ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

STRENGTHENING CARE CLOSER TO HOME

ALGOMA OHT ANNUAL PLAN 2021-22

Table of Contents

Our Mission

The AOHT will collaborate in a model of care that is person-centred, efficient, and simplified for both individuals and providers.

Strengthening Care Closer to Home

Strengthening care closer to home is all about working across organizations as one large team to improve the care journey right here in Algoma. This includes better transitions from hospital to home, new models of care that enable health to be delivered in the community, and supporting the management of chronic conditions to allow people to remain independent.

Letter From Tri-Chairs

To our community:

On behalf of the Algoma Ontario Health Team (AOHT) Leadership Council, it's our pleasure to present our inaugural plan, *Strengthening Care Closer to Home*, that will build a strong foundation for collaboration while putting patients and communities at the centre of everything that we do.

For us, integrated care means coordinating efforts across health and social service organizations to improve the experience of Algoma residents. From a patient perspective, integrated care means receiving a continuum of connected services from one large team, regardless of where care, services, and resources are accessed. This is a fundamental shift that asks us to have a dual duty – first, to the people we currently serve and our organizations, and second, to the health of the community. Although each AOHT member retains their independence with an independent board and oversight, we have all made a public commitment to seize opportunities to work together on a shared vision of providing a continuum of integrated health, social, and health promotion services in Algoma.

The journey to releasing our first plan has been the culmination of two years' work in engaging hundreds of stakeholders, including caregivers, clinicians, and patients, about how we might more effectively plan and deliver services in Algoma. In the midst of our application to becoming an Ontario Health Team (OHT), the COVID-19 pandemic has been an abrupt reminder of fault lines in our health system and society, whether that's how we care for older adults, better manage conditions in the community, or deal with the growing burden of mental health and addictions. As the pandemic has taught us, we're only as healthy as our most vulnerable members of society – and we have a lot of work to do to ensure that we don't leave anyone behind.

This plan is our commitment to the community, not only on what we will be working on, but how we will be working together. We invite you to get involved and continue to hold us accountable for this important work.

S Parniak

Stephanie Parniak
AOHT Tri-Chair

D Fera

Dr. David Fera
AOHT Tri-Chair

W Hansson

Wendy Hansson
AOHT Tri-Chair

Who We Are

Our vision is an integrated health system focused on the unique needs of Algoma residents, where people receive seamless, effective care where and when they need it.

We are a team of local health professionals, organizations, and community members working together towards a more integrated health system for Algoma residents.

The AOHT was officially formed in 2020 to improve coordination of care for Algoma communities. We're working to create a network where patients will have access to the right care, right team, and right care setting when they need it. We want individuals to experience seamless transitions throughout their care journey in a system that is understandable, digitally-enabled, and collaborative.

The AOHT is one of 42 Ontario Health Teams (OHT) approved by the Ministry of Health to support integrated care in Ontario.

These teams have been introduced as a new way to connect healthcare providers, health promotion organizations, and social services within Ontario communities. The OHT model is designed to support integrated care centred around patients, families, and caregivers by building connections with community services, improving system navigation, and simplifying transitions of care.

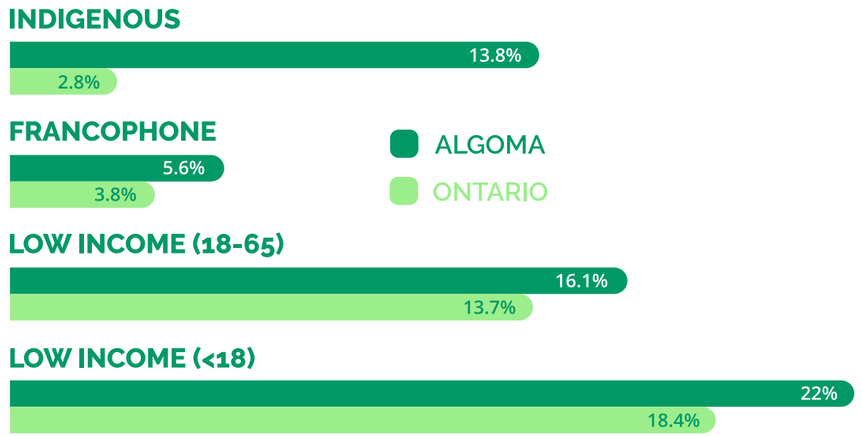
Community Health in Algoma

Algoma's vast geography and diverse population can create opportunities and challenges in equitable access and delivery of health and social services. The total region covered by the AOHT is roughly 32,000 square kilometers, including more than 20 municipalities and 100,000 community members. Over 30% of these individuals reside in areas outside of Sault Ste. Marie.

We're working towards an integrated health system focused on the creation of equitable and collaborative strategies to improve the health of Algoma's population. While Algoma's population has significant health potential, it is important to recognize our unique health challenges. Many citizens of Algoma are negatively impacted by a broad range of social determinants such as income, Indigenous status, education, employment, and access to healthcare[1]. In particular, our communities have a **higher number of Indigenous and Francophone community members and a higher percentage of residents with low income** (graph)[1]. Creating equitable strategies means recognizing and acknowledging the impact of these social determinants of health on our population. Because Algoma is a diverse and widespread community, these population characteristics underpin the importance of taking an equity-focused approach and emphasize the value of culturally appropriate care.

Addressing the social determinants of health and their impact on the health of Algoma's citizens will require partnerships across healthcare, public health, and social service providers to ensure that the physical, mental, and social well-being of our population is taken into consideration.

1. Algoma Public Health (2018). *Community Health Profile*. Algoma Public Health.



Our Team

To date, more than 150 individuals have taken part in bringing the AOHT and its projects to life. And we're just getting started.

Leadership Council

The AOHT is overseen by a Leadership Council that guides project planning, design, and implementation. It is currently composed of 15 organizational members and has enshrined patient and clinical leadership as part of its executive structure. A unique feature of the AOHT is that it is inclusive of both social services and health promotion, signaling our intent to move our work more upstream in the community.

Stephanie Parniak*
Patient Partner
AOHT

Michelle Brisbois
Executive Director
Superior Family Health Team

Terry Caporossi
Executive Director
Alzheimer Society, SSM and Algoma District

Janik Guy
Agente de planification et d'engagement communautaire, région d'Algoma
Réseau du mieux-être francophone du Nord de l'Ontario

Ali Juma
CEO
Algoma Family Services

Dr. David Fera*
Family Physician
Algoma District Medical Group

Annette Katajamaki
Executive Director
Canadian Mental Health Association SSM Branch

Alex Lambert
President and CEO
Group Health Centre

Connie Lee
Executive Director
F.J. Davey Home

Dr. Jennifer Loo
Medical Officer of Health and CEO
Algoma Public Health

Christianne Monico
Executive Director
Algoma Residential Community Hospice (ARCH)

Wendy Hansson*
President and CEO
Sault Area Hospital

Mike Nadeau
Chief Administrative Officer
District of SSM Social Services Administration Board

Dominic Noel
Executive Director and Nurse Practitioner Lead
Algoma Nurse Practitioner-Led Clinic

Dr. Jodie Stewart
CEO and Physician
Algoma District Medical Group

Dr. Cassandra Taylor
Lead Physician
Sault Family Health Organization

Dr. Sarita Verma
Dean, President, and CEO
Northern Ontario School of Medicine

*AOHT Tri-Chairs

Rural Health and Remote Partners

The AOHT recognizes the unique challenges of planning and delivering services across the vast geography of Algoma. The AOHT is committed to a supportive and collaborative relationship with the North Algoma OHT and the East Algoma OHT, recognizing their rural lens experience and garnered expertise. The AOHT benefits from the inclusion of neighbouring rural OHT representation as part of its work.

Mary Ellen Luukkonen
Co-chair
East Algoma OHT

Kadean Ogilvie
Chief Executive Officer
Lady Dunn Health Centre
(North Algoma Representative)

Transformation Office

The AOHT is mobilizing work across organizations in its membership and beyond with support from the AOHT Transformation Office, which is responsible for supporting leadership, decision-making, and operations.

Erik Landriault
Director, Integrated Care
AOHT

Ila Watson
Implementation Advisor & Vice President, People and Partnerships
Sault Area Hospital

Jennifer Osesky
Implementation Advisor & Director, Planning and Integration
Ontario Health (North)

Tracy Galizia
Project Management Specialist
Sault Area Hospital

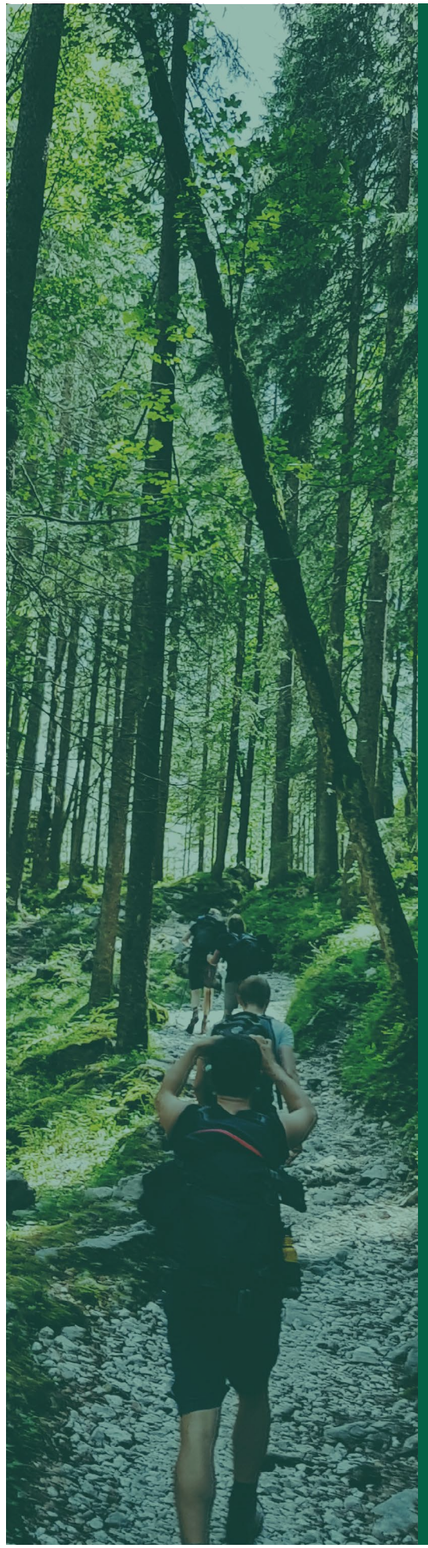
Brandy Sharp Young
Manager, Communications and Media Services
Sault Area Hospital

Jeff Dorans
Research Analyst
AOHT

Cassandra Lepore
Project Coordinator
AOHT

Leah Hodgson
Associate, Community Engagement and Communications
AOHT

> "The creation of the new Algoma Ontario Health Team – as well as the additional funding – will not only help our region effectively respond to the dangers posed by COVID-19, but help to build a new, integrated health care system for all patients."
>
> **Ross Romano,** MPP, Sault Ste. Marie



Integrated Care

For our team, integrated care means coordinating efforts across health and social service organizations to improve the experience of Algoma residents.

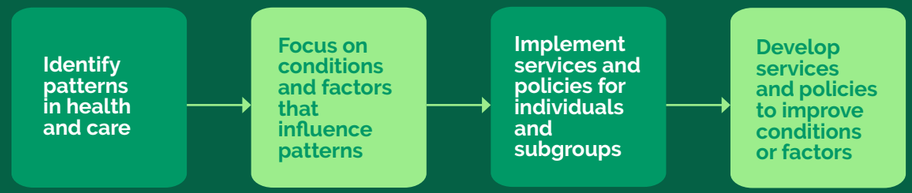
For patients, this means receiving coordinated services from one large team, as opposed to individual organizations.

Integrated health graphic adapted from Ontario Ministry of Health, Ministry of Long-Term Care. (2021, January 11). *Become an Ontario Health Team*. Ontario Ministry of Health, Ministry of Long-Term Care. http://health.gov.on.ca/en/pro/programs/connectedcare/oht/.

Planning for a Diverse Region

To ensure that no one is left behind, our team takes a **population health approach** to planning and project design. This involves identifying patterns of health and care throughout Algoma and using this information to identify areas for system improvement (graphic).[2]

2. Reid, R. J., & Pinto, A. D. (2020, March 12). Ontario Health Teams & Population Health Management: a Recap from the OHT Forum [Webinar]. Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum. https://www.mcmasterforum.org/rise/join-events/event-item/population-health-management.



Resources	Activities	Outputs (by 2022)	Outcomes (at maturity)	Impact
				NO ONE LEFT BEHIND.
1 STRENGTHENING CARE CLOSER TO HOME **We will integrate care to improve patient experience and access.**				**An integrated health system focused on the unique needs of Algoma residents, where people receive seamless, effective care where and when they need it.**
AOHT partner organizations Health and social system stakeholders Aligned funding, people, and initiatives Population and planning data	**Healthy Aging** Implement post-falls pathway across community, hospital, and primary care	Care has been redesigned for community-dwelling frail older adults and their caregivers, restoring independence and improving health and well-being	High quality care and experience for patients, families, and caregivers: • 24/7 coordination and system navigation • Seamless transitions • Patient access to information (when/where they need it) • Deliver full continuum of care for all but the most highly specialized conditions AOHT is actively managing health outcomes for attributed population	
	Conditions Better Managed in the Community Design and launch an integrated complex chronic disease management program Design and launch the Community Wellness Bus	Improved health and social care coordination and transitions in the community for: • High users of hospital-based services with complex chronic conditions • Underserved populations with unmet mental health and addictions issues		
	COVID-19 Support community-based approaches to reduce the impact of COVID-19	Efficient and equitable vaccination of community members against COVID-19		
2 ENGAGING PATIENTS AND COMMUNITIES IN CO-DESIGN **We will use upstream engagement and ongoing connection to improve health system outcomes.**				
Patients Families Caregivers Community Members	Convene a Citizens' Reference Panel to engage a representative sample of individuals across Algoma	AOHT and partners integrate and implement citizen-initiated recommendations	Citizens are meaningfully engaged and are driving priority setting	
	Develop and operationalize a patient engagement framework	Regional alignment and uptake of the Algoma People's Health Charter (Patient Declaration of Values)		
	Test and launch Caregiver ID program	Improved recognition and engagement of essential caregivers across AOHT partners and regionally		
3 BUILDING A FOUNDATION FOR COLLABORATION **We will create a unified network of organizations to better serve our community.**				
Leadership Council Boards of Directors AOHT Transformation Office AOHT Action Teams Implementation Funding (Ministry of Health) OHT Provincial Supports and Oversight	Operationalize collaborative decision making across clinical stakeholders, organizational leaders, and boards of directors	Approval of a central brand, communications, joint initiatives, and strategic plan (2022–2025) for the AOHT	AOHT single clinical and fiscal accountability framework Integrated funding envelope based on care needs of attributed population AOHT providing care according to the best available evidence and clinical standards Digital health underpins service delivery, ongoing quality and performance improvements, and better patient experience	
	Develop a mechanism to measure performance and advance quality improvement	Baseline measures are in place, including a performance dashboard and a Collaborative Quality Improvement Plan (cQIP 2022)		
	Develop a Harmonized Information Plan to guide digital priorities	Mechanisms to share information across organizations are established and digital solutions are adopted, improving clinical and patient experience		

1

STRENGTHENING CARE CLOSER TO HOME

Strengthening Care Closer to Home

We will integrate care to improve patient experience and access.

The core purpose of all Ontario Health Teams is to integrate care to improve experience and outcomes for patients, families, and caregivers. Our team will achieve these goals through cross-organizational initiatives that improve access and transition to community services, thereby providing a high quality care experience for patients in the community and reducing visits to the Emergency Department. Based on impact and feasibility, we are focusing on **two populations** in our initial operations.

1. **Frail community-dwelling older adults (healthy aging)**
2. **Individuals with conditions better managed in the community**

We have also added support for an **integrated community-based response to COVID-19** as an area of focus, particularly for the influenza and COVID-19 vaccination campaigns.

What we're working toward:

High quality care and experience for patients, families, and caregivers:

- 24/7 coordination and system navigation.
- Seamless transitions.
- Patient access to information (when/where they need it).
- Deliver full continuum of care for all but the most highly specialized conditions.

AOHT is actively managing health outcomes for attributed population.

This year, we will:

Healthy Aging:

Implement the post-falls pathway across community, hospital, and primary care

Conditions Better Managed in the Community:

Design and launch an integrated complex chronic disease management program

Design and launch the Community Wellness Bus

COVID-19:

Support community-based approaches to reduce the impact of COVID-19

Healthy Aging

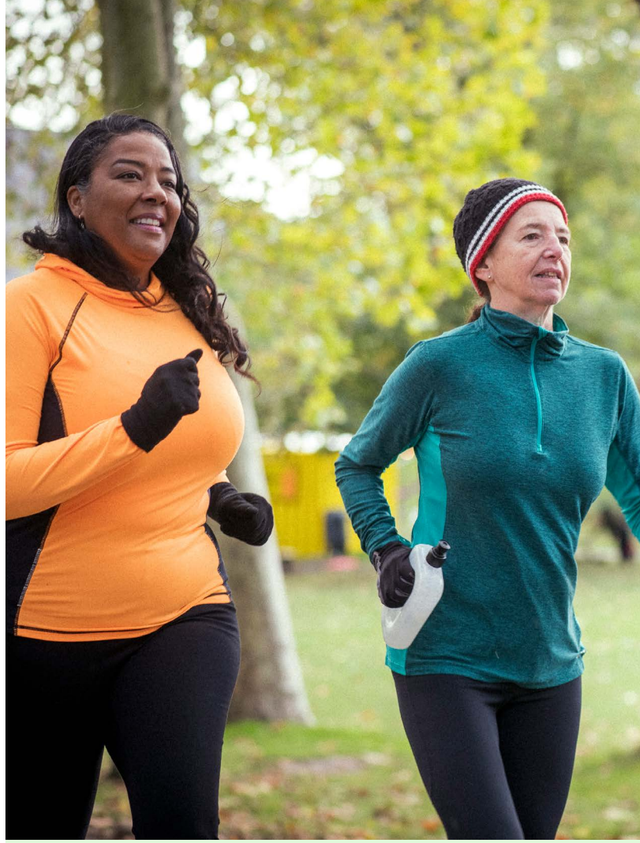
Algoma's older adults are a diverse generation rich in history and expertise. Within this generation are over 7,000 individuals living with frailty, a geriatric syndrome characterized by reduced strength, endurance, and physical function.

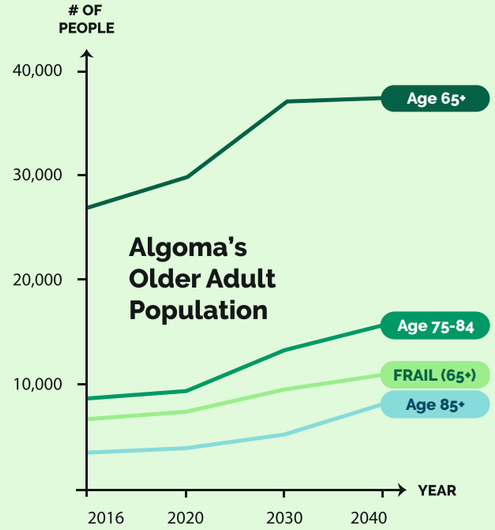
It is estimated by 2040, there will be 11,000 individuals that will be living with frailty in Algoma (graph)[3]. Maintaining older adult independence improves quality of life, decreases the amount of time spent accessing care, and reduces the overall cost to the healthcare system. **Algoma's older adults living with frailty, especially those who have potential to improve with intervention, are one of the first groups we hope to positively impact through our projects.** To do this, we're bringing together local and regional health professionals to co-design improved care pathways for older adults living with frailty.

Areas for improvement:

1. Reducing the number of falls and functional losses
2. Focusing on the restorative potential of older adults
3. Implementing proactive, early models of care in order to maintain independence

> "Our older adults are living longer. Working towards integrated care will better provide support for our community where they want to be - at home."
>
> **Registered Nurse,** Emergency Department





Above photo: Centre for Ageing Better, CC BY-ND 4.0, https://creativecommons.org/licenses/by-nd/4.0/, no changes.

3. Provincial Geriatrics Leadership Office (2020). *Regional Frailty Estimates North* [Data set]. Provincial Geriatrics Leadership Office.

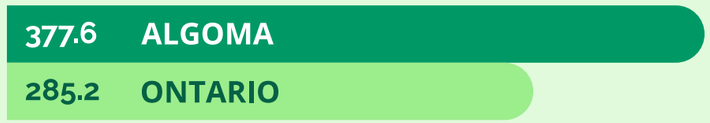
PROJECT:
Implementing the post-falls pathway for frail adults

In Algoma, falls are the most common reason for injury-related hospitalization. In 2018/19, over 1,500 patients ages 65+ visited the Sault Area Hospital Emergency Department after a fall.

The Rehab Care Alliance post-falls pathway[4] is being implemented as an initial AOHT project to improve health outcomes for those living with frailty and reduce the burden faced by caregivers. As frequent users of health and social services, individuals living with frailty represent some of the most complex needs in the health system. The post-falls pathways include evidence-based information for primary care providers and emergency departments on how to identify, assess, and connect frail older adults who fall with rehabilitative care to prevent additional falls and further functional decline. In our community, the post-falls pathway will connect older adults living with frailty to local Specialized Geriatric Services, with its interdisciplinary approach to care. Programs like the Algoma Geriatric Clinic are evidence-based and have been proven to prevent falls and maximize function and independence in older adults.

4. Rehabilitative Care Alliance (2020). Pathways to rehabilitative care for frail older adults in the community presenting to Primary Care or ED post-fall (Pilot Report). Rehabilitative Care Alliance.

PEOPLE HOSPITALIZED FOR FALLS (PER 100,000)



The rate of hospitalizations for falls is notably higher in Algoma than in Ontario as a whole. Data: Algoma Public Health (2018). *Community Health Profile*. Algoma Public Health.

> "As a family doctor, I see older adults and their caregivers who are struggling to navigate the health system and in need of greater support every day. As clinicians, many of us struggle with how to support frail older adults as well, which is why I'm excited to be working jointly with my colleagues from community and acute care to more proactively identify and support people living with frailty. This means better support, so that people can stay at their homes for as long and as safe as possible."
>
> **Dr. Winyan Chung,** Primary Care Co-Lead, Healthy Aging and Family Physician, Group Health Centre

Conditions Better Managed in the Community

In Ontario, much of the burden on the health system is related to chronic disease. Chronic disease is the leading cause of death across the province, with cancers, cardiovascular diseases, chronic lower respiratory diseases, and diabetes alone accounting for almost 65% of total deaths and over $10 billion in annual healthcare expenses[5].

Many Algoma residents are living with chronic diseases such as diabetes, heart disease, COPD, and arthritis (graph)[6]. As Algoma's population ages, more citizens will be living longer with chronic conditions. It is common for individuals who have one chronic condition to have others. If not well-managed in the community, having multiple chronic conditions can drastically reduce quality of life and use substantial healthcare resources.

As one of our intial priority populations, one of our main projects will involve looking at a model of care for integrated complex chronic disease management.

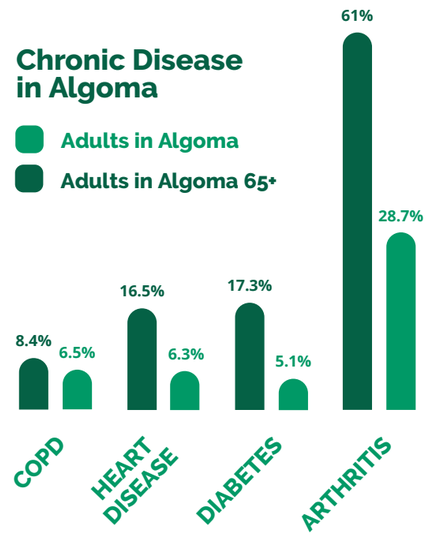
Patients with multiple chronic diseases experience significant treatment burden in terms of understanding and self-management of chronic conditions, attending frequent healthcare appointments, and managing complex drug therapies. In addition to negatively impacting quality of life, having two or more chronic conditions increases fragmentation of care and care or treatment burden, and can affect relationships[7]. For health professionals, the complexity and intensity of interventions for complex chronic patients can also present challenges.

By integrating care for those with complex chronic disease and improving access to primary care, we can provide citizens with the necessary care, knowledge, skills, and resources they need to better manage their conditions. By doing so, we hope to keep these individuals as healthy, functional, and independent as possible in the community.

5. CCO & Ontario Agency for Health Protection and Promotion (Public Health Ontario, 2019). *The burden of chronic diseases in Ontario: key estimates to support efforts in prevention.* Queen's Printer for Ontario.

6. Algoma Public Health (2018). *Community Health Profile*. Algoma Public Health.

7. Poitras, M. E., Maltais, M. E., Bestard-Denommé, L., Stewart, M., & Fortin, M. (2018). What are the effective elements in patient-centered and multimorbidity care? A scoping review. *BMC Health Services Research, 18*(446). https://doi.org/10.1186/s12913-018-3213-8.



Under the umbrella of **Conditions Better Managed in the Community**, we are also aiming to positively impact individuals living with mental health and addictions. Mental health and addictions issues have emerged widely as being influential on chronic disease risk factors and outcomes[8] and are increasingly being considered a life-long chronic condition. Ongoing concerns with mental health and addictions in Algoma include substance abuse, self-harm, and suicide[9].

When compared with all of Ontario, Algoma communities experience over twice the rate of hospitalization due to:

- Self-harm
- Drug toxicity
- Opioid toxicity[9]

In 2018, Algoma Public Health reported the rate of hospitalization due to mental health and addictions as 554 per 100,000 residents, compared to only 184 per 100,000 in Ontario as a whole[9]. As an ongoing concern in Algoma communities, and in conjunction with the burden of the COVID-19 pandemic, mental health and addictions initiatives are being accelerated as a priority of the AOHT.

8. CCO & Ontario Agency for Health Protection and Promotion (Public Health Ontario, 2019). *The burden of chronic diseases in Ontario: key estimates to support efforts in prevention.* Queen's Printer for Ontario.

9. Algoma Public Health (2018). *Community Health Profile*. Algoma Public Health.

"The AOHT is pushing the boundaries of how health and social service organizations are coming together aligned on the needs of the individual. Working in the field of mental health and addictions, we often hear from clients that their mental health needs are seen separately from their chronic physical needs. In the short time that we're working together, I'm seeing great strides being made by our community to embrace people in all their complexity".

Annette Katajamaki, Executive Director, Canadian Mental Health Association Sault Ste. Marie Branch

PROJECT: Integrated complex chronic disease management

As of 2018, there were over 26,000 documented cases of chronic disease in the AOHT's attributed population. A large portion of these cases represent individuals who have multiple chronic conditions. To date, we have segmented the top users of the Emergency Department who present with exacerbations of chronic disease and grouped them into five patient populations (cardiovascular, lung, diabetes, mental health and addictions, and neurological) in order to get a better understanding of our target population.

After much research, the key elements of effective complex chronic management disease initiatives have been identified as:

- Providing a patient-centered approach;
- Supporting patient self-management;
- Developing training for healthcare providers;
- Enhancing an interdisciplinary team approach;
- Providing case management and discharge planning;
- Specialized nursing; and
- Integrating information technology[10,11]

We are currently working on staffing a team to lead in the development of one or more interventions related to the key elements listed above to support better management and integrated care for those with complex chronic disease.

10. Poitras, M. E., Maltais, M. E., Bestard-Denommé, L., Stewart, M., & Fortin, M. (2018). What are the effective elements in patient-centered and multimorbidity care? A scoping review. *BMC Health Services Research, 18*(446). https://doi.org/10.1186/s12913-018-3213-8.

11. Ontario Health Technology Advisory Committee (OHTAC) OCDM Collaborative (2013). Optimizing chronic disease management in the community (outpatient) setting (OCDM): an evidentiary framework. *Ontario Health Technology Assessment Series, 13*(3), 1-78.

"There is a growing need for care to be well-coordinated and community-based. Far too many patients experience a diminished quality of life because of having to be constantly admitted and discharged from the hospital due to exacerbations of chronic illness. Improving access to good healthcare in the community is key to improving quality of life for these individuals."

Cynthia MacKay, Director of Clinical Operations, Group Health Centre

PROJECT:
On the road to community wellness

The Community Wellness Bus represents a new way for AOHT partners to come together to address unmet needs in the downtown core. An evidence-based model of outreach services, this project is grounded in an approach of primary healthcare that looks at physical, mental, and social well-being. Due to the large homeless and underhoused population who suffer disproportionately from the burden of mental health and addictions, a major area of focus will be providing basic levels of care and interventions from a primary care nursing, addictions, and peer support perspective. There will also be a heavy focus on engaging patients in further services based on their needs. This will support patients in receiving the appropriate level of care at the right time, thus reducing unnecessary Emergency Department visits and escalation in acuity of needs due to inaccessibility.

Targeted for a Spring 2021 launch in Sault Ste. Marie, the Community Wellness Bus will provide a safe and welcoming presence – particularly in the downtown core where residents struggle to access services and overcome barriers to care. We expect program growth through an increased scope of care, integration of community partners, and increased hours and availability. This project has been designed as a proactive outreach model on wheels to increase continuity of care for those experiencing access issues.

PROJECT:
Coming together on COVID-19

Further to the two priority populations identified in our original OHT application, the COVID-19 pandemic necessitated additional initiatives to coordinate care in the Algoma region, including working with community-based partners to support flu and COVID-19 vaccine delivery.

As part of its work in coordinating efforts across health and social service organizations, the AOHT supported the development of a 2020 general access flu vaccination clinic. Running over five days, including weekends, over 12 organizations (including non-AOHT members such as home care, midwives, paramedics, and nursing students) administered 2,315 flu shots. The partnership between organizations demonstrated how, in a region with limited access to health human resources, greater alignment can bring additional capacity to deliver essential health services. The AOHT provided the coordination mechanism to bring partners together while relying on clinical leadership and public health oversight regarding vaccine administration and safety, with the City of Sault Ste. Marie providing the GFL Memorial Gardens arena venue.

Having laid the foundation for collaboration, the AOHT will be using a similar approach to provide a community-based Mass Immunization Clinic for residents to receive the COVID-19 vaccine. Mobile teams for community outreach initiatives will also ensure that nobody gets left behind. This AOHT collaboration will enable the safe and efficient administration of vaccines to Sault Ste. Marie citizens, as part of Algoma Public Health and partners' Algoma-wide effort to immunize and protect residents from COVID-19.

"The AOHT's mass immunization clinic model is an excellent example of community health partners pooling local resources to immunize residents in a safe and efficient way."

Dr. Jennifer Loo, Medical Officer of Health and CEO, Algoma Public Health

Engaging Patients and Communities in Co-design

We will use upstream engagement and ongoing connection to improve health system outcomes.

Putting patients, families, and caregivers at the centre of the health system is intrinsic to Ontario Health Teams. But integrated care isn't only achieved by changing the way care is delivered and organized – it's also influenced by patient and community voices in project design. Our team has committed to upstream patient and community engagement and co-design to ensure that our work is truly reflective of the needs of our community.

"Being involved in the patient movement for many years; it's easy for clinical or organizational interests to take over. That's why it was important for the AOHT to build patient leadership into its structure. Over the next year, I'm keen to engage with community members whose voices have traditionally been underrepresented and hear what outcomes matter to them."

Stephanie Parniak, Patient Lead and Tri-Chair, AOHT

What we're working toward:

Citizens are meaningfully engaged and are driving priority setting.

This year, we will:

Convene a Citizens' Reference Panel to engage a representative sample of individuals across Algoma

Develop and operationalize a patient engagement framework

Test and launch Caregiver ID program

PROJECT:
Engaging upstream with the Citizens' Reference Panel on Integrated Care

As part of our commitment to meaningfully engage citizens in system design, our team will be convening a Citizens' Reference Panel on Integrated Care to hear from a representative group of citizens that broadly reflect the diversity found within the community. Working together, this diverse group of randomly-selected citizens will provide the AOHT with recommendations that will shape the future of health in our region through a process known as "deliberative engagement".

Deliberative engagement differs from traditional methods by engaging a smaller group of representatives in learning related to an issue, and then asking them to develop recommendations and solutions for the organization to implement.[12] By incorporating this engagement into our work, we will both improve project design and outcomes while identifying the best ways to form ongoing connection and accountability to our community representatives.

12. MASS LBP (2020). Deliberative engagement: an introduction [Workshop].

"Algoma is made up of a diverse and diffusely dispersed population, thus requiring a new way to engage in a more representative and deliberative manner to ensure our communities are at the centre of our healthcare system. Our Citizens' Reference Panel on Integrated Care is a way of simultaneously addressing an imbalance and also actively ensuring our initiatives are co-designed with those that very system serves."

Christianne Monico, Executive Director, Algoma Residential Community Hospice (ARCH)

PROJECT:
Caregivers - we're essential.

The COVID-19 pandemic has created unprecedented circumstances on many fronts.

In hospitals, long-term care homes, retirement homes, hospices, and across community health partners, early restrictions to visitation and the exclusion of caregivers had numerous unintended consequences. It is recognized that caregivers play a vital role as members of the care team. Healthcare providers were challenged with how they could effectively integrate caregivers into the circle of care while maintaining a safe environment for both patients and staff.

Caregivers are integral to the patient journey. They provide critical and often ongoing personal, social, psychological, and physical support, assistance, and care, without pay, for people in need of support due to frailty, illness, degenerative disease, physical/cognitive/mental disability, or end of life circumstances. Caregiver presence provides support for patient physical care and mental well-being.

From COVID-19 challenges grew the **Caregiver ID** project, which aims to recognize caregivers in a formalized capacity as essential partners in care. This project, launching at Sault Area Hospital in conjunction with community health partners, will identify, prioritize, and equip caregivers with the tools needed to continue providing care to their loved ones throughout the COVID-19 pandemic. It involves updating essential caregiver policies, formalizing their roles, providing caregivers with a visual identification card, and providing resources on topics such as infection prevention and control. The roll out of the project is being done in a manner that standardizes an approach to the inclusion and recognition of caregivers across the AOHT. If someone is identified by a participating organization as an essential caregiver, they will maintain that role as they seamlessly transition across the continuum of care throughout the community.

Identifying the caregiver is an important step in establishing and strengthening a relationship that can yield better patient care and outcomes and provide the team with a better understanding of the patient, their medical condition, and beyond.

Essential caregiver Mary with husband Rick at Sault Area Hospital.

> "I don't think anyone would have described me as a fighter. But every day, when I try to see and take care of my parents in long-term care I feel like I'm fighting a system that undervalues my contribution. I've got almost 60 years of experience of knowing what matters most to them; so please learn to work with me and let me help."
>
> **Micheline Findlay,** Caregiver

> "Serving a community of persons living with dementia, it is abundantly clear that caregivers are an essential part of the health system and we need to continue to ensure they feel supported and valued. Now more than ever, the continued involvement and engagement of caregivers increases patient/client satisfaction, enhanced quality, and safety."
>
> **Terry Caporossi,** Executive Director, Alzheimer Society, Sault Ste. Marie & Algoma District

Building a Foundation for Collaboration

We will create a unified network of organizations to better serve our community.

Integrated care is founded on the principle of inter-organizational teamwork and collaboration, where groups of people are designing and implementing a set of interrelated initiatives to shift the health system towards a shared purpose. That is, ensuring that there are the necessary elements in place to eventually allow the AOHT to operate under a single clinical and fiscal accountability framework to meet all the care needs for its attributed population.

What we're working toward:

- AOHT single clinical and fiscal accountability framework
- Integrated funding envelope based on care needs of attributed population
- AOHT providing care according to the best available evidence and clinical standards
- Digital health underpins service delivery, ongoing quality and performance improvements, and better patient experience

This year, we will:

- Develop a mechanism to measure performance and advance quality improvement
- Develop a Harmonized Information Plan to guide digital priorities
- Operationalize collaborative decision making across clinical stakeholders, organizational leaders, and boards of directors

Leadership, Accountability, and Governance

Work in leadership, accountability, and governance ensures organizational alignment with the AOHT at the highest level of each partner organization – enabling and supporting change. This is being accomplished by the creation of the Leadership Council, which is facilitated by the AOHT Transformation Office, and works across all AOHT partners to develop a strategy and mobilize resources to operationalize the plan. By the end of the first year of operations, the AOHT is responsible for establishing its first Strategic Plan starting in 2022 that leverages its integrated leadership and governance structure.

Digital Health

Digital health initiatives are primarily about providing better information and access for patients through digital tools – and they underpin the patient experience. Objectives of this working group include growing virtual care options, online appointment booking, and digital access for patients, as well as finding connection tools, data integration, and predictive analytics for providers. As part of the first year of operations, the AOHT will be undertaking a Harmonized Information Management Plan and identifying the initial areas of focus for digital health, whether that's managing community referrals or supporting scheduling and workflow across organizations.

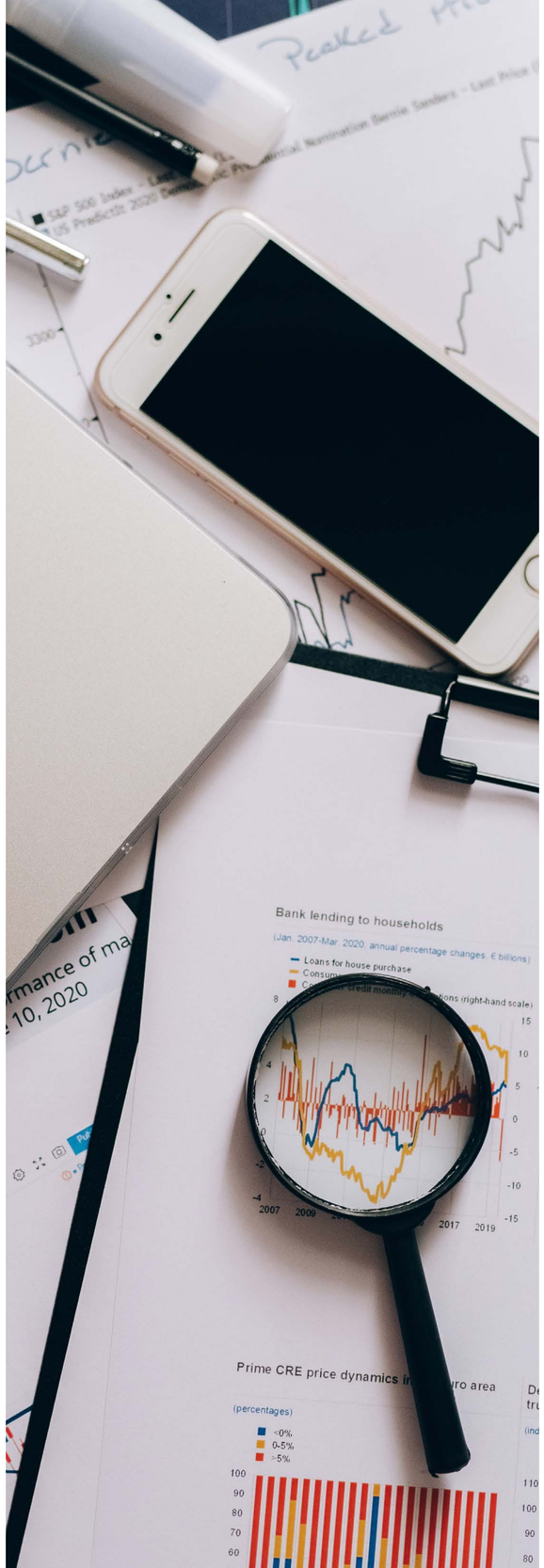
Performance Measurement, Quality Improvement, and Continuous Learning

Quality improvement is all about delivering the best possible care and achieving the best possible outcomes for people every time they deal with the health system or use its services. The AOHT has created a Quality Improvement Committee that is providing active expert guidance on design, execution, measurement, monitoring, sustainability, and spread of initiatives. The Committee is responsible for establishing a Community of Practice to help provide a forum for rapid improvement and laying the foundation for a joint Collaborative Quality Improvement Plan (cQIP) across partners.

An important component of integrated care is performance measurement – setting goals and measuring what matters to support rapid improvement and learning. As part of our first year of operations, we'll be putting a performance measurement dashboard in place to support improvement both at the project level and across the AOHT.

"It is important not to stop when you actually get good initial results. Even when initial feedback is excellent, we have to quickly realize that not all information and results will be applicable in all situations and for all patients."

Dominic Noel, Executive Director and Nurse Practitioner Lead, Algoma Nurse Practitioner-Led Clinic



AOHT Indicators

We have chosen three overarching indicators to guide our work:

1. **Proportion of patients who are contacted by their primary care provider within 7 days of discharge from the hospital**

   Increasing this measure will ensure that patients are receiving well-rounded and continuous care from providers.

2. **Number of visits to the Emergency Department with a main problem that is "better served in the community"**

   Improving and shifting care for chronic conditions into the community will reduce the number of visits to the Emergency Department, both improving the patient experience and reducing traffic at the hospital.

3. **Median wait time for community care**

   Improving efficiency and health system infrastructure will reduce the wait time for community care options.

"Our chosen indicators for success focus on those very difficult transitions of care – improving the relationship between community services, the hospital, and primary care. As a better-connected team that communicates data across organizations, we'll be able to keep our eyes on what matters to our community."

Jennifer Pettalia, Manager, Analytics, Sault Area Hospital

Algoma District Medical Group

Alzheimer Society
Sault Ste. Marie & Algoma District

Group Health Centre

Sault Area Hospital
Hôpital de Sault-Sainte-Marie

Algoma Family Services
Services aux familles d'Algoma

ARCH hospice

Sault Family Health Organization

Algoma
Nurse Practitioner-Led Clinic

Canadian Mental Health Association
Sault Ste. Marie Branch
Mental health for all

Lakehead · Laurentian · Medicine
Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Social Services | Services Sociaux
Zhawenimi-Anokiitaagewin
Sault Ste. Marie District

Algoma Public Health
Santé publique Algoma

F.J. Davey Home

Le Réseau du mieux-être francophone du Nord de l'Ontario

Superior Family Health Team

ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

Connect with us!

info@algomaoht.ca
www.algomaoht.ca
705-989-4813