Osler Health System (Osler) co-hosts events with the Brampton chapter of the Canadian Association for Retired Persons (CARP) and holds telephone town halls to stay connected to the community and keep local residents up-to-date around health care initiatives;
- Nurse Next Door invites community members to quarterly Board meetings as a means to provide an update on data for the quarter, and hear feedback on strategies to improve care for the next quarter;
- Dorothy Ley Hospice has a community outreach and education program to increase knowledge and awareness of hospice palliative care and increase community understanding of how to access hospice services if needed;
- The Peel Addiction Assessment and Referral Centre (PAARC) is engaged in over 60 networks and planning tables with multiple organizations across the broader community, both in health care and outside of health care, including sitting at several tables with the Region of Peel. The information and tools PAARC gains from their participation with the broader community heavily informs PAARC's operational service delivery;
- Osler is a part of a Region of Peel committee where planning takes place to improve care for the community (i.e. EMS redesign which led to an improvement in ambulance offload times);
- Osler used a co-design strategy by forming a sub-committee of patients using a Patient and Family Advisory Committee (PFAC) to collect development feedback. For example, during the MyChart project, a PFAC was used to gain perspective and insights for the development of the 'dictated notes' feature;
- Peel Senior Link has a Family Client Caregiver Advisory Panel that informs quality initiatives to better serve the broader community; and
- In 2014, the Region of Peel, in collaboration with their municipalities, conducted an extensive resident-engagement strategy to inform the development of its 20-year corporate strategic plan, 'Community for Life'. The community voice formed the

foundation of the corporate vision and mandate. Continuous efforts were made to engage with the community at large to monitor progress of implementation of the strategic plan, and to ensure that objectives were fulfilled.

5.5. What is your team's capacity to manage cross-provider funding and understand health care spending? (500 words)

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?

There is a range of experience among partner organizations in terms of managing cross-provider funding for integrated care, with only a few partners expressing limited experience. Partners have facilitated bundled care for various initiatives, including musculoskeletal (MSK), stroke rehabilitation, chronic obstructive pulmonary disease (COPD) pathways, motor vehicle accident client care, improved client/patient flow from acute care to home care, integrated health and social service care pathways, and jointly funded programs. Many of the partner organizations have worked together and shared funding for various programs and services. For example:

- Queen Square Family Health Team (FHT) will be managing funding for a joint program with Canadian Mental Health Association Peel Dufferin (CMHAPD);
- William Osler Health System (Osler) has vast experience managing cross-provider funding, including managing bundled care and regional care programs (such as diabetes);
- Peel Seniors Link partners with Supportive Housing in the Province (SHIP) and Punjabi Community Health Services (PCHS) will form the Integrated Seniors Team that provides care for individuals with mental health challenges. This program is made up of FTE from each agency who support care coordination for clients in the program; and
- West Park Healthcare Centre participated in bundled care for MSK and stroke Rehabilitation.

Partner organizations also have experience pooling financial resources with other partners and community organizations to advance integrated care through resourcing various FTE roles to support care coordination and other operational processes. Some examples include:

- West Park Healthcare Centre: Care coordinators who provide consultation, navigation and facilitate collaborative care for long term ventilation (LTV)/COPD/frail seniors
- Sienna Senior Living: Behavioural Supports Ontario Recreational Therapist
- WellFort Community Health Services: Staffing for the functional centre, including care coordinators for clients with multiple comorbidities
- CANES Community Care: Three employees (employed by three different organizations) for the Treat at Home Program
- Woodbine FHT: Data Specialists for the Quality Improvement Decision Support (QIDS) Program are shared by multiple FHTs
- Dorothy Ley Hospice: Community Outreach Educator (shared with Heart House Hospice and Acclaim Hospice), as well as actively looking to share back office staffing with other hospices
- Etobicoke Services for Seniors: Shared back office staffing with other providers

- Peel Senior Link: Supervisors of Client Services at each of Peel Senior Link's 11 locations provide a care coordination function for clients (intake, assessment, care planning, referrals, coordination with home and community care and primary care)

A limited number of the partners have experience tracking patient costs or health care spending across different sectors. Partners with experience in this area typically are larger, provincial organizations with branches in different regions (such as Saint Elizabeth Health Care, Bayshore Healthcare Ltd., CMHAPD, 1to1 Rehab, Central West Local Health Integration Network (LHIN), and Osler). These partners are required to track spending service delivery, costs and outcomes for clients/patients receiving service/care in various locations or throughout different points of the care continuum, with funding coming from a variety of different sources. Further, these partners will be able to lead the development of tracked patient costs and health care spending across the Integrated Care Hub.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan? (1500 words)

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.

Maximum word count: 1500

During Year 1, the objectives of the OHT are to build the framework of the Integrated Care Hub (ICH), SCOPE and develop the diabetes care pathway that will scale and spread the OHT as it matures. Much of the work during Year 1 will be centred on building foundations, structures and solutions for these regional assets that will become a comprehensive service model for the attributed population.

Critical success factors include technology and data sharing requirements; the OHT will utilize a phased approach to the roll-out of technology solutions and data sharing agreements which will take several months to complete due to the OHT's large membership. Master agreements will act as a starting point, modified and then distributed for OHT members' signature. Although many members utilize virtual care as part of their care processes, not all OHT members will have immediate access to Ontario Telemedicine Network (OTN), or regional data repositories. It will take time before all members have full access, and change management strategies will be developed to enhance the adoption of these new solutions.

Also critical to success will be to standardize intake data and relevant clinical pathways, streamline physician onboarding to SCOPE, and supporting the segmentation of participating physician patient rosters to ensure the identification of complex patients with diabetes. The OHT's proposed implementation timelines, with associated high-level milestones, are as follows:

Day 0

Prior to the Ministry's approval process, preliminary low risk work will be undertaken to prepare for initial OHT operations. Upon designation as an OHT Candidate, full execution of the implementation plan will begin. It is anticipated that Year 1 of the OHT will commence April 1, 2020. Project work will continue throughout Year 1 as the OHT operationalizes the ICH, SCOPE and diabetes care pathway. Below, high level milestones are highlighted for the first six months of implementation:

<u>At 30 Days</u>

- 1-800# identified for ICH
- Physical site selection completed for ICH
- Single fund holder identified
- ConnectingOntario (cON) rollout begins
- Client Health and Related Information System/Health Partner Gateway (CHRIS/HPG) rollout begins
- OneID rollout begins

- Engagement with specialists completed to inform development of SCOPE model completed

At 60 Days

- Establish Diabetes Clinical Advisory Working Group
- Determine physician after-hours access and next day appointments processes for ICH
- Complete asset mapping of diabetes resources, coordination services, SCOPE, navigation services and capacity analysis
- Identify human resource requirements for ICH and SCOPE
- Explore the mental health and addictions supports for SCOPE
- Identify fiscal resources required and source(s) for SCOPE
- Patient stratification criteria and resource matching criteria finalized for diabetes care pathway
- Standardize Centre for Complex Diabetes Care (CCDC) and Diabetes Education Centre (DEC) education

At 90 Days

- Develop Community Patient and Family Advisory Committee
- Develop Community Medical Advisory Committee
- Create OHT Steering Committee and project teams
- Conduct due diligence process for OHT members
- Identify governor engagement and change management strategies
- Identify measurement framework and metrics for OHT
- Develop ICH proof of concept/refinements to model finalized
- Develop ICH engagement plan
- Complete environmental scan of Family Health Team/Interprofessional Care models for future support of SCOPE
- Diabetes pathway completed inclusive of consistent care delivery, pathways, common measures and outcomes

At Six Months

- OHT branding process complete
- Business processes, agreements and funding mechanisms for SCOPE model developed
- Business processes for 24/7 system navigation and care coordination to support ICH developed
- Patient consent process for ICH, SCOPE and diabetes care pathway identified
- Develop clinic pathway referral form and implementation plan for diabetes care pathway
- Assign staff to the ICH
- Pilot testing for 24/7 system navigation and care coordination
- Develop marketing plan and education materials
- Master Data/Info Sharing Agreement developed
- OHT IM/IT level setting procurement process, system roadmap and budget completed
- Diabetes care pathway care plan processes developed
- eConsults for diabetes care pathway identified
- Referral process (paper) for diabetes care pathway developed

- Compendium of services for SCOPE navigation completed
- Secure messaging (One ID, OneMail) strategy for SCOPE determined
- Telecom network for ICH determined
- OTN Personal Videoconference (PCVC) implementation
- Clinical Operator to Provider Compendium
- ICH Resource Directory completed
- Soft launch of ICH (May 2020)
- Create PCP SCOPE engagement strategy
- Soft launch of SCOPE (May 2020)
- Soft launch of Diabetes Care Pathway (May 2020)

6.2. What is your change management plan? (1000 words)

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.

Maximum word count: 1000

Change Management Strategy Overview

The Integrated Care Hub (ICH) model at the core of the OHT application will require various partners and stakeholders to work together in significantly new ways in order to facilitate the seamless delivery of patient care. Key partners and stakeholders include but are not limited to: clinician leaders; primary care physicians; front line clinicians; clients/patients; caregivers and community members; and organizational and board leadership.

The change strategy to support the implementation of the new model will involve the implementation of an agile framework designed to guide the development of three core components required for change of this magnitude and complexity:

1. Change processes and toolkits to support organizational and individual change;

2. Change management levers to set objectives and plan change activities during phases of implementation; and

3. Change outcome areas that will guide activities to achieve alignment, agility, trust, mindsets and behaviours that support co-creation and new ways of working together.

The overall framework, including these core components, is visually represented and described in Appendix 14.

Change Processes and Tools

The OHT will use the PROSCI change management process to support the work. It is a world-renowned methodology that has been used effectively in other integrated health care initiatives. PROSCI is recognized in the field of change management for addressing both organizational and individual level change, and will be supplemented with other tools and processes.

Change Management Levers and Objectives

The change levers and objectives the OHT will achieve over this multi-year journey are the following:

1. Partnership and Collaboration: Build trust, alignment, and collaboration between partners, reinforcing co-creation and consensus-based decision-making

2. Stakeholder Engagement and Communication: Involve partners in the change in ways that establish meaningful commitment; ensure change is guided from clients/patients and partners, and led by front-line team members; Continually reinforce a compelling change story that generates buy-in

3. Governance and Partnership: Solidify a collaborative governance structure that brings together organizations to deliver integrated care; co-design the OHT to align strategy, structure, process, technology, people practices and metrics to achieve goals

4. Leadership: Develop active and visible leaders who can sponsor change in ways that inspire trust and enable collaboration

5. Learning and Coaching: Develop new, sustainable skills and expertise to ensure individuals and teams are agile and able to perform in an integrated care environment

6. Culture: Evolve the culture and embed a shared set of values and front-line behaviours so that clients/patients, caregivers and providers feel they are dealing with one entity

7. Change Planning: Design the appropriate change process and activities to facilitate and manage the transition

8. Measurement and Risk Mitigation: Manage and monitor change readiness, risks, and results

Recognizing the transformational nature of this change, the OHT will adopt an agile approach to change planning, measurement and risk mitigation in order to be both:

- Planful in areas where outcomes are predictable to deliver on, and
- Responsive to evolving requirements at key implementation phases.

Outcomes that will focus the OHT plan are the following:

- Alignment: Supporting organizations to develop integrated care as part of their core business – providing a “one team” approach to the client’s/patient’s health care journey
- Agility: Developing systems and processes that support teams in implementing new care processes to ensure clients/patients have a seamless experience
- Mindset: Addressing the cultural changes needed to support new ways of working
- Trust: Fostering effective professional and interpersonal relationships and collaborative ways of working for interprofessional provider teams.

Current Change Management Activities – Pre-Assessment to Full Application

To date, early readiness work has been conducted to prepare for change in the timeframe between “pre” Self-Assessment to Full Application. Structures and processes already have been put in place to involve and engage partners to co-design, plan, and co-decide on the ICH model and full submission development. For a detailed summary of these activities, which are also referenced this application in sections 2-5, see Appendix 15.

Change Management Activities - Year 1 and Beyond

The OHT will reference a menu of sequenced best practices designed to support both organizational and individual change. Some of the potential examples for Year 1 planning are summarized below. For a full list of the potential change activities in Year 1 and beyond, see Appendix 16.

Partnership and Collaboration

- Establish basic protocols and ground rules for collaboration
- Establish MOU and Partnership Agreements
- Interprofessional team launch “ICH go live” sessions for Navigation and Care Coordination and Digital Access teams
- Team development and collaboration sessions for interprofessional ICH care teams
- Partnership Transparency Workshops to build trust, surface learnings and course correct

6.3. How will you maintain care levels or care for patients who are not part of your Year 1 population? (500 words)

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.

Maximum word count: 500

As mentioned, in Year 1 the OHT will be focusing on rostered patients of primary care provider partners. These include complex patients with diabetes. The Year 1 population will continue to receive high-quality care through their primary care providers, and will access the Integrated Care Hub (ICH) when their primary care provider may not be available (such as weekends). The purpose of the ICH is to act as a safety net for when a primary care provider is not available - ensuring that the client/patient has access to appropriate, high-quality care 24/7. Members are committed to reallocating internal resources to serve both the needs of the Year 1 target population and existing patients.

For those who are not part of the Year 1 roster, they will continue to access high-quality care through their primary care and other providers. At maturity, all clients/patients will have access to the ICH. OHT partners will continue to maintain individual balanced scorecards and Quality Improvement Plans to ensure that those who are not part of Year 1 are receiving appropriate care.

The OHT partners will continue to be accountable to their existing quality mechanisms (e.g. individual balanced score cards and quality improvement plans), and will be required to comply with their existing contracts and standards to ensure care levels are maintained for existing clients/patients. There will however likely be an overlap with the OHT's Year 1 target population in the patient populations of all partner organizations. OHT partners will monitor quality of care for patients not in the Year 1 target population to ensure high-quality care is maintained.

6.4. Have you identified any systemic barriers or facilitators to change? (1000 words)

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*.

Maximum word count: 1000

There are many systematic barriers and facilitators for change that will require policy, legislative, regulatory or other changes.

Barriers to Change

Key Systemic Barriers

- Sector-specific restrictive accountability agreements
- Overly-specific funding that cannot be repurposed/moved to other organizations; including disease state or institution funding allocations;
- Privacy legislation related to data sharing agreements;
- A lack of clarity about the future system structure and the relationship among the Ministry of Health (MOH), Ontario Health, and the OHTs;
- Greater access to individualized data for planning purposes, as the OHT will need to access the databases of multiple partners;
- Access to partners' discrete data for analytical purposes;
- Integrating some provincial assets like eConsults and eReferral into clinician workflows; and
- Investment in resources to implement technological solutions to partners.

Accountability and Improvement Incentives

- An actionable and timely accountability framework enabled by more real-time data to drive outcome-based performance indicators (rather than process measures) to support performance monitoring and transformational thinking.

Funding challenges

- The OHT area encompasses one of the largest growing populations in Canada;
- Proximity to airport means the hospital and community provide care for an increasing number of out-of-country, uninsured patients (for instance, in 2018/19, 8684 uninsured non-Canadian residents and/or visitors received care, an 85% increase since 2015/16);
- Rapid growth is exacerbating already substantial inequities in per capita funding;
- Funding shortfalls create a significant impact on acute care services, and a supply/demand mismatch for regional community services, particularly care coordination, navigation, and home care and community support services;

- The OHT's integration efforts will help improve value and efficiency, but will remain insufficient to address the growing needs of the population and demand for services across sectors.

Physician Compensation and Capacity

Data indicates that primary care involvement and centrality is crucial to the success of accountable care organizations. The lack of clarity around how physicians will be compensated or held accountable for participating in the OHT creates uncertainty. Amongst change facilitators, the MOH could create new or amend appropriate OHIP fee codes to incent and stabilize physician participation in OHTs.

Physicians (particular from Family Health Organization (FHO) models) have expressed concerns about sending patients to walk-in clinics, due to penalizations. This encourages the use of emergency departments (ED) for non-emergent conditions. Re-alignment of incentives to enable greater partnership among providers and walk-ins would remove this barrier.

Incentives for physicians to provide care after hours are minimal. A goal of the OHT model is 24/7 access for patients and caregivers, which may eventually include access to primary care. To facilitate physician participation, incentives should encourage physician availability to patients and balance this with preventing physician burnout. Clarity around billing for virtual care is required, as this is not well understood by physicians.

Specialist services capacity is critical to the SCOPE model, so specialist capacity/availability and appropriate compensation must be determined. In the medium-term, the OHT may benefit from MOH policy supports that will ensure sufficient specialist physician capacity to meet rapidly growing demands for chronic disease care and treatment.

Information sharing

There is a patchwork of data-sharing arrangements and agreements across the province that leaves some patients/providers excluded. A standardized provincial approach to data and information sharing will help all OHTs. As an example, E-notification, operated through Client Health and Related Information System (CHRIS) by Health Shared Services Ontario, notifies Home and Community Care when a patient has been seen at/admitted to an acute care facility, but only within current Local Health Integration Network (LHIN) boundaries. Expanding this instrument to function provincially will improve care coordination and transitions for Ontarians.

IT implementation challenges

Funding and time required to conduct digital integration activities across a large and diverse partner group could pose a challenge to implementation. Funding for future digital assets will also be a challenge as capital dollars are scarce. There are several technological solutions that will address workflow challenges that improve the speed of transitions in care and maximize the usefulness of data and information. Both eConsults and eReferral can be further integrated into primary care electronic medical records (EMRs), Home and Community

and Hospital Information Systems which will save time for all users involved in the process. An investment in resources will close these gaps in a timely fashion.

Accountability/Governance Clarity

The Boards of OHT member organizations have been engaged in the development of a sign-off process. Part of the willingness to sign is the assurance that indication of partnership is not yet legally binding. All partners are aware that mutual accountability agreements are required. Clarity about prospective accountability agreements, future governance of the OHT and current board responsibilities, and the role in fundraising (especially for agencies who are reliant on fundraising, i.e. hospice), will help Boards understand how best to move forward.

Facilitators to Change

The greatest facilitator is the strong partnership among the participants, many of which pre-date the notion of OHTs. The intense work undertaken to date has created new working relationships and strengthened existing ones. Irrespective of the outcome of the application's review by the MOH, these relationships will support greater integration across the system and improve care for patients.

Specific existing instruments that will help to facilitate the OHT model include:

- The HealthLine: This system navigation instrument exists across the province and includes a wealth of information;
- Telehealth: One of the goals of the Integrated Care Hub (ICH) is the ability to provide 24/7 access to patients to help make decisions about the best destination for their care, and facilitate primary care appointments when appropriate. The OHT sees this as an enhanced Telehealth service and would prefer to reallocate funding from Telehealth to the OHT operations;
- William Osler Health System's (Osler) current role as a Health Information Network Provider provides a foundation for the digital strategy;
- Multiple partners have been early adopters of provincial assets and there is a willingness to continue to early-adopt new solutions that meet patient and provider needs;
- Focusing on change management for all partners to ensure their specific needs are met.

6.5. What non-financial resources or supports would your team find most helpful? (1000 words)

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*.

Maximum word count: 1000

A robust provincial digital health structure would help a great deal in supporting integrated, coordinated care. Current options tend to be offered at very high prices by for-profit organizations across the province, and thus uptake is inconsistent. An ideal system would include:

- A single, standardized EMR format for all Ontarians;
- Robust data gathering and reporting for all sectors in the way that the acute care sector is currently measured;
- Connection and coordination of all health databases so that each patient's journey can be tracked in one place;
- A 'one-stop' web-enabled instrument for every Ontarian to log into where they can see all their health information, including upcoming appointments, prescriptions with renewal dates, diagnoses and assessments, etc.;
- Assigned/seconded staff from Ontario Health and other partners;
    - Project management
    - Decision support
    - System navigation
    - Care coordination
    - Some direct services (nursing, etc.)
- Telehealth linked to OHTs—someone to pick up the phone who can both triage and provide advice about whether or not to go to the emergency department (ED), and if not, who can make an appointment for the next day for appropriate follow-up; and
- Identification (by name) of all the primary care providers (including solo practitioners) and specialists in the assigned networks.

In addition, some other helpful resources would include:

- More flexibility in funding envelopes;
- Revisions to the privacy legislation;
- Solo fee-for-service and walk-in clinic physician data;
- Roles, responsibilities and expectations of the 'fundholder';
- Clarity on where home care contracts are going (i.e. whether they will be opened up to reallocate relative market share for the provider groups); and
- Guidance on private/public partnerships.

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

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

6.7. Additional comments (500 words)

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

Maximum word count: 500

A population health approach to care is primarily focused on equity, to ensure that variation in the health status of a population decreases over time, and that the health status of the entire population improves over time.

The OHT proposal is rooted in this as well, focusing on equity of access for clients/patients/caregivers regardless of where they seek care, and for primary care providers regardless of their practice model. The OHT is focused on better supporting priority populations, enhancing health care service equity across the region, coordinating health and related service needs for patients, enhancing transitions and client/patient/caregiver and provider access. The approach has been centred on the clients/patients in the community, grounded in primary care and the community, and reflects the engagement of a large cohort of organizations and providers across the continuum of care.

The OHT has interesting challenges, including a large geography, large attributed population, and low numbers of team-based primary care providers. Despite these challenges, the OHT has a highly engaged group of physicians who have garnered support from various primary care practices across the region and who are actively providing leadership and development to the OHT. Numerous studies highlight the importance of primary care leadership as the foundation for a successful health care system, and the OHT is embracing this for patients. In addition, the OHT has a large number of participants from across the entire continuum of care who have provided leadership and development to the OHT. The number of members and affiliates who continue to be engaged in working groups and partner tables is encouraging, and provides all of the perspectives necessary to develop solutions to the complex problem of population health and integrated care. As new services are deployed, OHT members will have access to support personnel (to support training and troubleshooting problems) to assist with the new technical systems needed to support the OHT related activities and workflows. An investment in digital-focused resources would help ensure support is staffed at an appropriate level and additional funding would be valuable in ensuring members digital needs are met. The willingness to embrace change, to be inclusive and to value the perspectives from across the system positions the OHT well to deliver on its mandate. Furthermore, the history OHT partners have of working together effectively and performing well in various collective endeavours demonstrates the ability to create a highly-effective and integrated system of care.

The OHT represents an opportunity for the next stage for care as this regions looks towards a 30-year vision for health care infrastructure, including increased number of inpatient beds and embedded digital care, as well as care that also addresses the significant diversity in the area. The collaborative efforts of OHT partners and collective vision to improve care across the continuum will ultimate reduce the reliance and pressures on acute care services and emergency departments. This vision for the OHT is the next building block for a longer-term plan for health care in the region.

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	128 member physician declarations of intent included in this link.
Position	
Organization *(where applicable)*	
Signature	
Date	
Please repeat signature lines as necessary	

See end of document for member organization sign-offs.

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? (1500 words)

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.

Maximum word count: 1500

With the patient and caregiver voice at the forefront of service redesign, the OHT will apply patient journey mapping to redesign home and community care along health and social population profiles that focus on rising risk profiles of the broad emphasis of clinical, social and behavioural care.

The long-term vision of home care sees integrated care delivery teams organized around primary care where care begins in the community.

The delivery of home and community care will be offered by health service providers that will include the full continuum of community support services, home service supports (formerly service provider organizations (SPO)), direct nursing care programs, primary care allied interprofessional teams and care coordination functions. All partners will be health information custodians responsible for documenting and sharing information contained within coordinated

care plans and service planning documentation focused on outcome-based pathways and long term-independent models of care.

The patient and care team will experience and operate as one core team (regardless of employment arrangement) and the client/patient will have one main point of contact as a lead who will have full access to all elements of information related to the patient and family's needs, goals and care issues within an integrated digital approach.

The main areas of focus for home care redesign will include the following:

- Transformed home and community care assessment practices and information sharing across all partners to streamline efficiencies and improve the care experience (data sharing standards to be established);

- Service pathways for stratified patient profiles of home and community care cohorts, which will include outcome-based pathways to allow for more autonomous and accountable care delivery by providers;

- Increase in virtual care approaches;

- More congregate care delivery and associated funding models that support value for money and maximize health human resources;

- Interprofessional care design that supports maximizing scopes of practice and reduces redundant processes to support an improved care experience and assist with health human resource challenges;

- Appropriate level of intensity of care coordination and system navigation functions consistently across the OHT and by all coordination roles that support primary care, patient transitions, self-management and population health risk monitoring;

- Timely access to home and community care services at points of transitions from acute care back to community, through a smooth handoff to neighbourhood networks of care; and

- Funding models appropriately compensating home and community care providers.

Home and Community Care Service Delivery - Neighbourhood Networks of Care

Goals of Neighbourhood Networks of Care

- Formally connect providers to work together (**shared accountability**);
- Effectively manage care for populations (**accountability to outcomes**);
- Incent care in the most appropriate setting (**efficiency**);
- Reduce inappropriate demand (**efficiency**); and
- Simplify the system (**integration**, reduce administrative complexity).

Home and community care partner organizations (contracted SPO's and community support services (CSS) health service providers), in partnership with the existing Central West Local Health Integration Network (LHIN) Home and Community Care leadership team and patient

representatives, will collaborate to develop networks of full service care delivery. These networks of care will be based on primary care alignment and natural neighbourhood profiles to increase an integrated team approach by improved consistency and dedication of providers working together. Through shared and agreed-to principles, all home and community care partners (SPO and CSS providers) will voluntarily explore how to best align service capacity resources and business processes to create a network of care approach within reasonable neighbourhood geographies. This approach will not only strengthen the relationship and trust within the OHT, but it will also support increased service accountabilities at a neighbourhood level, and streamline administrative functions and reduce duplication in many facets of service delivery and integrated care coordination. These networks of care will execute on the foundation of evolving care pathways to streamline care provision, avoiding duplication and providing more cost-effective and value-based health care.

Through the patient risk stratification that will take place through the centralized intake of the Integrated Care Hub (ICH), access to Home and Community Care services will be matched to the presenting needs, based on the most appropriate service intervention and the strength of the neighbourhood networks. This approach of all partners working more closely together will result in the patient having care delivery by the best-matched service intervention that will reduce the potential of duplication and will in turn, create less fragmentation in care delivery. The network of care approach will allow providers to organize staffing models in new ways that can increase better scheduling practices within neighbourhoods that can improve the working conditions of front-line home care workers – thereby creating better stability of the valued work force.

Based on lessons learned from several years of small scale planning and implementation of tests of change that has taken place within this region, the OHT will expand and implement care models based on examples such as Health Links, Health Quality Ontario (HQO)'s best practices related to bundled care, transitions in care, wound care, and the PACE models of integrated care, as well as relevant components of previous levels of care modelling.

Existing care pathways of wound care, hip and knee bundled care, stroke care and palliative care will serve as model frameworks to build and implement additional community-based care delivery approaches.

Roles and responsibilities of the delivery partners will be clarified, and will contribute to a core set of team members supporting primary care. Overall, this will lead to an improved expected outcomes of care will maximize scopes of practice. Areas of assessment and care planning will be done consistently and will not be repeated unless significant changes make it necessary.

Expansion of upstream preventative and rehabilitation models of care will be delivered by the most appropriate community provider based on the success of restorative and 'living well' models of care such as has been executed in the Central West LHIN through the Home Independence Program.

In the future, care will be better integrated as there will be streamlined practices to one central point of contact for patients/caregivers and other interprofessional team members. More home and community care will be delivered in 'Convenient Care' sites (congregate settings) which will make use of existing home care, community-based Nursing Care Clinics. Further, existing exercise and falls prevention class sites will offer enhanced interprofessional service offerings. Support services, programs and resources will be accessed from across primary

care, social services, and home and community care to coordinate a true, integrated approach to care.

Care Coordination Functions in Home and Community Care Delivery

Care coordination will take place across the entire continuum with increased intensity and consistency for the most complex patient needs. The scopes of practice of all partners will be maximized where the most appropriate partner will be accountable for collaborating in the design and monitoring with patients/caregivers and primary care in the care plan implementation. In other more complex scenarios, the Care Coordinator will be expected to serve as a Systems Coordinator supporting the full care team and patient in the system view of all aspects of care. The OHT partners will collaboratively develop the standard operational requirements of coordination and individual patient care planning accountability so that regardless of who employs a coordinator, the role is consistently executed so that primary care, patients and families can reliably count on that main point of contact.

Home Care Delivery through Virtual Care

The successes of virtual care delivery in home and community care will be expanded to increase access to care. Models such as eShift (virtual directing nurse providing direction and supervision of care to an enhanced Personal Support Worker (PSW) at the bedside), that have been launched by the Central West LHIN Home and Community Care, will be expanded to support an increased access to care through efficient means. In addition, the virtual approach to care of Ontario Telemedicine Network (OTN) Guest link will continue to be leveraged to support virtual care between primary care, care coordination, the neighbourhood network care team and primary care. This intervention has been particularly successful for patients with mobility or transportation issues impacting their ability to access primary care. By increasing the use of virtual visits in primary care, the savings to patients, the system and clinicians will be significant.

Care delivery at the bedside will be maximized through the use of virtual care to support the integrated care team in collaborating in real time. Additionally, models of virtual care to support self-management and health teaching approaches will be leveraged while aligning all telehomecare and direct nursing interventions to support the full range of transition and upstream care approaches. Virtual care in wound care related to complex diabetes needs for the Year 1 population will see a significant improvement in care delivery. Through digital tools and remote monitoring, the patient care team and leaders can evaluate care delivery progress to expected outcomes, thereby increasing real time accountability and performance oversight.

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 service 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		

Maximum word count: 1000

Based on historic analysis and alignment with the attributed population, the Year 1 focus on complex patients with diabetes who are expected to require home care is approximately 22% of all home care patients served (about 6000 patients per year). Additionally, it is expected that approximately 40,000 patients will call into the Integrated Care Hub (ICH) per year to be connected with care across the broad home and community care continuum.

The goal in Year 1 is to maintain home care stability while working toward a transformed longer-term vision of modernized and better integrated home care.

Incremental changes in home care will occur in Year 1 with aims to:

- Reduce duplication of assessments and coordination among service providers, community support service providers, family health teams, community health centres (CHCs) and other interprofessional models of care;
- Creating integrated teams by building the neighbourhood network model of care;
- Establishment a self-autonomous care delivery with outcomes and accountabilities created for streamlined home care delivery; and
- Launch coordinated care and system navigation within the ICH.

Operating as an interprofessional team will occur through a coordinated operationalization of primary care, service provider, care coordination team and community support service (CSS) partners in the Year 1 of the home and community care offering. Depending on the population, health needs of the client/patient/caregiver will be navigated from the ICH to the most appropriate lead coordinator. Over the course of the first year, existing local home and community care levels will be offered until common leveled care pathways and funded levels can be put in place, where increased self-directed autonomous and accountable teams can be responsible for care delivery.

In Year 1, centralized intake for home and community care will take place within the ICH that will be leveraged from the existing Central West Local Health Integration Network (LHIN) Home and Community Care intake infrastructure. The ICH will take shape as the broader mandate of navigation to health and social care across the region. All assets of home and community care will be required to execute on the central intake approach. Existing practices of central intake for home care, convalescent care, assisted living/supportive housing, Central West LHIN-led exercise and falls prevention classes, and adult day programs will be maximized and improved to best utilize skills and infrastructure to connect patients and families to care quickly. A full review of assessment practices will be undertaken to look for inefficiencies and redundancies in processes that impact access to care, patient experience and provider experience. Areas that require a transformed approach will be prioritized in Year 1 to be improved to build a solid foundation of broad system-level intake. The success of the Integrated Care Coordinator Team between William Osler Health System (Osler) and the Central West LHIN Home and Community Care team will continue to be leveraged to assist with smooth handoffs from the hospital to community.

Some opportunities include stratifying care coordination functions at intake and assessment to ensure the most appropriate level of transition planning is offered. Beyond this, the responsible role for coordinating care and creating service plans will be tested across the population health profiles that are created in Year 1. Currently, a trial is underway that utilizes a home and community care coordinator who follows a patient between the hospital and into the community for the most complex transitions. Alternatively in Year 1, a trial will be explored for the less complex patient cohorts to have a lead nurse coordinator (who also serves as the clinical nurse provider) assigned to serve as the transition coach from hospital into the community. In both scenarios, strong and appropriate methods of partnering with primary care and other team members will be essential in supporting integrated care planning and oversight of home and community care delivery. The desired state is that primary care will be able to be more involved in individual care planning, through identifying resource needs that can be operationalized by many different parts of the system – not solely the traditional parts of the home care delivery offering. For this reason, the focus in Year 1 to support care coordination modeling, that includes the broadest definition of coordination, will be required that is beyond the traditional home care basket of services alone. Change management and education to existing care coordinator roles across the system will take place.

Central West LHIN Home and Community Care has all care coordination functions aligned by sub regions that match this OHT boundary and all care coordinators are aligned to primary care practices with caseloads being built primarily around the primary care practice and active home care patients. This model requires some additional resourcing to increase the strength of collaboration with primary care and to be more upstream in home care delivery and planning. The review of the alignment model would take place in Year 1 in collaboration with primary care leaders, patients and front-line staff so as to plan what future alterations to the approach may be required.

Care delivery at a network neighbourhood level will require a great deal of joint planning and leadership. In Year 1, the existing contracts and service volumes are expected to remain the same, so the work to begin to plan, develop shared principles across the home care, and CSS sectors in order to move to voluntary alignment of service volumes.

In Year 1, several additional nursing clinics will be in place. These clinics are expected at maturity to evolve and to expand to full interprofessional care models, therefore continual planning and implementation will take place in Year 1 and beyond. In the future, the OHT anticipates that virtual care of eShift will be expanded to palliative care.

The Rapid Response Nursing Program in home care will prioritize rapid transitional intervention for at-risk patients with diabetes. These opportunities, along with the broader touch that shared resourcing can offer in self-management care through the planning of the ICH, will allow for other upstream opportunities to reduce further home care risk interventions.

A.3 How do you propose to transition home and community care responsibilities? (1000 words)

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.

Maximum word count: 1000

Central intake, care coordination (community programs and transitional care), health care connect, centralwesthealthline.ca, information and referral, long-term care placement, direct hired nursing and pharmacy programs, exercise and falls prevention class resources and leadership roles will be assigned as deployed resources to the OHT in Year 1. These will initially remain as resources of Ontario Health until the full governance and leadership structure of the OHT is in place.

As the home and community care management structure and appropriate operational support are aligned by geography, the resources will be easily mapped to this OHT without risk of de-stabilizing home care and access to care services.

Appropriate support functions of finance, decision support quality/risk, contract, performance and procurement, information technology and human resources will also need to continue to support the day-to-day operations of delivering home and community care within this OHT, and will be a critical success factor.

Digital assets of the Client Health and Related Information System (CHRIS) and Health Partner Gateway (HPG), Guest Link of Ontario Telemedicine Network (OTN) programming, bi-directional Health Report Manager (HRM), expansion of ConnectingOntario (cON) datasets, and access to discreet data will also need to be continued and ideally enhanced to maintain and improve home and community care in Year 1. As the OHT matures, a review of clinical digital supports will take place and alignment of information sharing and reduction of any duplication of information management will be a prime goal of review as the OHT works toward the vision of a comprehensive electronic health record (EHR) that supports all of the members, including the patients within this OHT, and supports the information needs of other non-OHT stakeholders.

For the transition period, all existing service provider organization (SPO) contracts are expected to be transitioned over to the OHT, based on presence of market share representation with the OHT geography. As the model of care evolves and integrated opportunities exist, the potential realignment of full service home care contracts or staffing models should be explored as outlined in the previous sections related to the vision of the neighbourhood networks of care.

The resources of the Central West LHIN Home and Community Care teams will be deployed as they are now to serve these neighbourhoods and the associated primary care and community partners within this OHT. The initial care team function of intake will also be leveraged to begin to build the Integrated Care Hub in its expanded model and in the meantime, the intake function of this team will continue to support the intake and transitional service planning for all home care patient needs.

At maturity, these resources will be used to execute on the transformed home and community care vision and the priorities of the OHT.

A.4 Have you identified any barriers to home and community care modernization? (1000 words)

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.*

Maximum word count: 1000

Centralize Patient Data and Information Sharing Barriers

Data from community care must be pooled with all data for clients to make client-centric decisions. Currently Home and Community Care data is not shared with primary care due to lack of IT infrastructure. Data needs to be seen by all providers (i.e. home care has access to community data but not vice versa). Sharing between the agencies is also not available. In order to see system level and care delivery outcomes, there needs to be an investment in standardizing data definitions – particularly as multiple sectors come together - all who up to now, have a different understanding of data and approaches to capture data. In order to further satisfy stakeholders' information needs, access to data must be discreet. In today's health care environment, many sources of information are images that are challenging for providers to review as the process is not user-friendly (i.e. it is a time consuming process for a provider to find what they are looking for, so search capabilities would make things easier for providers and their patients).

Care Continuum and Delivery Barriers

The Assisted Living Policy 2011 as well as other provincial policy may need to be reviewed to ensure that the full care continuum is met in the community. The OHT partners will look to maximize the operationalization of the full care continuum in this community, based on the population health needs and strengths of service delivery to execute improved value for money and patient-centred care responsiveness.

Expanding the definition of an approved agency in *Home Care and Community Services Act* will be explored to consider working as a better integrated care team while also maximizing critical value for money and eligibility of services.

All partners are being appropriately considered as Health Information Custodians under the *Personal Health Information Protection Act* to strengthen real time health information sharing and care planning.

Funding Barriers

Funding models that appropriately compensate home and community care delivery providers are required in order to maintain stable health human resources that contribute to reliable and continuous home care.

Health human resource risks exist in the home and community care sector. New considerations of funding models in home and community care should be examined where more full time work can be offered. There is a requirement to fund home and community care

(in the broadest sense) in this community at appropriate per capita home and community care levels.

Virtual Care Barriers

The definition of home care visit must include virtual care under the *Home and Community Care Act*.

Appropriate funding to increase incentives for physicians to partner more purposefully with home and community care for home visiting or virtual care visiting are required.

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, 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 viewers** *ClinicalConnect or Connecting Ontario*	**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 patient access channel and if it is accessible by your proposed Year 1 target population*

For the completed table, see the "Supplementary Excel for Teams – Brampton, Etobicoke and Area" document.

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.

B.2.1 Virtual Care (1000 words)

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).

Maximum word count: 1000

The OHT plans to redesign care through the creation of an Integrated Care Hub (ICH), providing clients with a 24/7 system access model through 'one door' to connect them to appropriate health related services based on individual needs. Virtual care will be integrated into the care delivery approach and the OHT will work with groups like Ontario Telemedicine Network (OTN) and other health care providers to continue to learn and implement successful, leading edge, patient- and provider-friendly virtual care tools that will enhance practice, support system transformation and improve outcomes. The vision is to enable clients to use virtual care services with the OHT at multiple points in their care journey:

- Tele-triage* and system navigation* via phone
- Video and audio client-provider visits*
- Digital self-management tools*
- eCheck-in*
- Online self-booking

Instead of heading to the emergency department (ED), a patient will be able to virtually access the ICH in Year 1 and securely engage with a care professional and connect to the required care services. Proper execution of the ICH will provide clients with new points of access for care which aligns with ending hallway medicine.

Given the focus on diabetes within the Year 1 population, the OHT will prioritize connecting endocrinologists, dieticians and other providers through virtual care channels to support the proposed diabetes integrated care pathway.

Existing Capabilities

Members of the OHT have been early adopters of OTN initiatives, and the plan is to build on the successful Telehomecare (THC), Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) virtual care experience and learnings and deploy them to the

diabetes team. Over the next five years, the OHT will scale and spread to other chronic conditions and beyond. As catalogued in the Current State Assessment (B.1), multiple partners are already using one or more virtual channels to interact with clients and providers. Being early adopters of OTN opportunities, multiple cross-sector partners in this OHT have deployed care using telephone, secure messaging and video interactions for some time.

The availability of OTN throughout the province provides an accessible choice for partners in the OHT who currently do not have virtual capabilities, and would be easiest for partners to adopt in sectors like community care that do not traditionally provide virtual care. Patients will value the convenience of the device agnostic, mobile-friendly solutions. Some of the partners also have eVisit and eConsult experience including an OTN-sponsored primary care project that was piloted in the Central West Local Health Integration Network (LHIN). Novari's eVisit allows patients and providers to engage via audio or video call and secure messaging, providing connectivity options for clients. Although this technology does not directly integrate with the client's chart, the eVisit module can send electronic case notes of each client-provider virtual care appointments back to the client's primary care provider (PCP), which supports the closed-loop vision of the ICH. The eConsult will enable the provider to provider connections and Service Level agreements will be developed to ensure agreed-upon response times are adhered to by the ICH providers.

Gaps and Mitigating Steps

Although OTN has been identified as the OHT's easiest asset to scale, there are challenges with the technology that could serve as a barrier for physicians and specialists. OTN does not currently integrate with many of the partners' electronic medical records (EMRs), creating work for providers who need to transfer the information to their clients' chart. Adoption would increase if solutions like eConsult and eVisits integrated with the EMRs. Although virtual care is widely used by salaried care providers, another challenge will be physician remuneration for 'fee for service' care providers. One mitigating factor is that billing codes for virtual services be re-evaluated. The OHT will work with OTN to improve EMR integration.

With the introduction of the ICH, there is a need for a change management plan. The OHT will take steps to ensure its clients are well-informed and educated on the ICH points of access for care, and the types of services that will be available.

Year 1 Target

The OHT identified that many partners are already routinely using virtual care services to engage with their patients. Given the OHT's existing capabilities and steps outlined in Year 1, the OHT feels confident that the 2-5% virtual care utilization target is achievable.

Future Vision

Build upon the work completed by partners that successfully use virtual care as alternatives for their clients as demonstrated by a partner's relationship with Geek Squad to retrofit a patient's home so a family can virtually monitor their loved ones (self-management) and quickly act should an incident arise. Another example is the remote monitoring by a partner that provides culturally-sensitive care due to stigma around nursing homes.

As mentioned, several partners have been early adopters of virtual care and the plan calls for a continued approach to introduce new virtual care solutions that enhance patient and

provider experience. There are relationships in place with OTN and discussions are underway to redesign pathways and integrate systems into workflows, including integrating into EMRs, Client Health and Related Information System (CHRIS), and Hospital systems.

Evaluation

The OHT expects that through virtual care, there will be an improvement in client flow through the system and timely access to care. Metrics like avoidable ED/walk-in/urgent care visits, 30-day inpatient readmission rate, timely access to primary care, and seven-day physician follow-up post-discharge will be used by the OHT partners in determining the efficiency of its virtual care services.

Regardless of the type of virtual care, meeting the needs of patients and their families, providers, and administrative leadership is essential. Metrics will be incorporated to ensure objectives are met. The OHT will also focus on obtaining client-reported experience measures after accessing a virtual care service to learn from and improve on dimensions important to clients (e.g. convenience, satisfaction, confidence in managing their care). Similarly, OHT plans to measure provider-reported metrics following virtual care encounters through means like the existing OTN physician survey to measure efficacy, and ensure the virtual care tools are effective.

B.2.2 Digital Access to Health Information (1000 words)

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.

Maximum word count: 1000

Digital Health Access to Information Plan

The OHT plans to use its current regional Clinical Data Repository (CDR), explained further in B.2.3, to aggregate data from all partners and enhance a centralized patient portal for all clients in the OHT at maturity. In Year 1, the OHT will continue to add content to the provincial asset, MyChart, to share information with patients, There is an existing relationship with Sunnybrook Health Sciences Centre ('Sunnybrook') for MyChart. OHT members have been in contact with Sunnybrook, and discussed being an early adopter for new functionality and to populate patient information from other sources, for example, the eHealth provincial repository. In parallel to this, there have been discussions with OntarioMD (OMD) on the idea of building on the success of the Hospital Report Manager (HRM) and working with OMD as an early adopter to make HRM bi-directional and add primary care and specialists' EMRs core patient data into ConnectingOntario (cON). This OHT will also work with Sunnybrook to populate MyChart with patient data from the provincial repository. This type of initiative could be scaled to meet the needs of other OHTs. This data could also be sent to another regional patient-facing information system which could be fed from the Regional Clinical Data Repository. In essence, this OHT has options but wishes to support the Ministry and its vision.

Without having clear indication on the vision, the current Year 1 plan is to have three to five organizations focused on integrating data into the CDR and develop a one-stop patient-facing digital companion that can operate independently or integrate with MyChart, and to have it accessible for Year 1 clients who access services from the partners. Each following year, more partners will be able to offer a patient digital companion and have their patient data added to the CDR, and subsequently the centralized patient digital-companion portal will be available to patients and families.

If the Ministry's vision is to leverage MyChart, the patient companion will augment the MyChart to fill gaps that patients and families deem as critical and/or time sensitive. The plan would be to work in conjunction with MyChart to collectively enhance the functionalities for patients and families.

Existing Capabilities

As catalogued in the Current State Assessment (B.1) of the OHT partners' digital health capabilities, members of this OHT use patient portals with varying degrees of functionality, including access to their diagnostic results, lab results, consult notes, scheduled appointments, booking appointments, secure messaging, and other information. The plan is to learn from each partners' experience, spread existing solutions, and continue to expand functionality based on what patients and families identify as priorities and what the Ministry is asking the OHTs to accomplish.

Future Capabilities

The patient-facing digital-companion can use the CDR to securely present information to the patient. Over the course of the next few years, new functionality will continue to be made available, for example: self-scheduling; access to educational material; a gateway to virtual care functions; and enable patients to set individual communication preferences like email, text, and voice.

As the OHT forms its steering teams, there is agreement that enhancing patient convenience functionality will be a priority. As part of each steering team-recommended strategy, a project team will be created to determine that all the deliverables required are successfully delivered.

Gaps and Mitigating Steps

With multiple experienced health information custodians (HICs) and an experienced health information network provider (HINP) this OHT has the capability to address the *Personal Health Information Protection Act* (PHIPA) responsibilities like data sharing requirements. The plan is to leverage existing agreements to develop a Master Service Agreement, and introduce processes to add amendments to the agreement so that expansion of patient-facing functionality is not delayed due to facilitating agreement processes.

OHTs would benefit from funding that is dedicated to introducing new and enhancing current digital solutions.

There are community sector and solo practice physician partners, who are not currently able to provide digital health information to their patients. Although the goal at maturity is to have a centralized portal for clients to access integrated information from all OHT partners, there are barriers to overcome in the first couple of years. Aside from a significant cost component to integrate information to one patient portal, there are restrictions with privacy legislation in both sharing information between providers and enrolling clients to create their account. The OHT is hopeful that there will be a OneID strategy for both patients and providers and although the OHT sees the value of having a provincial methodology for authentication, it can continue to progress in the interim.

Ability to Meet Year 1 Digital Access Target

Working toward the target of having 10-15% of the patient population who received care from The OHT digitally access their health information is achievable. The OHT plans to build a communications strategy into its processes that will promote patient awareness of their digital portal for receiving their health information. All clients/patients accessing the OHT's services will have the ability to sign up and use the OHT's patient portal to access their health information. Information on how to use the portal will be provided during visits to OHT partner sites or during engagements with the ICH. The OHT will request permission from patients to send information via text, email or other preferred means to help raise awareness and educate them on how to access their patient information digitally. By encouraging patients to sign up whenever there is engagement, raising awareness of the self-help portal and offering education on the portal's use, efforts will be made to maximize success of getting patients to access their health information digitally. Throughout the year, the OHT will monitor results and course correct if the plan is not working.

B.2.3 Digitally Enabled Information Sharing (1000 words)

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).

Maximum word count: 1000

Capabilities

The OHT will work with partners to ensure care providers have access to the provincial systems like ConnectingOntario (cON), Diagnostic Imaging-repositories (DI-r), and that primary care physicians are using a Health Report Manager (HRM) to e-populate their respective electronic medical record (EMR).

This OHT can take advantage of a Health Information Network Provider (HINP) hosted Clinical Data Repository (CDR) that was designed to protect the privacy and security requirements of all Health Information Custodians (HICs) that contribute personal health information (PHI) to CDR. Data is housed in separate databases and system access is audited regularly. This regional system is actively used for accessing detailed patient information including electronic inter-professional clinical notes and Client Health and Related Information System (CHRIS) information. The Digital team has learned that EMR vendors have a secure ability to electronically populate the CDR with their clients' core data set.

The plan calls to work with primary care to help move their on-premise EMR to a hosted environment and/or where available, encourage them to migrate to their vendors' Application Service Provider (ASP) solutions. By consolidating systems, this will ease the integration of members' data with the CDR and if OntarioMD (OMD) makes HRM bi-directional, then integration with the provincial repository will be easier. OHTs would benefit from funding that is dedicated to introducing new and enhancing current digital solutions. This would help incentivize and speed up adoption of the proposed system consolidation models.

The team has been working with the EMR vendors to develop a digital plan to contribute data or develop a query mechanism to extract core data and present it to the circle of care user, so there is a complete view of a patient's information.

To make clinician workflow easier, the plan is to work with the EMR vendors to launch the regional portal and cON from their respective EMR, and launch the portal with patient context. This will ease adoption and enables these systems to become part of the providers' workflow.

An opportunity for employing existing tools to support the SCOPE Model is to use a mobile-friendly secure messaging system like the unified communications tool used by William Osler Health System (Osler). The system will enable care providers to communicate securely, link pictures, and have patient context information drawn from EMR systems. The mobile messaging solution can be used to support point to point electronic access between primary care and the appropriate specialist. This system can be used to track patient flow by sending alerts to the primary care physician, appropriate specialist, or other care provider as the patient moves through their care pathway.

Gaps and Challenges

A team will be established to market, on-board, and develop training plans (such as building on Cancer Care Ontario's Learning Management System), for all providers that aren't accessing a provider portal.

If the Ministry has a plan to invest in cON the plan would be to work with organizations like Ontario Health and OntarioMD to become an early adopter or beta-tester to have physician EMR core data use HRM as a bi-directional gateway to send/receive data to/from the provincial repository and to make primary care and specialist office EMR data available in cON. Discussions have occurred and members have expressed interest to OMD and Ontario Health to be early adopters for future enhancements. Until clear direction is identified, the plan above will be explored and executed.

Another gap to be addressed is around solo practice physician sign on. Adoption has been limited as care providers are frustrated by the need to remember multiple login credentials. Adoption would increase if single sign on was addressed.

Based on the interpretation of the Digital Playbook, it appears data sharing agreements will be required unless there is a solution to overcome existing privacy constraints. There is a plan to apply and modify existing information sharing agreements (ISA) and use a master ISA or data sharing agreement (DSA) and to use an amendment process to add to the master agreement.

Many members have been early adopters and working with the provincial assets, and also engaging OntarioMD and OTN to align with their vision and roadmap. Members have been actively using PCVC, eConsults, eVisits, eReferral and other assets. The plan calls for scaling and repeating successes to support the Integrated Care Hub, SCOPE model, and the diabetes care pathways.

In order to meet the needs of those involved with the diabetes care pathways, the digital group will work with the care team stakeholders to determine the short-term and long-term plan to create an OHT care plan that can scale to future care programs. Early indications point to using Health Partner Gateway (HPG) however, the lack of integration with existing EMRs is a concern that the Ministry, through HSSO, may choose to resolve.

Community service organizations, solo practice physicians, and community-based specialists that have independent EMRs residing in their offices (i.e. on-premise) are a gap that will need to be addressed after Year 1. With some investment from the Ministry, these challenges can be used to incentivize partners to overcome these challenges at a faster rate. Another alternative that the Ministry may consider is to invest in and use a solution like HRM to close these gaps.

Evaluation

Most partners use Microsoft O365 which provides this OHT with an ability to scale across partners including back office tools, including email and solutions for secure communications. Microsoft's Power Apps (i.e. PowerBI) can be used to address the population health needs and collaboration tools to facilitate decision support, analytics, reporting, mobile clinical

alerting systems, and secure messaging to enable clinicians to securely communicate and collaborate.

Advanced use of scorecards and metrics are in place along with advanced artificial intelligence analytical capabilities. These can be expanded to present aggregate metrics for the targeted population. The plan is to work with care groups to address the metrics stated earlier in this submission, and to determine other meaningful metrics as they relate to the OHT's strategic priorities.

B.2.4 Digitally Enabled Quality Improvement (500 words)

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?

Maximum word count: 500

The plan calls for all member partners to submit an inventory of current metrics to a newly formed cross-member working group. The team would be comprised of leaders and care providers. The first mandate of the team is to ensure there is a process to meet current reporting requirements, then to review the inventory and select common metrics that align to the OHT's vision.

Sophisticated systems are in place already. These systems have advanced analytical capabilities like retrospective, real-time, and predictive analysis using Artificial Intelligence (AI) and Machine Learning cloud-based services that are in use, albeit at an introductory level to aid in the progression through the learning curve.

William Osler Health System (Osler) has already deployed a mobile communications alerting and paging solution to monitor patients in order to detect sepsis, alert on unfavorable lab results from Nasopharyngeal (NP) swab analysis, and track patient flow to minimize wait times within the hospital. Osler employs a number of dashboards to monitor historical and real-time performance.

These solutions all already have dashboards in place. They are perfect examples of the use of digital health tools and information to drive quality and performance improvement. All in-line with the Quadruple Aim by improving patient and caregiver experience, and patient and population health outcomes. The intent would be to grant all OHT members access to population health data.

See Appendices 17-19 for examples of real time dashboards and patient tracking reports.

These abilities are all already within the skill sets of OHT members. These solutions can be expanded to all OHT partners. As more data is captured from OHT members, the Clinical Data Repository (CDR) can be used for analytical and performance purposes. Eventually, once the OHT is comprised of all its members, the CDR will securely house all clinical information and population health analysis for past, current, and future predictions at an aggregate level.

The OHT anticipates being able to develop quality improvement plans with KPIs and measures by leveraging experiences as those mentioned above, to create OHT-relevant metrics that are audited throughout the year to ensure targets are being met.

The team will target metrics to:

- Focus on preventive care (immunization and screening), prevent people from being designated Alternate Level of Care (ALC), go into Long Term Care (LTC), early home care assessments while in hospital, etc.;
- Limit wait times (for example for mental health consults);

- Increase emergency department (ED) diversions;
- Reduce time from assessment to start a service'
- Monitor data from the entire continuum (e.g. ED Pay for Results + time to start service after discharge);
- Correlate with other databases using various data marts, lakes, and views and then use these metrics to compare costs/outcomes between providers to standardize practices across the OHT; and
- Track the success of virtual care users and virtual care utilization.

B.2.5 Other digital health plans (500 words)

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

Maximum word count: 500

Processes

Create a regional Digital Service Desk and begin aligning resources and processes to assist users with accessing and understanding the OHT systems.

Enhance technical security posture by working with partners to address disaster recovery processes. Where systems do not have an Application Service Provider (ASP) alternative and are located on premise in less sophisticated technical environments, the OHT will use available assets like sophisticated tier three data centres.

Systems Consolidation

By encouraging members to have their respective electronic medical records (EMRs) hosted by the vendor (e.g. Practice Solutions hosted by Telus in the cloud through an ASP model) it provides a one to one integration between vendor and Health Report Manager (HRM) or the OHT Clinical Data Repository (CDR), for example, Telus' Health Information Exchange integrated with ConnectingOntario through HRM and one point to point integration with the Regional CDR. This enables the interfaces to be built once and used to the benefit of all members that are using the same cloud-based solution. Discussions have taken place between some of the vendors and various partner reps. If the Ministry and/or OntarioMD have a reverse flow of primary care and community clinical data through HRM, this need goes away. This OHT's plan can be successful fairly quickly and could be deployed while waiting for the provincial strategy. Another innovative possibility is to investigate Robotic Process Automation (RPA) to extract data from the EMRs and populate the CDR.

The plan is to establish a cross-member Digital Infrastructure and Operations Steering Team to develop a system request intake process, a scoring model, and prioritize system requests to determine a rolling three to five year forecast. This process would identify high-level strategic initiatives and set out the process for developing a budget and to make recommendations to this OHT's governors, and be an advocate for the Ministry.

Virtual Command Centre

The maturity vision is to achieve a regional virtual command centre by starting with the work that has been accomplished by the hospital. This Broader Public Sector (BPS) compliant work includes capturing and documenting system specifications and functionalities required and this will be the foundation for requirements in a Request for Proposal (RFP) should it be required. Although not deployed, there is a working hospital Virtual Command Centre that is built and has been demonstrated to senior hospital leaders. This sophisticated system comprised of many transaction-based systems has end-to-end information from a patient's point of entry to their discharge from hospital. This system can be further expanded to be regional and include flow information from members so patients are transitioned from member to member as required by the patients' needs.

Patient Needs

Work has begun to take advantage of cloud-based services (from Amazon, Microsoft, Google). These services have natural language processing, have been tested, and in the near future will be used to address translation/language requirements, and accessibility requirements. These opportunities will add value to those patients and clients that may be newcomers, have disabilities, or speak another language.

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

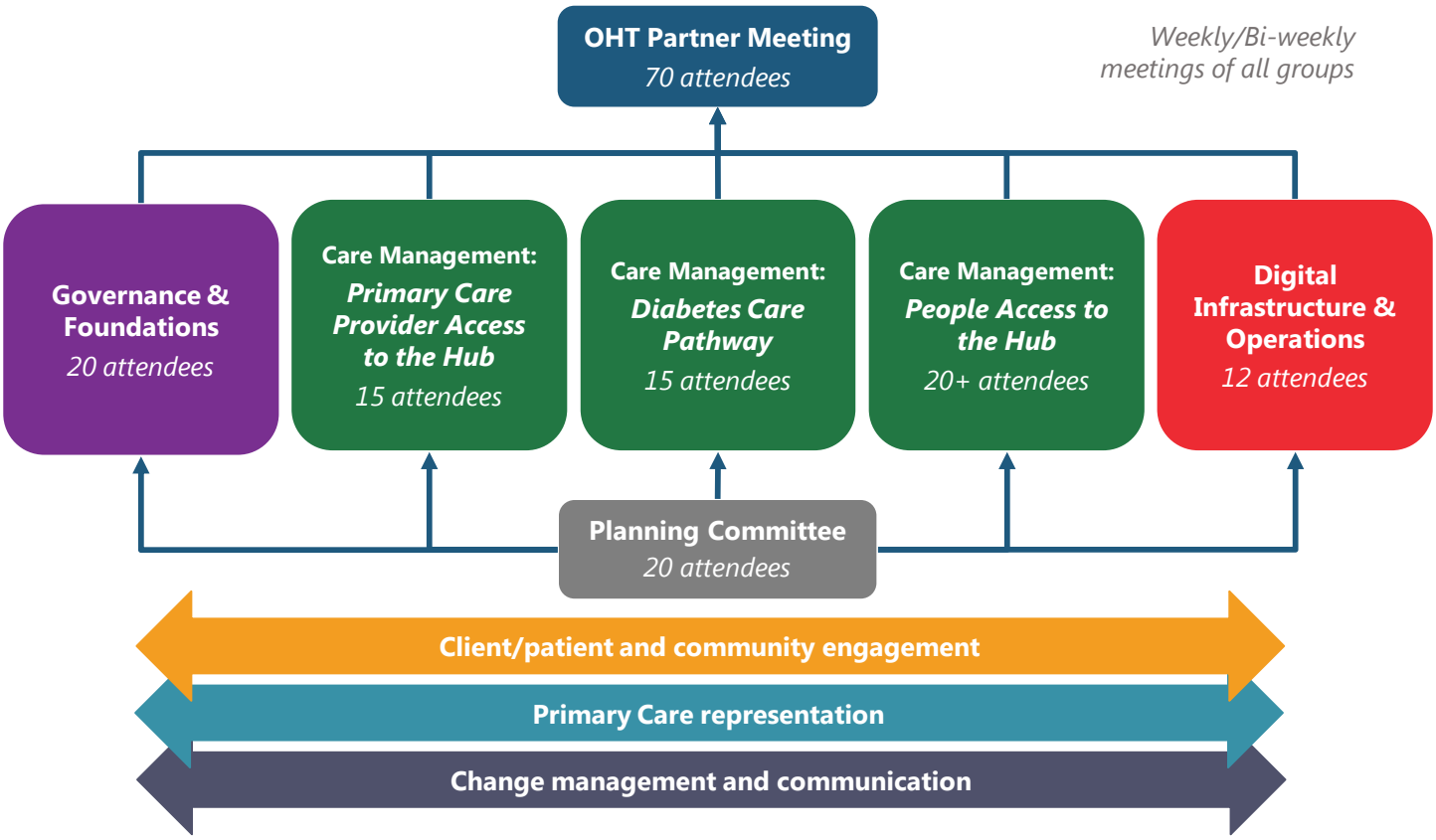
Please identify a single point of contact who will be the responsible for leading the implementation of digital health activities for your team.

Name:	James Moolecherry
Title & Organization:	Chief Information Officer, Information Services (Chair of OHT Digital Working Group), William Osler Health Systems
Email:	James.Moolecherry@williamoslerhs.ca
Phone:	905-494-2120 x56832

Appendix 1. Sub-Region Population vs. Attributed Population of the OHT

	Sub-Region Population	Attributed Population
Brampton	609,094 (75%)	464,562 (53%)
Toronto (Etobicoke)	≈ 121,895 (15%)	139,703 (16%)
Mississauga (Malton)	38, 470 (5%)	74,499 (9%)
Vaughan (West Woodbridge)	≈ 40,000 (5%)	50,972 (6%)
All Other Communities	0	142,116 (16%)

Appendix 2. Summary of Working Group Structure

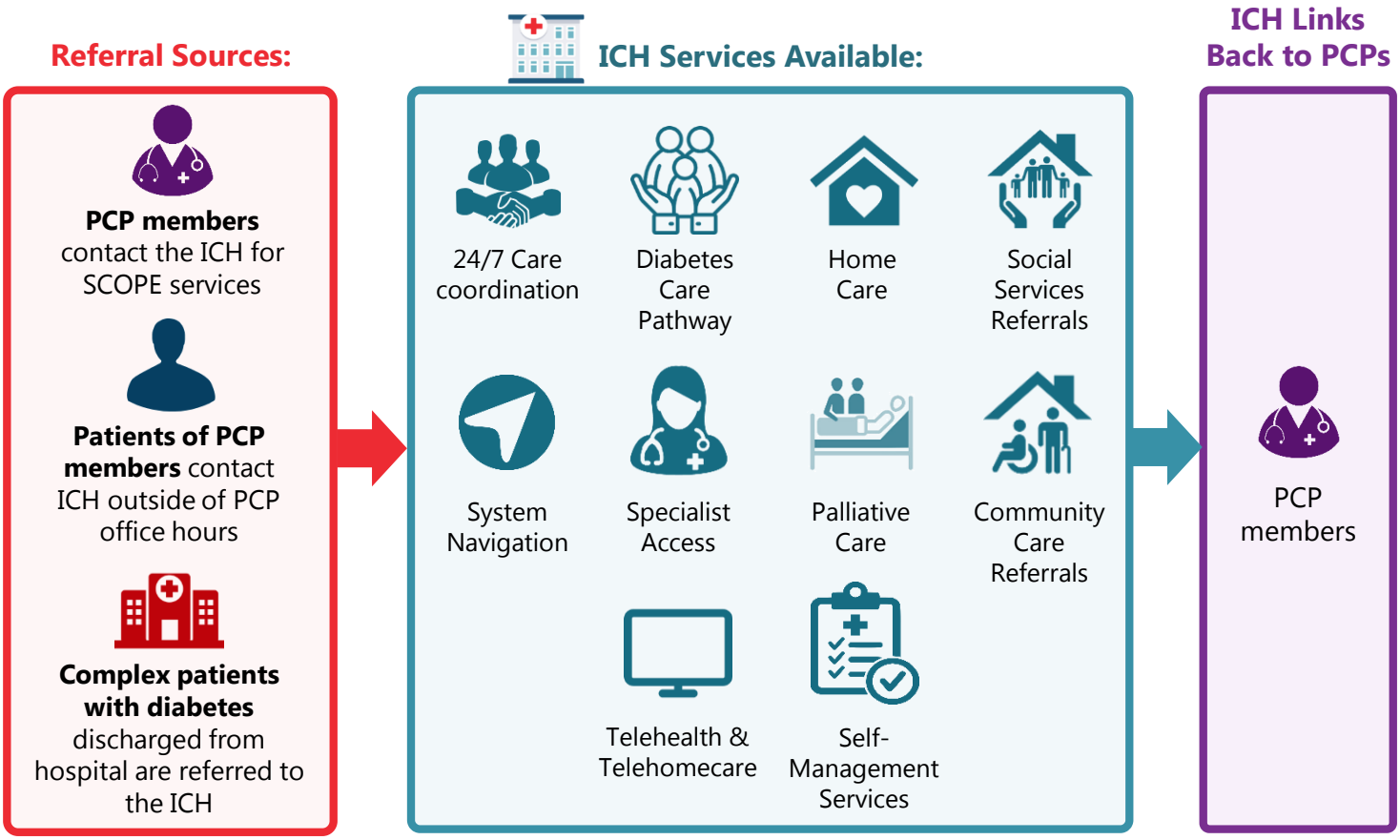


Appendix 3. Patient/Community Engagement Survey Themes

Appendix 4. Year 1 Performance Measures

	OHT Attributed Population		2017/18 Q4 Performance	
Measure	**Volume**	**%**	**OHT**	**Ontario**
Same day/next day access to primary care (desired direction ↑)	N/A	N/A	50.0%	44.7%
ED visit rate for visits best managed elsewhere per 1,000 population (desired direction ↓)	1,291	0.15%	1.6	4.6
ACSC hospitalization rate per 100,000 population (desired direction ↓)	535	0.06%	65.0	90.6
7-day follow-up (desired direction ↑)	1,067	0.12%	54.9%	44.8%
Readmissions (desired direction ↓)	317	0.04%	15.6%	16.3%

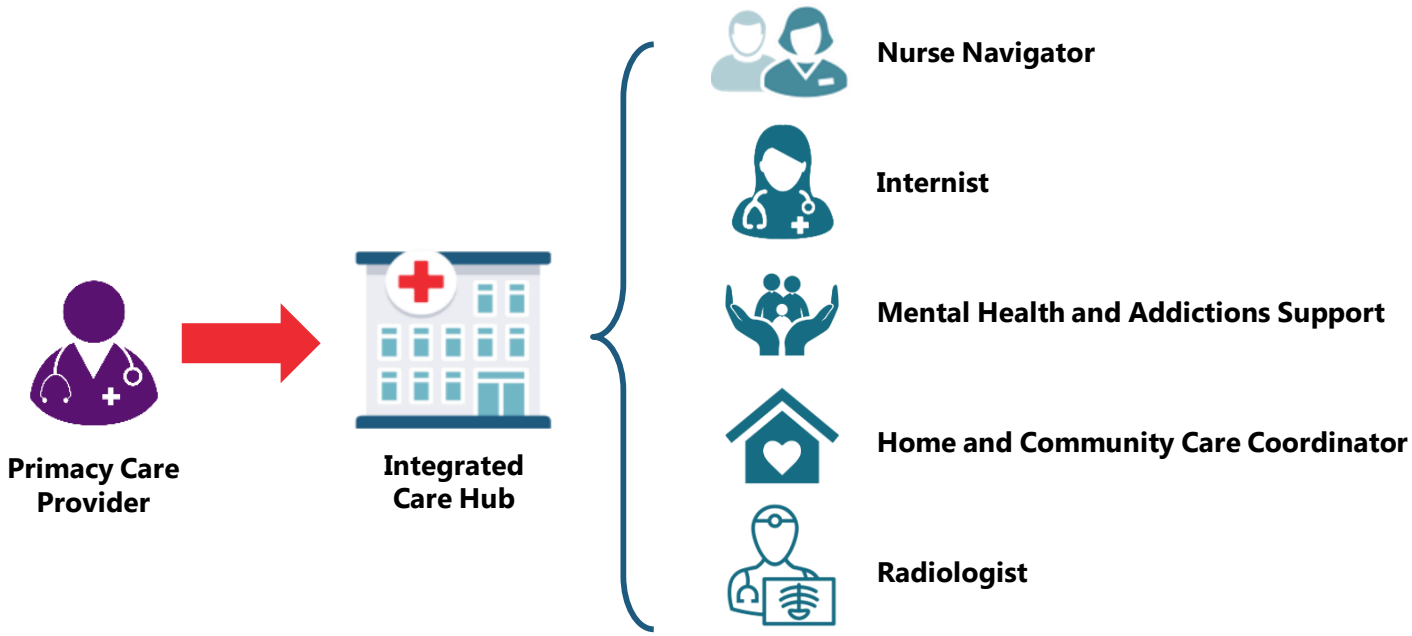
Appendix 5. The Integrated Care Hub (ICH) Model



Appendix 6. The SCOPE Model

Highlights

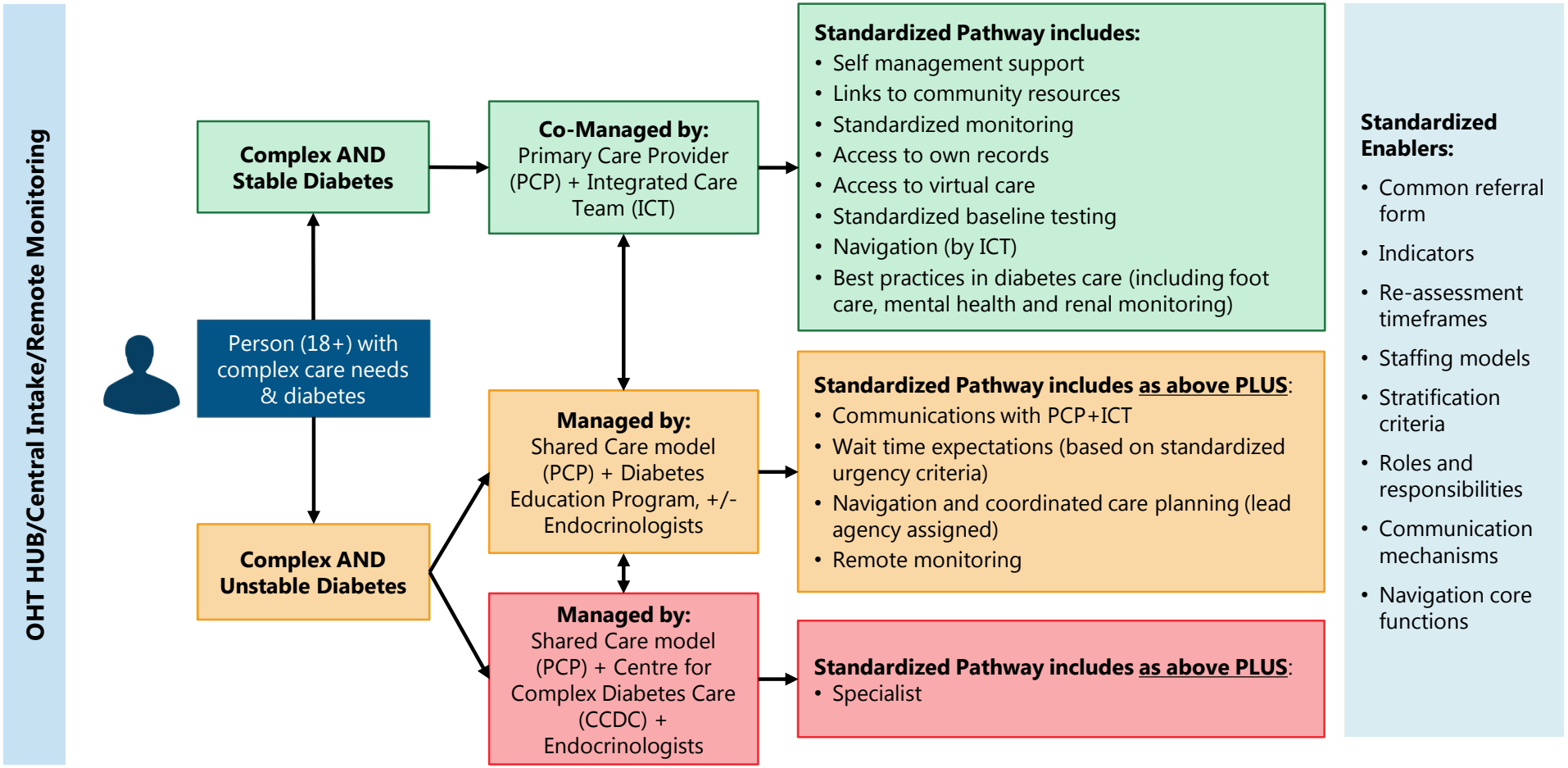
- Designed by Primary Care Providers for Primary Care Providers
- Proven success in other jurisdictions
- Will promote increased participation in the OHT over time
- Helps to address inequity in comprehensive Primary Care resources across the region



Appendix 7. OHT Diabetes Care Pathway

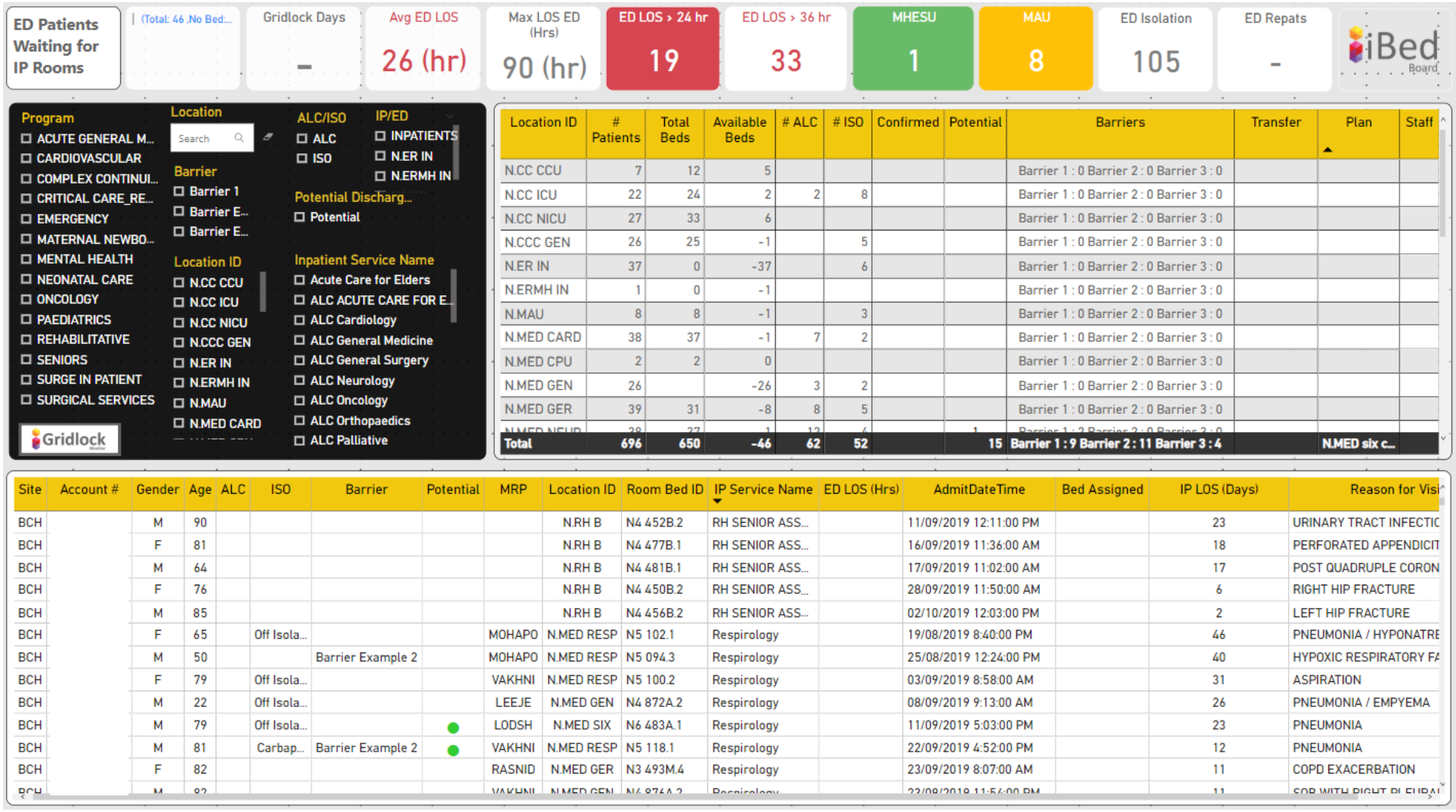
OHT Diabetes Pathway

Guiding Principles: Equity and access to the right resources for each patient in OHT attributed population



Developed by the OHT Care Management: Diabetes Working Group & Clinical Advisors and informed by Health Quality Ontario Quality Standards (Draft Transitions from Hospital to Home, COPD, and Diabetic Foot Ulcers)

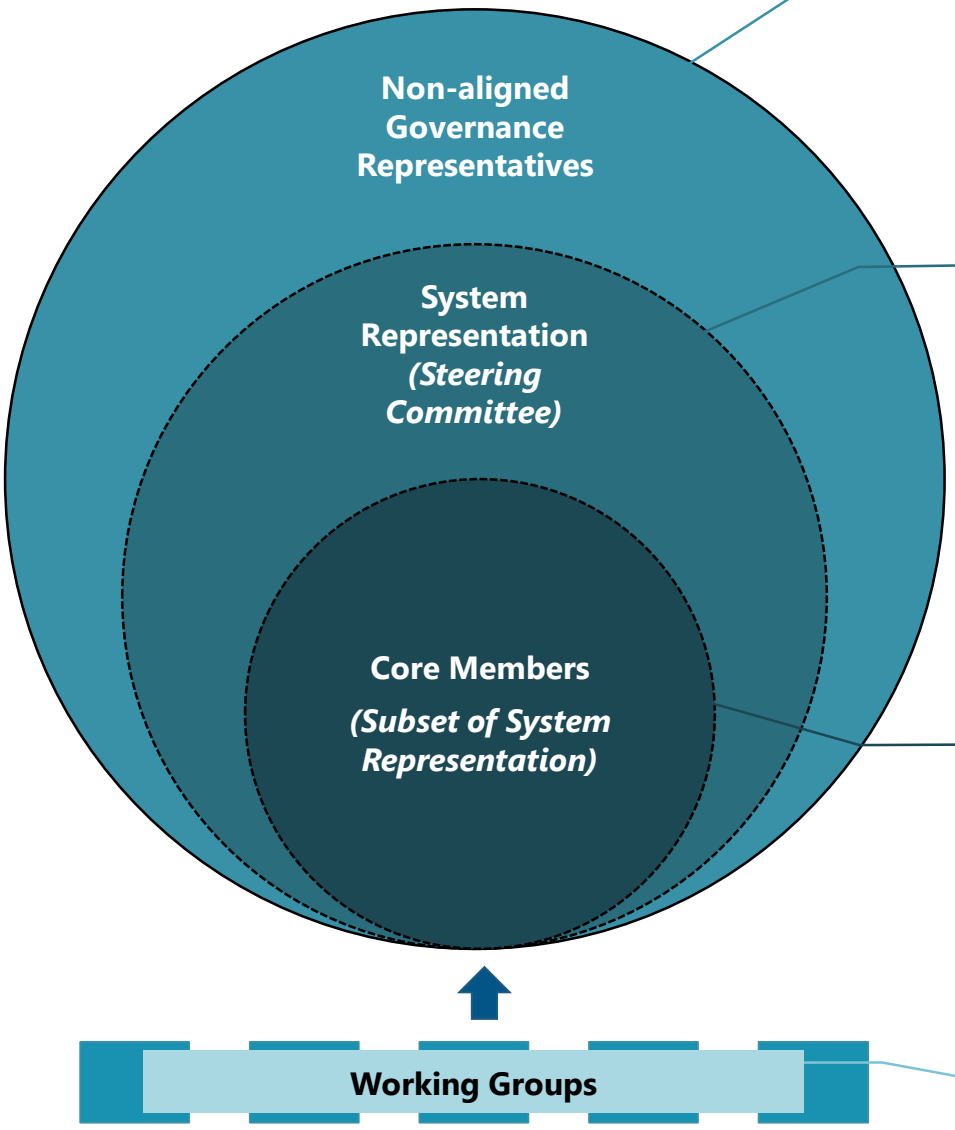
Appendix 8. Real Time ED In-Patient Status



Location ID	# Patients	Total Beds	Available Beds	# ALC	# ISO	Confirmed	Potential	Barriers	Transfer	Plan	Staff
N.CC CCU	7	12	5					Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.CC ICU	22	24	2	2	8			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.CC NICU	27	33	6					Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.CCC GEN	26	25	-1		5			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.ER IN	37	0	-37		6			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.ERMH IN	1	0	-1					Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MAU	8	8	-1		3			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MED CARD	38	37	-1	7	2			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MED CPU	2	2	0					Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MED GEN	26		-26	3	2			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MED GER	39	31	-8	8	5			Barrier 1 : 0 Barrier 2 : 0 Barrier 3 : 0			
N.MED NEUR	28	27	1	12	4		1	Barrier 1 : 2 Barrier 2 : 0 Barrier 3 : 0			
Total	**696**	**650**	**-46**	**62**	**52**		**15**	**Barrier 1 : 9 Barrier 2 : 11 Barrier 3 : 4**		**N.MED six c...**	

Site	Account #	Gender	Age	ALC	ISO	Barrier	Potential	MRP	Location ID	Room Bed ID	IP Service Name	ED LOS (Hrs)	AdmitDateTime	Bed Assigned	IP LOS (Days)	Reason for Visi
BCH		M	90						N.RH B	N4 452B.2	RH SENIOR ASS...		11/09/2019 12:11:00 PM		23	URINARY TRACT INFECTIC
BCH		F	81						N.RH B	N4 477B.1	RH SENIOR ASS...		16/09/2019 11:36:00 AM		18	PERFORATED APPENDICIT
BCH		M	64						N.RH B	N4 481B.1	RH SENIOR ASS...		17/09/2019 11:02:00 AM		17	POST QUADRUPLE CORON
BCH		F	76						N.RH B	N4 450B.2	RH SENIOR ASS...		28/09/2019 11:50:00 AM		6	RIGHT HIP FRACTURE
BCH		M	85						N.RH B	N4 456B.2	RH SENIOR ASS...		02/10/2019 12:03:00 PM		2	LEFT HIP FRACTURE
BCH		F	65		Off Isola...			MOHAPO	N.MED RESP	N5 102.1	Respirology		19/08/2019 8:40:00 PM		46	PNEUMONIA / HYPONATRE
BCH		M	50			Barrier Example 2		MOHAPO	N.MED RESP	N5 094.3	Respirology		25/08/2019 12:24:00 PM		40	HYPOXIC RESPIRATORY FA
BCH		F	79		Off Isola...			VAKHNI	N.MED RESP	N5 100.2	Respirology		03/09/2019 8:58:00 AM		31	ASPIRATION
BCH		M	22		Off Isola...			LEEJE	N.MED GEN	N4 872A.2	Respirology		08/09/2019 9:13:00 AM		26	PNEUMONIA / EMPYEMA
BCH		M	79		Off Isola...		●	LODSH	N.MED SIX	N6 483A.1	Respirology		11/09/2019 5:03:00 PM		23	PNEUMONIA
BCH		M	81		Carbap...	Barrier Example 2	●	VAKHNI	N.MED RESP	N5 118.1	Respirology		22/09/2019 4:52:00 PM		12	PNEUMONIA
BCH		F	82					RASNID	N.MED GER	N3 493M.4	Respirology		23/09/2019 8:07:00 AM		11	COPD EXACERBATION
BCH		M	82					VAKHNI	N.MED GEN	N4 874A.2	Respirology		22/09/2019 11:54:00 PM		11	SOB WITH RIGHT PLEURAL

Appendix 9. Interim OHT Oversight Collaborative Structure and Membership



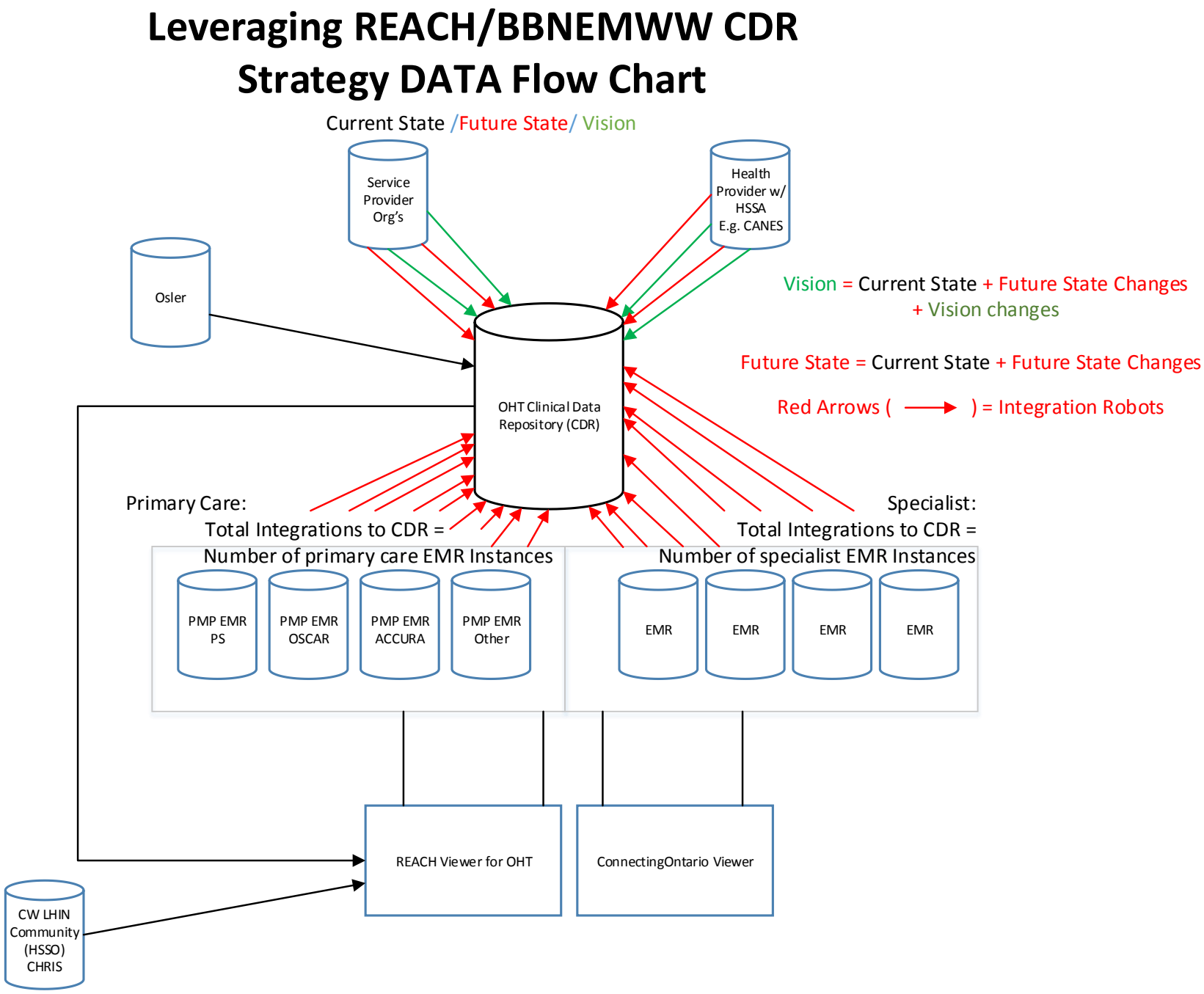
- Non-employees of any partner with strong healthcare governance experience
- Ex-Officio
- Purpose is to observe Interim OHT Oversight Collaborative and assist and contribute to the evolution and design of a longer-term governance model for the OHT

- System representatives – chosen by OHT members and affiliates, Senior Executives (SE) or Physicians (P) where indicated:
  - Patients and Family
  - Physicians from representative Community MAC
  - Primary Care (SE) or (P)
  - Long-Term Care
  - Community Support Services
  - Home and Community Care
  - Mental Health and Addictions
  - Acute Care
- Voting Members for governance, structural or strategic issues and for systems insights for Core Members groups

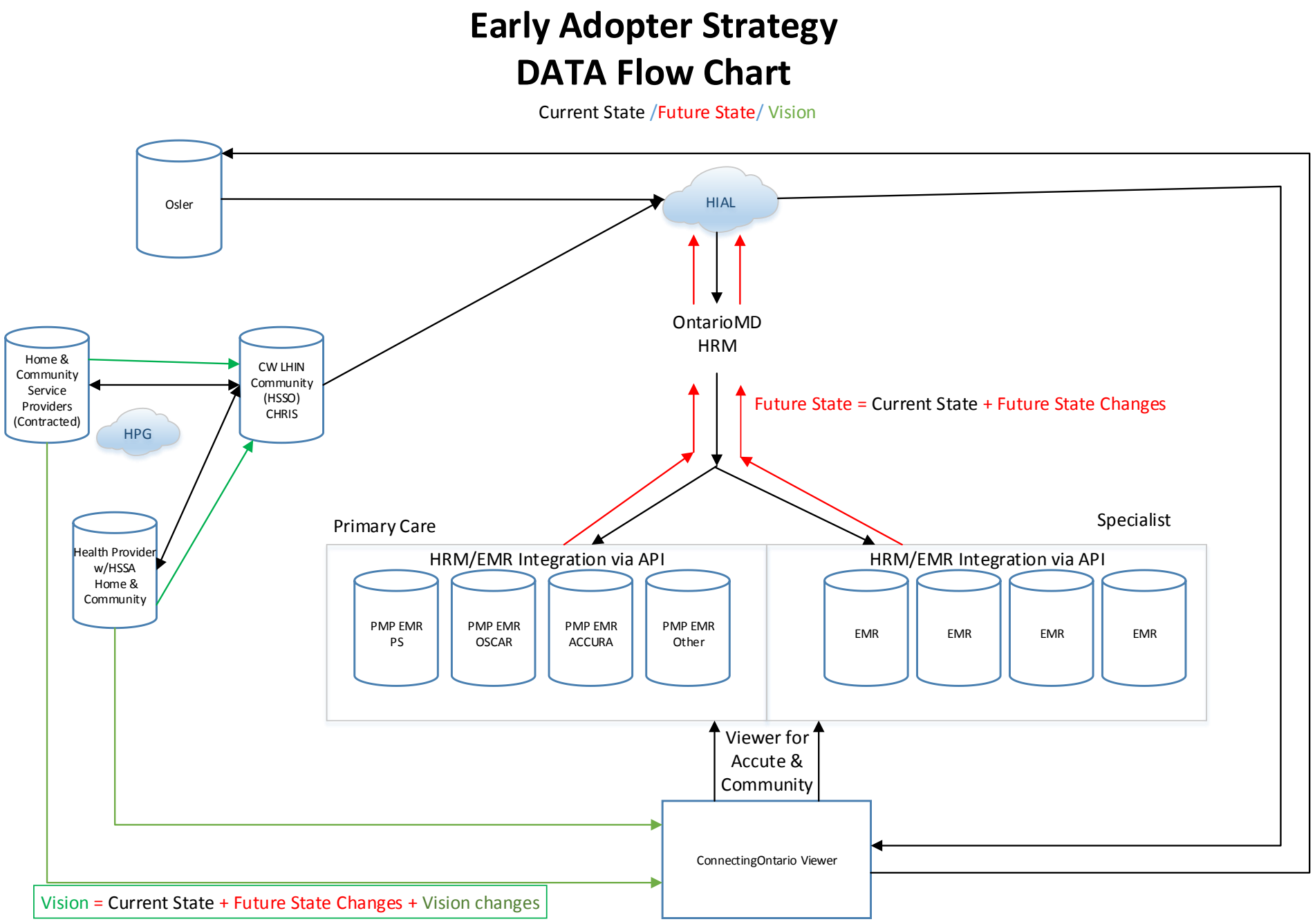
- Flexible Membership based on participation in shared budget and risk for Year One projects
- Responsible for operational oversight and decision making for Year One Project and other duties as agreed by Interim OHT Oversight Collaborative
- Responsible for decisions related to the allocation of shared resources for Year One and operational decisions, processes and policies for Year One

- Working groups created to focus on specific deliverables, guided by the Steering Committee

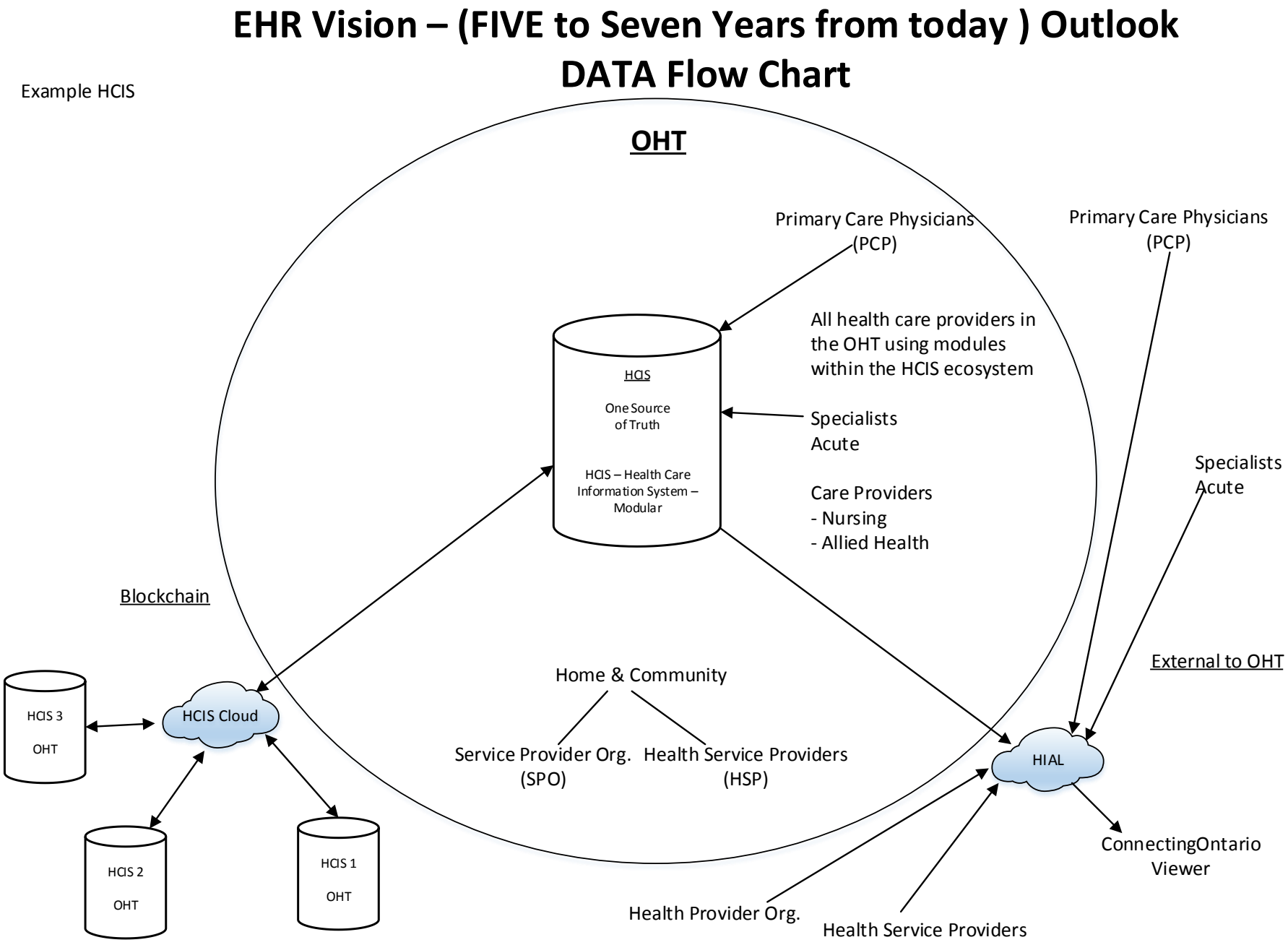
Appendix 10. Leveraging REACH/BBNEMWW CDR Strategy DATA Flow Chart



Appendix 11. Early Adopter Strategy DATA Flow Chart



Appendix 12. EHR Vision – (Five to seven years from today) Outlook DATA Flow Chart



Appendix 13. Attestation Form Signed by OHT Members

BRAMPTON, NORTH ETOBICOKE AND AREA ONTARIO HEALTH TEAM

ATTESTATION

(This attestation has been created to support the first step of the Ontario Health Teams Full Application Submission. Additional documentation will be required in the event of advancement to the next step involving selection as an Ontario Health Team Candidate.)

To: **All Organizations signing on to the Full Application as potential Members of the Brampton, North Etobicoke and Area Ontario Health Team**

From: **Member Full Legal Name:**

_____

(the "Member Organization")

The Ontario Health Teams Full Application requires team members to identify issues with governance, financial management, compliance with contractual performance obligations and applicable legislation or regulation, in s. 5.1 of the Full Application. Where there are issues, a plan to address these matters is required.

On behalf of the Member Organization, I/we attest that:

a) The Member Organization is organized to operate in accordance with its constating documents, By-Laws, policies and procedures.

b) The Member Organization has existing internal controls and industry standard practices for financial management, reporting, and oversight of financial risk.

c) The Member Organization holds all permits, licences, approvals, consents, authorizations, registrations, or certificates that are required to carry on its business as presently conducted by it and the Member Organization is in compliance with same.

d) The Member Organization has taken all reasonable steps to operate in compliance with all applicable federal, provincial and municipal laws and regulations, orders, rules and by-laws of any governmental authority applicable to the Member Organization.

e) The Member Organization has taken all reasonable steps to operate in compliance with all its existing contractual obligations, including the terms and conditions of any funding agreement with any governmental authorities which may include doing any required performance improvement.

f) The Member Organization has taken all reasonable steps to ensure there are no legal proceedings, judicial or administrative against the Member Organization which pertain to the Member Organization's health care or related services, including privacy of personal health information, which have not been addressed with appropriate action plans, such that they would prevent or hinder the Member Organization from participating as a responsible Member Organization capable of effective, prudent functioning in the Brampton, North Etobicoke & Area Ontario Health Team.

The above attestations are made in support of the Ontario Health Team Full Application being made by the Brampton, North Etobicoke and Area Ontario Health Team due October 9th, 2019.

Dated at _____ this ____ day of _____, 2019.

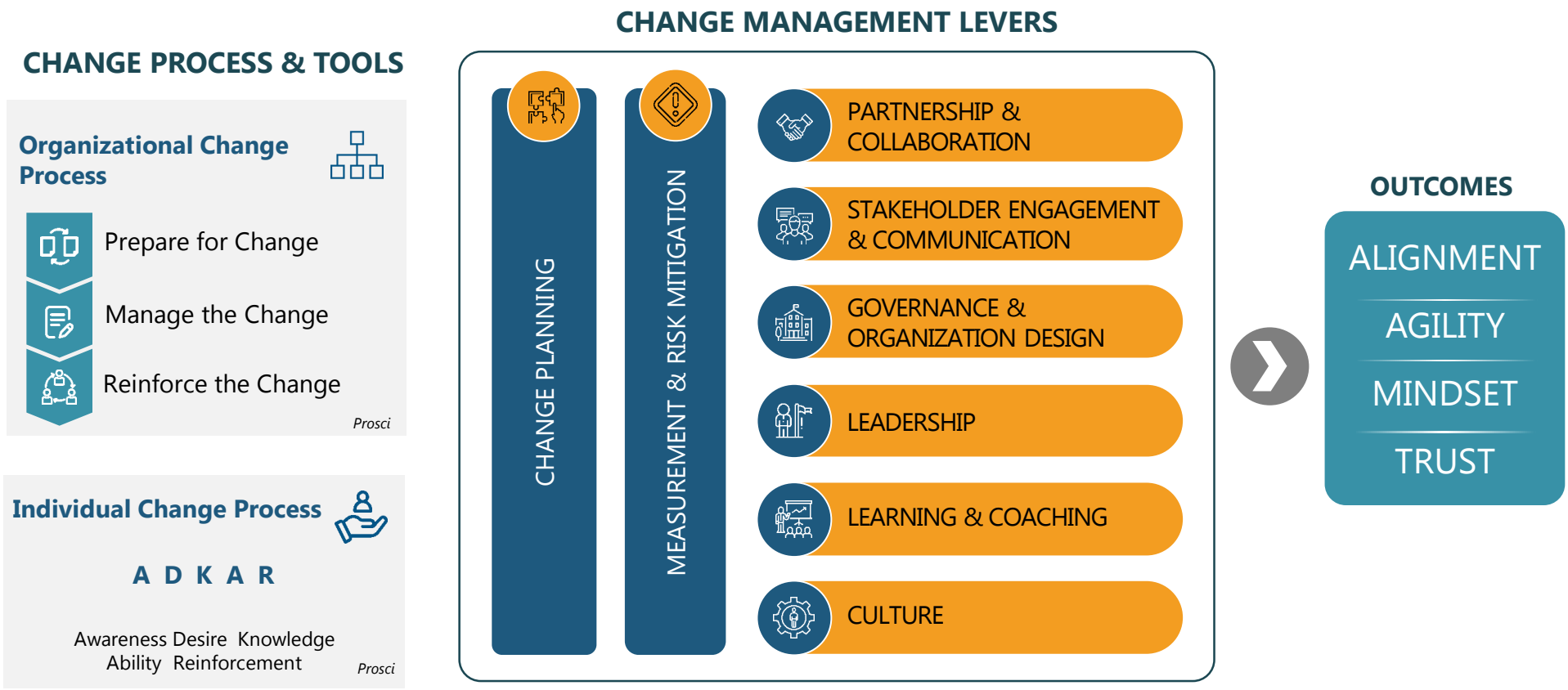
_____

Member Organization full legal name

Per:_____

Name & Title:_____

Appendix 14. OHT Change Management Strategy and Planning Framework



Appendix 15. OHT Change Strategy – Activities Completed From Pre-Assessment to Submission

Four Implementation Phases of Integrated Care

1. Initiative and design phase
2. Experimental and execution phase
3. Expansion and monitoring phase
4. Consolidation and transformation phase

Organizational Change Process

- Prepare for Change
- Manage the Change
- Reinforce the Change

Individual Change Process

A D K A R

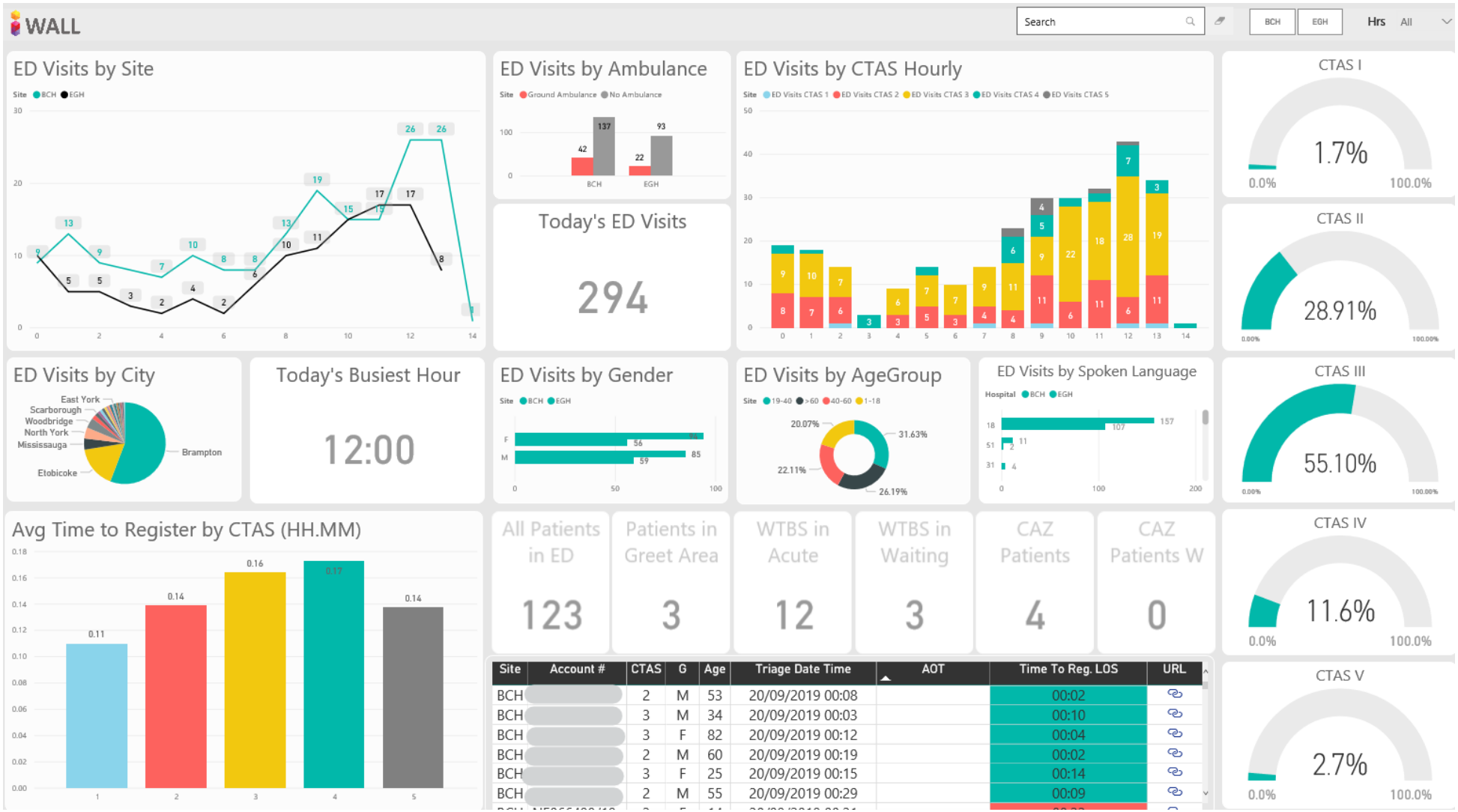
Awareness Desire Knowledge Ability Reinforcement

		Pre-Assessment to Full Application Submission Acceptance (March – October 2019 tbc)	
Change lever	**Change Management Objectives**	**1. Initiative & Design Phase – Prepare for Change**	
Partnership & Collaboration	• Build trust, alignment, and collaboration between all partners and stakeholders, including clients/patients, care delivery partners, front line clinicians, primary care physicians and leaders.	• Co-creation of self assessment and full application with partners • Identified Member and Affiliate partners	• Sharing resources and expertise across OHT working groups and partners to enable collective planning and design of the OHT
Stakeholder Engagement & Communication	• Involve stakeholders in the change in ways that establish meaningful influence and commitment. • Ensure change is guided from the partners and led by front line team members . • Continually reinforce a compelling change story that is understood and generates buy-in .	• Hosted OHT introduction meetings with all stakeholders • Physician engagement and information sessions were held • Regular 1:1 partner planning meetings to inform the OHT process • Expanded physician participation (care, specialist and nurse practitioner) • Board engagement sessions for submission sign-off • Physician engagement plan in progress	• Community-wide engagement event and survey • Organized OHT check-ins with planning committee and working groups • Identified an engagement and communication tool for consensus building during face to face meetings (Slido) • Enabled broader OHT communications for partners and boards • OHT branding and logo process in development
Governance & Organization Design	• Solidify and operationalize a collaborative structure that brings together organizations to deliver integrated care. • Co-design the organization to align strategy, structure, process, technology, people practices, and metrics and rewards to be agile and achieve integrated care goals.	• Created cross sectional partnership planning committee • Established working groups focused on: 1) care management, 2) governance and funding and 3) digital infrastructure and operations with meeting norms and rules of engagement • Reinforcement that decision making resides with OHT partners • Sign on process (MOU) for anchor partners and declaration of intent for physicians	• Designed Integrated Care Hub concept • Designed a patient stratification framework • Identified target Year 1 population and focus on diabetes • Identified geography
Leadership	• Develop active and visible leaders, who are adaptive and can sponsor change in ways that encourage engagement, inspire trust and enable collaboration throughout the whole system.	• Early stages of preparing leaders to lead change and different ways of working	• Involved partners and patient/family/community to lead the process
Learning & Coaching	• Develop new, sustainable skills and expertise to ensure individuals and teams are agile and able to perform in an integrated care environment.	• OHT-wide governance awareness and learning sessions	• OHT 101 education sessions
Culture	• Change the culture and embed a shared set of values and front line behaviours so that the client/patient feels they are dealing with one entity.	• Building a partnership collation to lead change beginning with shared power and membership on the planning committee, working groups, OHT partnership group	• Working in new ways to set the foundation for new behaviours and skills needed for partnership and collaboration

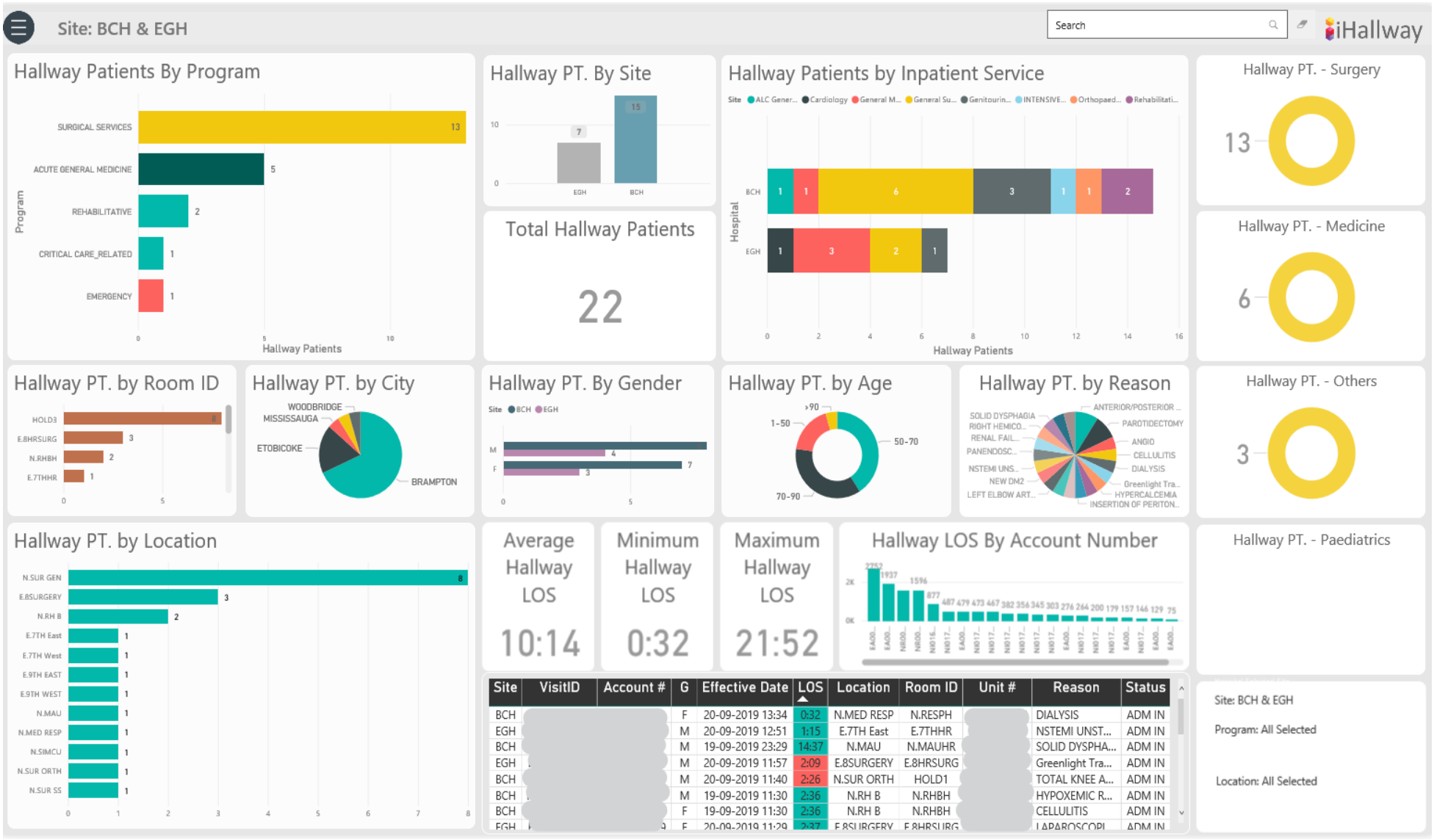
Appendix 16. OHT Change Strategy - Menu of Potential Activities for Year 1 & Beyond

		Year 1 & Beyond		
		1. Design Phase - Prepare for Change	2. Experimental and Execution Phase – Manage Change	3. Expansion & Monitoring
Change lever	**Change Management Objectives**	**First 6 Months**	**Next 6 – 18 Months**	**18 Months & Beyond**
Partnership & Collaboration	• Build trust, alignment, and collaboration between all partners and stakeholders, including clients/patients, care delivery partners, front line clinicians, primary care physicians, and leaders.	• Implementation of rules of engagement and norms for working groups • Establish basic protocols and ground rules for collaboration • Establish MOU & Partnership Agreements • ICH Interprofessional Team Launch Sessions for Navigation & Care Coordination and Digital Access teams	• Team development and collaboration sessions for inter professional health care teams in the hub (within and across organizations) • Design partnership workshops with partners to elevate trust, relationships and processes to deliver on agreements • Partnership Transparency Workshops (member partners & stakeholders) to build trust, surface learnings and adapt	• Continue implementing partnership workshops and team development sessions • Care delivery partners seek new opportunities for collaboration with current or new partners
Stakeholder Engagement & Communication	• Involve stakeholders in the change in ways that establish meaningful influence and commitment. • Ensure change is guided from the partners and led by front line team members. • Continually reinforce a compelling change story that is understood and generates buy in.	• Begin and continue stakeholder mapping • Conduct stakeholder interviews and/or focus groups • Prepare Stakeholder Impact Assessment to identify the impacts to people, process, technology • Begin to build a compelling change story on the "WHY" of OHT & Integrated Care Hub (ICH) • Continue to leverage OHT outreach efforts by applicable provincial and local groups (e.g. OMA, OCFP) for primary care providers • Establish additional two-way communication vehicles including social media	• Develop Sponsorship Roadmap and activities for partners to lead the change • Develop key messages/talk points for partners on vision for change and benefits for patients and stakeholders • Identify areas of risk and develop mitigation plans • Establish ongoing 'Change Check-in' process and cadence with key stakeholders • Prepare ongoing engagement plan for key stakeholder groups; clients/patients, Board/leaders, partners, front line clinicians, primary care physicians, & community, Union	• Share success stories and learning to create excitement for expansion phase • Revise Stakeholder Mapping for expanded care partners • Integrated lessons learned from Year 1 population and revise stakeholder engagement and communications plans accordingly
Governance & Organization Design	• Solidify and operationalize a collaborative governance structure that brings together organizations to deliver integrated care. • Co-design the organization to align strategy, structure, process, technology, people practices, and metrics and rewards to be agile and achieve integrated care goals.	• Identify stakeholders included in the governance process (including patient and community) • Operational oversight - develop ways of working and structure • Finalize phase 1 organizational design of new integrated hub • Complete required workforce planning and other associated HR needs • Determine Job Design Implications for roles in the Integrated Care Hub (ICH) • Staff roles and the interdisciplinary teams required for the ICH	• Establish a shared decision-making framework and structure for how organizational leaders (e.g., senior management and boards) will make decisions. • Clarify a problem solving and dispute resolution process • Evaluate where there is duplication of efforts and opportunities for streamlined efforts • Co-create shared OHT vision, values and strategy with clients/patients & community, Board, partners, front line clinicians • Identification of which population each neighbourhood hub serves	• Future state process mapping on next iteration hub focus • Lessons learned and continuous improvement of process, technology, and people practices • Organizational structures shift to support the new integrated delivery processes, as required
Leadership	• Develop active and visible leaders, who are adaptive and can sponsor change in ways that encourage engagement, inspire trust and enable collaboration throughout the whole system.	• Identify operational oversight membership/leadership • Prepare leaders on leadership role to sponsor change • Identify current and emerging leaders from partner network for future OHT leadership roles (including primary care providers)	• Engage operational leadership on development of OHT vision, values & strategy to guide OHT development • Leadership briefings on lessons learned • Change Leadership Workshops	• Build Partner coaching capability • Develop OHT Leadership Development Plan and Leadership Competencies • Develop and implement an OHT Leadership Training Program
Learning & Coaching	• Develop new, sustainable skills and expertise to ensure individuals and teams are agile and able to perform in an integrated care environment.	• Determine knowledge and skills required for roles in the Integrated Care Hub (ICH)	• Facilitate Change Management Training for project teams and Change Champions • Conduct a learning and training inventory assessment to identify current resources available • Identify where cross training could be leveraged • Facilitate Change Leadership Training	• Ongoing coaching and support for key stakeholders • Resilience training for 24/7 environment • Develop role based training (eLearning, job aids, toolkits) • Implement learning and coaching approach and plan to support new knowledge and skills required • Develop mentoring and buddy programs
Culture	• Change the culture and embed a shared set of values and front line behaviours so that the client/patient feels they are dealing with one entity.	• Celebrate progress through key events and regular communications	• Develop Leader-led engagement plan • Process to co-create OHT shared values and behaviours • Begin to develop culture branding and artifacts • Identify Culture Champions	• Value discussion toolkit • Host leader-led Eegagement sessions • Embed values and behaviours in ICH processes and systems

Appendix 17. Real time Tracking ED Visits/Admits/Length of Stay

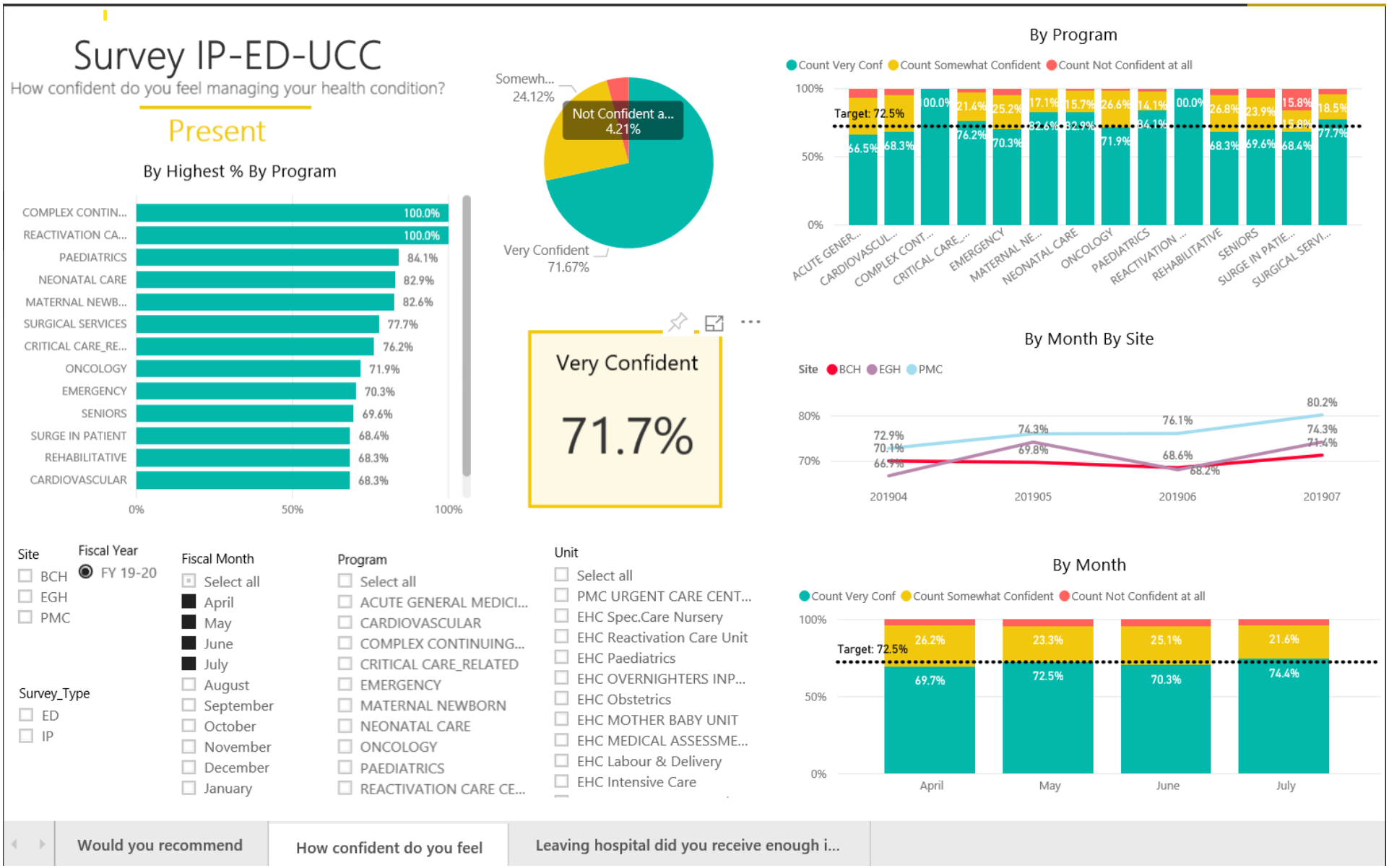


Appendix 18. Real Time Tracking Hallway Medicine



Site	VisitID	Account #	G	Effective Date	LOS	Location	Room ID	Unit #	Reason	Status
BCH			F	20-09-2019 13:34	0:32	N.MED RESP	N.RESPH		DIALYSIS	ADM IN
EGH			M	20-09-2019 12:51	1:15	E.7TH East	E.7THHR		NSTEMI UNST...	ADM IN
BCH			M	19-09-2019 23:29	14:37	N.MAU	N.MAUHR		SOLID DYSPHA...	ADM IN
EGH			M	20-09-2019 11:57	2:09	E.8SURGERY	E.8HRSURG		Greenlight Tra...	ADM IN
BCH			M	20-09-2019 11:40	2:26	N.SUR ORTH	HOLD1		TOTAL KNEE A...	ADM IN
BCH			M	19-09-2019 11:30	2:36	N.RH B	N.RHBH		HYPOXEMIC R...	ADM IN
BCH			F	19-09-2019 11:30	2:36	N.RH B	N.RHBH		CELLULITIS	ADM IN
EGH			F	20-09-2019 11:29	2:37	E.8SURGERY	E.8HRSURG		LAPAROSCOPI...	ADM IN

Appendix 19. Tracking Patient Satisfaction



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	128 member physician declarations of intent included in this link.
Position	
Organization *(where applicable)*	
Signature	
Date	
Please repeat signature lines as necessary	

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	Patrick Fradley-Davis
Position	Board Chair
Organization (where applicable)	Canadian Mental Health Association Peel Dufferin
Signature	
Date	September 27th, 2019
Please repeat signature lines as necessary	

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	LOUISE STRATFORD
Position	BOARD CHAIR
Organization (where applicable)	CANES COMMUNITY CARE
Signature	
Date	SEPT. 24, 2019

Please repeat signature lines as necessary

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	Eleni Kostopoulos
Position	Board Chair
Organization (where applicable)	Central Brampton Family Health Team
Signature	
Date	October 1, 2019
Please repeat signature lines as necessary	

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	SCOTT MCLEOD
Position	CEO
Organization (where applicable)	CENTRAL WEST LOCAL HEALTH INTEGRATION NETWORK \ HOME AND COMMUNITY CARE
Signature	
Date	SEPT 26, 2019
Please repeat signature lines as necessary	

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.

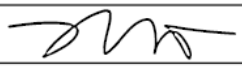
By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	Erica Teklits
Position	Board Chair
Organization (where applicable)	Etobicoke Services for Seniors
Signature	Erica Teklits
Date	September 23, 2019
Please repeat signature lines as necessary	

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	Shane Teper
Position	Board Chair
Organization (where applicable)	Queen Square Family Health Team
Signature	
Date	September 23, 2019
Please repeat signature lines as necessary	

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	RAKESH K. RIKHYE M.D.
Position	BOARD CHAIRMAN
Organization (where applicable)	WOODBINE FAMILY HEALTH TEAM
Signature	Rakesh Rikhye
Date	Sep. 20, 2019
Please repeat signature lines as necessary	

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 – B-OHT – Member Status	
Name	Derek Rodrigues
Position	Board Chair
Organization (where applicable)	Peel Senior Link
Signature	DRodrigues
Date	October 3, 2019
Please repeat signature lines as necessary (See supplementary Excel spreadsheet)	

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.

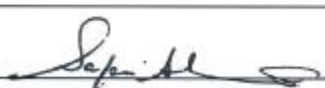
By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	**Nando Iannicca**
Position	Regional Chair
Organization (where applicable)	Region of Peel
Signature	
Date	Sept. 26 2019
Please repeat signature lines as necessary	

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.

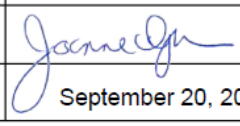
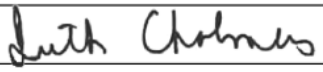
By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	SAFIA AHMED
Position	EXECUTIVE DIRECTOR
Organization (where applicable)	REXDALE COMMUNITY HEALTH CENTRE
Signature	
Date	SEPTEMBER 20, 2019
Please repeat signature lines as necessary	

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	Joanne Dykeman / Ruth Chalmers
Position	Executive Vice President, LTC Operations / Regional Vice President, Operations
Organization (where applicable)	Sienna Senior Living Hawthorn Woods Care Community, Maple Grove Care Community, Tullamore Care Community, Woodhall Park Care Community, Deerwood Creek Care Community
Signature	 
Date	September 20, 2019
Please repeat signature lines as necessary	

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	Carrie Anne Beltzner
Position	Board Chair
Organization *(where applicable)*	Peel Addiction Assessment and Referral Centre
Signature	
Date	September 19, 2019
Please repeat signature lines as necessary	

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	Jaineel Purohit
Position	Board Chair
Organization (where applicable)	WellFort Community Helath Services
Signature	Jaineel Purohit
Date	September 26th, 2019
Please repeat signature lines as necessary	

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	Charlie Rate
Position	Board Chair
Organization (where applicable)	West Park Healthcare Centre
Signature	Charlie Rate
Date	Sept 26, 2019
Please repeat signature lines as necessary	

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.

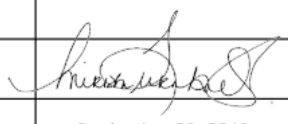
By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	JANE McMULLAN
Position	CHAIR, BOARD OF DIRECTORS
Organization (where applicable)	WILLIAM OSLER HEALTH SYSTEM
Signature	JMcmullan
Date	SEPTEMBER 25, 2019
Please repeat signature lines as necessary	

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	Miriam Freymond Turnbull, MBA, RRT
Position	President ; Board Chair
Organization (where applicable)	William Osler ProResp Inc.
Signature	
Date	September 23, 2019
Please repeat signature lines as necessary	