Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

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

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

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

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

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

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

Participation in Central Program Evaluation

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

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

Additional Notes

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

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

Ontario Health Teams
Full Application Form

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name:
	Title:
	Organization:
	Email:
	Phone:
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name:
	Title:
	Organization:
	Email:
	Phone:

1. About Your Population

In this section, you are asked to provide rationale and demonstrate your understanding of the populations that your team intends to cover in Year 1[2] and at maturity.

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

1.1. Who will you be accountable for at maturity?

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

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

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

[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.

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

The alignment between the population and service area proposed during the self-assessment and the attributed population provided is moderate. Our original proposal was Sault Ste. Marie and area whereas the attributed population has expanded our geographic service area to include the populations from both east and north of Sault Ste. Marie. This expansion means an increase in the population covered of approximately 37% but more importantly increases the geographic area covered from approximately 600 square kilometers to 32,000 square kilometers. It also means expanding to areas with unique needs and challenges that were not initially considered.

These areas are covered by other OHT applicants (North Algoma, East Algoma and Maamwesying) that have worked diligently to plan for their areas. Though they have been brought into conversations their perspectives have not been fully described. Data for attributed population was reviewed through the lens of access, equity, and quality, including clinical and cost effectiveness. A key next step will be to broaden our understanding of the data by further involving these affiliated teams.

There is a high degree of alignment between the attributed population and the Algoma Sub-Region population (greater than 95%). There is also notable alignment with the district and census sub-division of Algoma, only differing in areas to the far north and east of Algoma's boundaries. Where topics different from what was provided in the ministry data package were explored, we used available information based on both geographic areas.

Challenges and Opportunities

We acknowledge that the challenges that are identified provide opportunities to drive improvement within the broader health and social services systems.

Aging population

Seniors (65+), make up 22.2% of the population of Algoma, compared to 16.7% in Ontario. Although the population of Algoma is stable, population growth occurred in those 65 and older between 2011 and 2016. In the same period, population declined in the under 64 age group. These population changes drive an increase in the dependency ratio (children + seniors/working age). Rural populations east of Sault Ste. Marie tend to be older; populations north of Sault Ste. Marie tend to be younger.

Older adults are most affected by major chronic disease. Among Algoma adults aged 65+, 17.3% have diabetes, 16.5% have heart disease, 8.4% have chronic obstructive pulmonary disorder and 61.0% have some form of arthritis. The opportunity arises to target this quickly expanding demographic proactively by better supporting the people with these conditions in the community.

Approximately 70% of all in-patients at Sault Area Hospital are aged 65+. Their natural aging processes contribute to higher rates of chronic conditions, complexity and cost. This population represents a significant portion of the most costly health profile groups identified in the ministry data set. Better supporting frail seniors through early assessment and execution of identified interventions will facilitate improved outcomes.

Morbidity and mortality
Based on self-reported prevalence (2011-2014), one in five Algoma sub-region residents, aged 12 and older, suffered from Arthritis and one in five had high blood pressure. The diabetes rate was 6.8 per 100. Prevalence rates for COPD and CHF were second and fourth highest when compared to all other sub-regions in Ontario. Algoma Public Health has also identified a high rate of Hepatitis C.
Mortality rates are nearly double for Algoma (1,226 deaths per 100,000 population in 2017/18), compared to Ontario (734 deaths per 100,000).

Vast geography and sparse population
Our vast region has a population density of approximately 3.1 people per square kilometer and travel is one of the key challenges to equity in health care.

About 30% of the population lives 30 minutes or more outside of Sault Ste. Marie. Travel is often greater than 30 minutes to health services in remote and rural areas of Algoma and can be four to eight hours for some levels of care (e.g. tertiary care). The challenge presented by both low population density and large distances is a key impediment in the scope and breadth of service availability within the region.

All residents of Algoma have to travel for more specialized care, such as neurosurgery, that is only offered outside the region.

Behaviours negatively impacting health status
The Algoma sub-region has higher rates than Ontario of smoking (24.6% vs 16.7%) and being overweight or obese (59.3% vs 53.3%). Hospitalization rates for drug toxicity (131.1 per 100,000 people) were more than twice the Ontario rate (62.5).

There were 15 deaths due to opioid overdoses in 2016, more than double the experience in Ontario.

The adolescent pregnancy rate in Algoma (29.9 per 1,000 adolescent women) is nearly double the Ontario rate (15.8).

Diversity
The attributed population is significantly diverse in socio-demographics. 12.9% of residents of Algoma sub-region self-identified as Indigenous in the 2016 census. Many live on one of the six reserves within the sub-region and there are an estimated additional 11% of the population of Sault Ste. Marie identifying as Indigenous. There is a Francophone population per the Inclusive definition of Francophone (IDF) of 5.6% in Algoma. Sault Ste. Marie has a large population of European and Scandinavian descent as well as a growing new immigrant population. There is also an emerging population of Mennonites in Algoma. Culturally sensitive care is required.

There is also a broad range of social determinants of health in the region. Public Health Ontario identifies areas east and north of the city within the highest two quartiles in the Material Deprivation factor, and there are some neighbourhoods within the city in this group as well. These challenges are integral to understanding how to focus attention on the opportunities identified.

The complexities of our regional health needs, existing programs and services and implementation of cross-continuum solutions were considered. Efforts to review data reflective of our population were made; some assumptions have been made and will be further validated. Partner consultation and collaboration opportunities were identified across the participating agencies. Partners represented in this application, particularly Public Health, have had experience with implementing population health approaches that address the social determinants of health (see Section 2).

1.2. Who will you focus on in Year 1?

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

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

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

disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

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

Maximum word count: 1000

Evaluation of the data provided and additional data sources occurred to determine our priority populations for Years 1 and 2. The Algoma attributed population includes populations proposed for coverage by three other OHT candidates; North Algoma, East Algoma and Maamwesying North Shore Community Health Services. This presents new and emerging opportunities for system alignment and improvement.

The proposed populations were examined and evaluated based on several criteria:

Applicability to OHT Mandate: Improvements for the population are within the circle of influence of the OHT applicants (Signatories). Population will benefit from mandated services from Ontario Health (patient self-management, care-coordination and navigation, health literacy)

Opportunity: There is an opportunity within available resources to improve outcomes for this population.

Measureable: Improvements to the healthcare of this population can be measured using clearly defined indicators.

Transferability: Will procedures, processes, lessons learned be transferable to other segments of the population in Year 2 and beyond.

Clarity/Understandability: The target population should be easily defined, understood and identified by stakeholders.

Timeliness: Can improvements be accomplished and results seen within twelve months? We want to be able to show our efforts have made a difference.

Longevity: Will improvements for this population be felt 5-10 years later?

System Alignment: The population chosen reflects the system perspective and important goals or aspects of the health system. It aligns with one or more system imperative, and health system outcome objectives.

Two populations were chosen for Year 1: Patients under 75 years of age with “conditions better managed in the community” (Ambulatory Care Sensitive Conditions(ACSC)) and Frail Seniors. Broader consultation and validation is required to determine impacted work for Mental Health and Addictions unattached patients,

avoidable ED visits for LTC residents and rural health. These four additional priorities are multi-faceted and their complexity will be considered for Year 2.

Description: Conditions better managed in community
(0-74 years of age)
(Epilepsy, Asthma, Diabetes, Congestive Heart Failure, Hypertension, Angina, Chronic Obstructive Pulmonary Disease)

Why this population?
There is clinical evidence that care in the community can reduce the need for hospitalization for this population. Rates of ACSC are very high in Algoma and are especially high in rural and areas that have lower scores in socio-demographic factors.

Size and demographics
There are 26,511 incidences of these conditions in the attributed population. People with multiple conditions are counted in each condition. Work will be needed to determine the unique population in this group.
Epilepsy - 601, Asthma - 2,047, Diabetes - 8,743, Heart failure - 1,666, Hypertension - 9,714, Unstable Angina - 630, Chronic Obstructive Pulmonary Disease - 3,110

Costs and cost drivers
Approximately $75 million for patients in HPG that include these diagnoses. That is 19% of $401 million total costs for all HPGs.

Social determinants of health
The people most at risk for ACSC hospitalizations tend to be older; have poorer health, lower socioeconomic status, and comorbidities; be regular smokers; and live in rural areas.

Health status (disease prevalence, morbidity, mortality)
Algoma has the second highest COPD prevalence of all the sub-regions (8.3%) and the fourth highest CHF prevalence (5.6%). Diabetes prevalence is (14.9%). (HAIB Chronic conditions report).
A CIHI study, Hospitalization for ambulatory care sensitive conditions among urban Métis adults, showed hospitalization for these conditions in this population group was twice as high as in the non-indigenous population. Approximately 48.7 % of Francophones in North East LHIN have at least one chronic condition (including asthma, high blood pressure, diabetes, heart disease, cancer, stroke, arthritis or COPD)

Description: Frail Seniors
Community dwelling, 65 years of age and older that are determined to have restorative potential following a comprehensive geriatric assessment

Why this population?
The Rehabilitative Care Alliance (RCA) has developed post-fall rehabilitative care pathways to connect frail older adults who fall within rehabilitative care to prevent functional decline and additional falls. The care pathways make it easier for primary care and emergency departments to connect older patients who have fallen with appropriate rehabilitative services and they aim to reduce falls, one of the leading causes of preventable injuries among seniors, resulting in ED and hospital utilization.

Size and demographics
Estimated for 2016 - 5,500 people 65 years and older living with Frailty (North East Specialized Geriatric Centre [NESGC]). 1519 patients (aged 65+) registered at SAH ED in 2018/19 with presenting complaint of "fall": greater than 98% occurred as slip, trip or "from the same level".

Costs and cost drivers
Dementia (including Alzheimer's with significant comorbidities) is identified as the most costly HPG in the Population Costing profile for Algoma. The Clinically Frail Scale accounts for both physical and cognitive decline and may be used in consideration of fall risk.

Social determinants of health
Similar to "conditions better managed in the community population".

Health status (disease prevalence, morbidity, mortality)
The RCA Pathways considered are developed for seniors presenting to ED and/or primary care. Year 1 with focus on Emergency presentations.

The pathway leads the ED Provider to determine follow-on services required including:

• Referred to Specialized Geriatric Services (for comprehensive geriatric assessment);

• Referral to Direct Access programming for rehabilitative services.

In-year transferability to primary care will be determined. Early uptake in ED will ensure that patients receive the same pathway of care and access to specialized

services regardless of their primary care attachment.

These priority populations are closely aligned to one another and largely match the population proposed in the Self-Assessment. Expansion of our Year 1 target population increases the proposed patient population from 500 to 1500.

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

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

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

  The social demography of Algoma highlights important health care needs of the population. The unemployment rate is 10.2% with the youth unemployment rate (ages 15-24) at 22%: both of these are higher than the Ontario rate. There is a direct link to the 15.3% Algoma population living below the low income level – not surprisingly, also higher than the Ontario rate. Food insecurity in the population aged 12+ is 20.6% telling us that one in five will be hungry as early as their next meal.

  According to the 2015 BEST START Network report that cites 2006 Stats Canada Data, Algoma scores higher than the provincial average on a number of Social Risk Indicators: Lone-parent families (Algoma16.3%, Sault 18.2% and Ontario 15.8%); adult unemployment (Algoma 8.9%; Sault 8.1% and Ontario 6.4%); and, income from Government transfers (Algoma-14.6%, Sault 12.9% and Ontario 8.8%).

  Sault Ste. Marie has a significantly higher rate of teen pregnancy than Ontario at 10.4% verses 3%.

[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.

The top three mental health diagnosis for children (0-18 years) from 2013-2015 were Anxiety, Attention Deficit and Disruptive Behaviour Diagnosis. The most common presenting issue for children and youth are aggressive behaviour, attention and concentration difficulties, anxiety and depression.

Child injuries reported in the Emergency Department for ages 0-6 are higher than the Ontario average. In 2015, Algoma experienced 164.3/1000; Sault 149.6/1000 and Ontario at 98.9/1000.

Francophone
When we look to the data to address the specific issues of our Francophone population it is important to note the significant challenge posed by the lack of data on health outcomes and status. In consideration of this gap we have looked to data from the 2016 census as well as that sourced from the CCHS based on the Inclusive Definition of Francophones (IDF) and NE LHIN Sub-region information for Francophones.

Profile of the Francophone community in Algoma indicated 5.6% are Francophone; however, there are communities in the district that are predominately Francophone (e.g. Dubreuilville at 83%; North Shore at 21.8% and Blind River 19%). Currently, within Algoma only one health service provider has received partial French language service (FLS) designation. Fifteen additional providers have been identified as needing to plan for the provision of FLS and to work towards designation. Supporting designation will accelerate the delivery of service to our Francophone population.

Indigenous
In May of 2019 the Mamow Ahyamowen Partnership released a commissioned report entitled: Learning from Our Ancestors: Mortality Experience of Communities Served by Maamwesying North Shore Community Health Services. This report summarizes data regarding all-cause and premature mortality as well chronic conditions present at the time of death. The findings are startling. Members of these communities are twice more likely to die before retirement age than other Ontarians (53% for band members vs. 22% for Ontario). By the time band members die, more than half will have four or more chronic diseases. In comparing the chronic disease prevalence within the Indigenous population covered in the report it is important to look at the ages of the people who die in comparison to the provincial experience. The presence of high blood pressure, diabetes, chronic obstructive pulmonary disease, coronary artery disease, heart failure, mental illness, kidney failure and substance abuse are high in the Indigenous population at death than in the Ontario population within the same age groupings. Many of these conditions are considered to be responsive to effective management or earlier treatment. This can inform the prioritization of future health programming.

Rural and Remote
Algoma's vast geography and sparse population creates challenges for access and delivery of health care. Isolated communities, lack of public transportation in and between communities, travels costs and hazardous driving conditions are significant factors. In addition staff retention within small and isolated communities can be problematic (2011 Community Picture Report from Healthy Community Fund Partnership-Algoma District).

Summary
As indicated, the attributed population now includes the population under consideration by North Algoma, East Algoma, and Maamwesying OHT candidates. These partners are further examining the opportunities for alignment within the broader Algoma region. With that change, new work presents itself to expand the originally proposed OHT population and consider the newly attributed population challenges and needs. In considering the unique needs and gaps of this broader geography and population we acknowledge that there is additional engagement and analysis to be undertaken to ensure full understanding.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

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

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

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

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

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

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

Name of Organization	Type of Organization[5]	LHIN/Ministry Funding Relationship	Primary contact
Provide the legal name of the member organization		*Does the member organization have an existing contract or accountability agreement with a LHIN, MOH, or other ministry? If so, indicate which*	*Provide the primary contact for the organization (Name, Title, Email, Phone)*
See supplementary Excel spreadsheet			

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

Please describe the processes or strategies used to build your team's membership. Are there key members who are missing from your team at this point in time? Are there any challenges your team sees in moving forward with respect to membership?

In your response, please reflect on whether your team is well positioned to care for your Year 1 and maturity populations. Identify any strategic advantages your team has in relation to the health and health care needs of your Year 1 and maturity populations.

Max word count: 500

In the spring we held two facilitated sessions where all funded health providers and representative PCPs from across the region were invited to attend. Information from these sessions was shared back with all participants and from this group a subset of organizations felt that this was an excellent opportunity to move forward and complete the Self-Assessment. Central to this was the understanding that a future care system that was truly patient focused would require a much broader set of partners to participate and be fully engaged. Due to the tight timelines of the self-assessment process and the varied understanding of the implications of participating as a member of an Ontario Health Team many organizations maintained engagement with the work

[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

but were unable to 'sign on'.

The team has remained open throughout the journey from Self-Assessment to the submission of this full application and a number of critical partners have identified their desire for full participation and have 'signed on'. Our work with the data provided by the ministry and supported by additional local and regional datasets to identify and validate a Year 1 population has also led us to identify an additional subset of providers who need to be engaged.

Many organizations support the work and are providing letters of support with the intent of future full participation. A third group of organizations/providers are prepared to collaborate with our OHT however by virtue of the service they deliver may not participate as a signatory to a Ministry agreement. This list of providers continues to grow as we move forward and includes existing health service providers as well as organizations such as District of Sault Ste. Marie Social Services Administration Board, Algoma District Services Administration Board, Independent Health Facilities, Community Pharmacists, Life Labs and municipal and township representatives. Challenges that our team might experience in continuing to develop and expand our membership might be created by the model of governance selected. To mitigate this risk we have already held a facilitated 'all board' session to allow for an open and transparent exchange of ideas regarding future governance.

We acknowledge we have an advantage in having both the Group Health Centre (GHC) and the Algoma District Medical Group (ADMG) as full partners. The GHC is referenced internationally as an innovative model of an Integrated Care system, and was the only Canadian model referenced in the jurisdictional scan prepared by Research, Analysis & Evaluation Branch. GHC has a history of innovation from it conception in 1963 as the first union-sponsored community health centre in Canada, predating provincial health insurance. With ADMG and GHC partnering we have immediate and comprehensive coverage of approximately 80,000 patients with primary care providers as well as allied health providers. GHC has long utilized Family Health Workers (RNs) to augment primary care and provide in-home follow up to the highest risk patients. The learning from this model in conjunction with recent evidence informed the development of the Guided Care Nursing Model which we propose to evolve.

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

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

			member provides services in multiple regions)
See supplementary Excel spreadsheet			

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

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

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

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

Max word count: 2000

We are proud of the extent of collaboration that partner agencies and teams have to build on as part of the Algoma OHT. All members have worked with at least some of the other members previously on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level. We recognize no single organization can go it alone to create maximum value for patients and communities. There is substantial interest and widespread commitment among sector providers, physicians and system leaders for transformation and to be grounded in connections between multiple organizations, professionals, funders and levels of government coming to together.

We are fortunate to have gained significant momemtun in our community and region through work completed on many collabortive and informed approaches to advance integrated care that already exist. `

The Group Health Centre (GHC), Superior Family Health Team (SFHT) and the Nurse Practitioner Led clinics (NPLC) are examples of well established integrated primary care

within the region. Each are currently working with the NELHIN Home and Community Care to further integrate by embedding care coordination into primary care.
GHC serves over 80,000 patients in Sault Ste. Marie as a single integrated system. GHC provides ambulatory care with diagnostic services, comprehensive integrated care with primary care, specialty care and other health care services with one EMR. The team includes family physicians, specialists, nurse practitioners, nurses, physiotherapists, kineseologists, respiratory therapists and dietitians with a local pharmacy onsite.

Both Nurse Practitioner Led Clinics provide comprehensive primary health care incorporating nursing leadership within an inter-professional team.

SFHT includes family physicians, nurse practitioners, nurses, social workers, dietitians, and other professionals who work together to provide primary care and co-ordinate the highest possible quality care for their patients. In addition, SHFT has been instrumental in providing primary care to the orphan patients who are marginalized and vulnerable in Sault Ste. Marie via a walk-in clinic located at the Neighborhood Resource Centre. As of March 31, 2019, primary care has been provided to 1392 patients (2727 visits), most of whom have no primary care provider or health card. The collaboration between social and health organizations to meet the health and social needs of this population at the Neighborhood Resource Centre has been provincially recognized as a model that improves outcomes.

The Neighbourhood Resource Model (NRC) is a brilliant example of how health, social services, and policing agencies effectively deliver services to margilized and vulnerable populations that attend to the social determinants of health. The NRC was implemented in 2014 and provides the opportunity for community members residing in the area to access social service agencies who deliver programming, referrals and resources within the centre. By removing significant barriers to access services have increased the opportunity for social development to occur within this neighbourhood. NRC is a social innovation in Sault Ste. Marie. It has gained momentum for breaking down silos between social services agencies and developing relationships between these organizations, Sault Ste. Marie Police Services and the Gore Street neighbourhood. The NRC has served to establish trusting and respectful relationships between neighbours, among neighbours and agencies, and agencies to agencies. They also ensure that culturally appropriate services are included. Services targeted towards children and families, increasing employment opportunities and encouraging partnerships to support the sustainability of the NRC are also incorporated. Success has been demonstrated in the recognition of activity and programming occurring at the center as well as the client-centered approach to community engagement.

Health Link Sault Ste. Marie was initiated in 2015, building on earlier work within our district for medically complex patients by Superior Family Health Team whereby 50 medically complex patients were served. To date Health Link Sault Ste. Marie has served 250 people, which was successfully expanded to mental health and palliative patient populations. A key feature of our model is a Guided Care Nurse in primary care

who proactively monitors risk factors and provides a lot of health teaching to patients based on their goals of care. Group Health Centre, NELHIN Home and Community Care, Sault Area Hospital as well as local hospice, ARCH, allocated resources to perform the work of a Guide Care Nurse with accountability to a Steering Committee. Our results are impressive for the patient population served: 80% reduction in hospital admissions; 45% reduction in Emergency Department admissions; 90% reduction in conservable days; and 95% patient satisfaction. The Guided Care Model was adopted from Johns Hopkins that developed this model to respond to the growing challenge of caring for a rapidly aging population with complex medical issues. They have reported similar patient care results with high patient and provider satisfaction over the past 10 years. We are proud this service continues to this day with the intention to expand to the Integrated Care Model. This happened through partnerships and commitment to those we serve: our community. Partners included mulitple organizations, professionals, funders and levels of government coming together (e.g. Ministry of Health and Long Term Care, Local Integration Health Network, Sault Area Hospital, Community and Social Services, the City of Sault Ste Marie, Algoma Public Health, Group Health Centre, NPLC, Baawaating Family Health Team, Canadian Mental Health Association, ARCH Hospice and patient and family advisor). Working groups and system leaders (CEOs) participating via a steering committee in the Health Link design created a plan for how complex at risk populations can be better supported through greater alignment and linkages across the primary care, community support sector, mental heath and addictions sector, palliative care and the hospital sector. Accordingly, we are confident with our Health Team that we will positively transform the patient experience. There is enthusiam at all levels and acknowledgement that capacity building is required to drive and sustain system changes. Specifically, there is agreement that ownership and accountability must be embedded within each organization's systems, practices and policies with respective leaders, owning, driving and managing outcomes.

Algoma Leadership Table (ALT) brings together organizational, executive leadership coordinated planning, prevention and shared action on child, youth and family issues and initiatives. The CEO group is the decision-making body for the partner agencies (which include health, education, municipal, social services, police and indigenous organizations) and is evidence driven and committed to evaluation through appropriate outcome measurements. Some functions as relate to this proposal include: communicating the collective impact of initiatives across individual organizations/agencies while encouraging engagement within each organization/agency; recommending where appropriate, the amalgamation of existing committees that dulpicate services, priorities and/or objecitives (such as poverty reduction and mental health and addictions issues) ;acting together for high level solutions; providing leadership on cross-agency initiatives; establishing structural supports for integrated services; engaging Indigenous groups; seeking input from patients and caregivers.

Walk-in Counselling Services to service a burgeoning need for counselling is a proud parnership of five local agencies with overlapping mandates and we see many positive impacts as we strengthen our trust relationships. The staff providing the walk-in

counselling services has been provided by the following agencies/organization; Algoma Family Services, Canadian Mental Health Association, Algoma Public Health, Sault Area Hospital and John Howard Society. Client utilization of the walk-in counselling service has been steady over the past 4 years indicating a strong demand for this service within the community. Between November 2015 and September 2019 there 2,298 counselling sessions with accessed by approximately 2000 unique individuals. Based on self reported data up to June 30/19, service recepients report that if they could not attend the Walk In today they would have accessed services at the following: 164 at the emergency department; 332 at crisis services; and 411 reported they would have contacted a primary care provider. The walk-in counselling service survey results are positive and indicate a strong rate of cleint satisfaction with 92% of clients surveyed. It is expected the demand and client satisfaction will continue through the next year and beyond.

SSM and Area Drug Strategy was developed by a dedicated group of professionals representing health and social service providers and agencies who are dedicated to adovocate on behalf of the citizens of their community. Each individual member brings a unique perspective and expertise to the overall membership allowing for diverse representation. The Committee's stength can be attributed to its roots in front line work and the staff who came together to address substance use and related matters in our community. Their individual and collective efforts and passion are evident in addressing the local opiod crisis.

Apparent from the initiatives mentioned, the OHT member organizations have worked together in multiple capacities demonstrating collaboration and integration to advance local health care to meet the needs of our populations.

We are shifting from situations where the public and government have little reassurance investments made will yield the expected benefit and impact, to one where there are concrete measures to assess value to the patient, value for money and ensure resources are in alignment with the Quadrupile Aim.

We will continue building on past successes as highlighted and continue to use a deliberate approach to stakeholder engagement and influence strategies to create a sense of ownership for transformation efforts, spanning frontline to leaders. All CEOs and medical leaders will direct the necessary action within their organizations/team to embed the philosophy, ownership and accountbility systems necessary.

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

Based on analysis of patient flow patterns and the natural connections between

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

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

Max word count: 500

Based on the data provided by the Ministry in regard to provider networks and patient flow we would rate our degree of alignment as high. Of the physician networks identified, five are connected to the East Algoma and the North Algoma OHTs (Wawa Medical Centre, Central Algoma Medical Group, Richards Landing Medical Group, Thessalon Medical Associates and Huron Shores Family Health Organization (FHO)). The East Algoma and the North Algoma OHTs continue to collaborate with the Algoma OHT to facilitate improvement in transitions of care to our tertiary site, as well as repatriation back to our local communities. The Sault FHO and ADMG General Practice GHC are full members. The Group of 3 in Sault Ste. Marie will be approached to become a member with their four physicians. Our Ontario Health Team currently has the majority of Primary Care Providers as full members and represents approximately 80% of the population.

While our Readiness Self-Assessment identified our population as the greater Sault Ste. Marie and area we have always been cognizant of the reality that patient flow patterns dictate that by virtue of our community's size in the region we do support a much broader population through our hospital and the specialists who choose to practice here. Although originally invited to participate in one large OHT Self-Assessment a number of providers in the rural areas of the region felt that they were better positioned to move forward as independent OHT candidates at this time. We continue to acknowledge and support the desire of these three OHT candidates to evolve their own local priorities and clinical care pathways.

Following the provision of the Ministry data on the attributed population we have worked with the other OHT candidates (East Algoma, North Algoma and Maamwesying) to ensure that patients can benefit from any improvements or models of care developed to transition seamlessly across the vast geographic area that the attributed population resides in.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received

endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

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

2.6.2. Other Collaborating Organizations

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

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

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

Max word count: 500

We anticipate that between the patients with conditions better managed in community and the frail senior population approximately 500 patients will receive fully integrated and coordinated care through the use of the ICN model. The frail senior population who present in ED post fall will receive a frailty assessment and be routed to evidence based care pathways (estimated to be 1000 patients). In evaluating the data provided by the Ministry as part of the application development process and the data provided to support Health Link development within the sub-region it is expected that the Year 1 target population represents 5% of the total attributed patient population who would meet the criteria identified.

Given the experience gained from the development of the Health Link Guided Care Model and the understanding of the needs and complexity of the population served we feel that this volume of patients is achievable.

Key learnings from this that we are building on to develop fully integrated care are:

• Trust is foundational amongst the team, patient/caregivers and providers to allow for full collaboration to meet each patient's needs.

• Understanding that the needs of each patient will be unique and care must be completely patient focused.

• Health teaching to support the patient's health literacy in understanding the complexity of their combined conditions to help in self-management.

• Proactive monitoring and utilizing a patient specific 'action plan' indicating red flags to trigger early intervention thus preventing deterioration and potential hospitalization is critical.

Existing integrated primary care systems are being expanded via the embedding of (existing) Home and Community Care Coordinators. As we move forward with our implementation plan and continued evaluation of Year 1 progress additional learnings will be acknowledged in targets for Year 2.

With the continued commitment of each organization's CEOs and medical leaders to support the vision of the Ontario Health Team model and our combined experience we are confident we will achieve our Year 1 target with capacity to expand in future years.

2.8. What services does your team intend to provide in Year 1?

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

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

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

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

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

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

Max word count: 500

As indicated we will continue to work with our health and social service partners (District of Sault Ste. Marie Social Services Administration Board, Algoma District Services Administration Board, Independent Health Facilities, Community Pharmacists, Life Labs and municipal and township representatives) to expand our membership. As we run evaluation cycles to understand our Year 1 experience and outcomes we anticipate that we will need to expand our engagement and consultation circles to include additional members.

In our initial review of the available data we identified a number of priority populations with unmet care needs. This list included individuals with mental health and additions service needs, the unattached patient population, and patients from LTC with avoidable ED visits and patients in rural and remote areas. Knowing that there are gaps in care needs which will evolve over time and that we have not had the opportunity to fully engage with the entire area there is a requirement for additional engagement and analysis to be undertaken to fully understand the challenges and needs of the priority populations.

With this approach in mind, timelines will need to be further fleshed out in conjunction with membership engagement.

The ICN (and companion models) leverage the opportunity to realign care coordination into primary care settings while expanding the role to full scope. As the role is further defined and adapted it will meet the needs of the remaining priority populations. With acceptance of the model and sound leadership it is anticipated that spread and scale of a ‘companion model’ into other priority populations and the rural areas of the region will take place.

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

Max word count: 500

We currently have almost all PCPs (with the exception of 4) in our network involved in

the care of the attributed population either through direct membership or through letters of support with Ontario Health Team candidates who are not yet moving to full application (i.e. in development, in discovery).

Our medical leaders will continue to engage with their colleagues to promote the opportunity offered by participation in the Algoma Ontario Health Team.

2.10. How did you develop your Full Application submission?

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

Also consider in your response:

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

Max word count: 1000

We are proud to say that our application reflects a participatory process and represents a consensus among the signatory member organizations. The members established a Leadership Council (LC) to oversee the development of the Application. Membership includes the executive lead of each organization, a small steering

committee, the French language services planning entity, and a representative of the neighbouring “In Development” OHTs in East and North Algoma. The Indigenous “In Discovery” OHT from Maamwesying North Shore Community Health Services has been invited to participate and receives regular information from the leadership council.

The LC Chairs are two executive leads and a Patient and Family Advisor. A pool of 17 Patient/Resident and Family Advisors was established and has been consulted on various aspects of the development work. Their feedback has been utilized in the development of our draft Vision and Mission, in work to determine how care will be transformed, in our proposed single brand identity and ensuring a strong patient voice at a joint meeting of the member Boards of Directors.

Executive leads of member organizations have worked with their Boards individually to prepare for endorsement of the Application. We also had a facilitated “All Boards” event during which over 80 board members came together to learn about and build support for the work of the LC and specific aspects of the development of the Algoma OHT. Board Chairs, as a result, are building stronger relationships and will continue to meet.

A Community Partner Information Session was held in September. The invitees included a broad range of partners in Algoma, including the Algoma Leadership Table (mentioned earlier in this section). Their input was sought about the Application, how they can continue to be informed and involved and advice was solicited. Through ongoing dialogue, and furthered by the sharing at this event, a number of organizations have provided letters of support of our Application, some with an intent to join with us as part of the Algoma OHT. They have asked for regular meetings to receive information and provide input. Letters of support are available in our supplementary documentation.

Physicians have been involved in the development of the Application. Direct conversations have been occurring with individuals and groups of physicians. A pool of influential physicians has been identified to inform the work and ongoing evolution. The Medical Staff Association at Sault Area Hospital has been provided with information about the OHT and their input sought on priority populations and areas of opportunity.

Meetings have been taking place with Indigenous Leaders in Algoma, seeking to understand how best to involve the voices of the several nations and organizations within Algoma and to have their voice in setting priorities for the most impactful opportunities to transform care through early wins and a broader, longer term involvement strategy.

A further point of pride about our application is that the member organizations have generously and collaboratively contributed talent and subject-matter expertise, with enthusiastic involvement of front-line staff and leaders at various levels. We

established multidisciplinary working groups among the member organizations including patient and family advisors to undertake the work of various aspects of the application. A very successful "Kaizan" improvement event was an important step in identifying how we will transform care.

To develop this application, the total incremental cost, primarily for facilitation, is less than $10,000. In addition, the members of the OHT came together to pool their resources and talents providing hundreds of hours of in kind resourcing to the development of the application. This is a testament to the partners' ability to accomplish significant work within existing resources.

3. How will you transform care?

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

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

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

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

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

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

Max word count: 1000

We have identified that activities to reduce the burden of disease and the social determinants of health are foundational in nature and will occur in parallel with specific interventions to place individuals on pathways and support their navigation through the complexities of the health system. We must take advantage of every opportunity to alter the trajectory of our population as people age.

Our team has considered patient and population health improvement outcomes relative to the work proposed for Year 1. As an integrated team, the following performance improvement opportunities have been confirmed:

1. Through implementation of structured, transparent pathways and determining a complex patient population that would benefit from an integrated model of care we will improve patient and provider experience by 5%. This measure of system performance would align to our patient-centered models selected. Baseline is to be determined based on patient identification extrapolated from 2018-19 data.

2. Reduce 30-day inpatient readmission rates by 50%, for patients engaged in the Integrated Care Model. This improvement will be driven by optimized transitions in care, improved patient self-management, system navigation and patient focused education. Baseline is to be determined by 2018-19 data.

3. Reduce Emergency Department (ED) visits by 50%, for patients engaged in the Integrated Care Model. This improvement will be found through strengthened primary care supports and proactive monitoring. ED visits will be further mitigated by managing frail seniors post-fall by assessing and stratifying those patients to the service most required. This early intervention and reassurance is designed to secure pathways in a timely manner.

4. Reduce hospital admissions for those patients presenting with Ambulatory Care Sensitive Conditions (described as Conditions Better Managed in the Community) who are engaged in the Integrated Care Model by 10% in the first year. Through appropriate supports, management of such chronic conditions as angina, asthma, COPD, diabetes, epilepsy, heart failure and hypertension will be prioritized.

5. Reduce time from decision to admit to in-patient bed by 10%. Improvement in this metric will reflect work to ensure that frail seniors, admitted to acute, are moved to the right bed as soon as possible. Baseline is 23.1 hours (18/19 result).

6. As a monitoring metric, the team has selected the percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge. This metric has no existing data available; therefore we will work towards collecting data and developing a baseline.

Other relevant health system measures such as repeat ED visits for falls, direct admission to inpatient rehab from community and referral rate for frail seniors screened and determined to be at risk will be considered. These priorities have been confirmed by a multi-stakeholder, inter-professional team that included representation from various agencies and reflected the interests of our patients, including Indigenous and francophone stakeholders. Performance will be regularly monitored and evaluated.

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

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

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

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

Max word count: 2000

The high rates of tobacco smoking in Algoma contribute to many of the chronic conditions that currently require healthcare services, in particular the previously mentioned high rates of CHF and COPD. Concurrently with supports to assist in system navigation the members will work together to improve accessibility and uptake of smoking cessation services for smokers, including those who are not yet diagnosed with cardiac or pulmonary diseases. By reducing tobacco consumption across the population there will be fewer individuals requiring healthcare services.

High rates of chronic diseases and in particular diabetes can be reduced by effective interventions to promote healthy eating and active living. Members will support population based activities identified by public health aimed at reducing the incidence of chronic diseases.

The increasing use and misuse of opioids has placed additional demands on our acute care system. Partners will work together to identify at risk individuals and promote access to harm reduction and rehabilitation services.

Two priority populations were identified and therefore will be addressed concurrently with different approaches: 1) frail seniors and 2) people with conditions better managed in the community. While care for these populations may begin as discreet models and approaches, it is recognized that their care may intersect and further alignment opportunities will evolve.

Early engagement of front line staff was undertaken as a Kaizen (improvement) event to determine development of elements of most value to patients, providers and the system. The output of this event supported the concept of integrated care and development of "one assessment, one provider, one plan". A multisector representation of health care providers considered the work of the OHT and the enablers for improvement. These providers represented agencies from acute care, home and community care, home care services providers, primary care, consultant/ specialist care, regional geriatric rehabilitative care, specialized geriatrics services such as Memory clinic, Alzheimer's Society and the Regional Geriatric Clinic.

Conditions Better Managed in the Community
This team has identified the management of specific conditions in the community through an integrated model of care as an opportunity for improvement in Year 1. This work is developed from the evidence-based model of Guided Care, expanded to an Integrated Care Nurse (ICN) model.

This approach is team-based care coordination to provide comprehensive, coordinated, continuing care. The ICN is a RN working at maximum scope of practice in partnership with Primary Care Providers, patients, health care professionals and caregivers. The ICN provides care and support through alignment of patient goals and needs with patient-centered pathway development over the care journey and disease trajectory. The ICN serves as the primary point of contact and plays a central role in ensuring patients receive high quality, coordinated care through a "quarterback" approach by: assessing the patient, creating a Coordinated Care Plan and action plan, promoting patient self-management, proactively monitoring the patient, coordinating care between multiple providers, smoothing transitions from hospital to home, educating the family and caregivers and accessing community resources.

This model is currently embedded within a core primary care provider group demonstrating ongoing success in a cohort population which could be expanded across the region to any type of family health team or nurse-practitioner led clinic, as examples. The goal is to manage complex patients in the community, within their own environment and in conjunction with a multi-disciplinary team and collaborative case management i.e. "one assessment / one provider / one plan". This will mitigate

variation and improve efficiency. High-cost resource utilization, such as hospitalization, is avoided due to proactive monitoring and early interventions, consistent with patient goals of care.

As the Integrated Care Model is implemented, an important enabler will be embedding the care coordination role of the LHIN staff into Primary Care ICN roles. This simplifies the care process for patients and we expect this will optimize the use of the health human resources much more effectively from a systems perspective. Communication will be a critical component of the care coordination process and will identify early risks and strategies to mitigate them.

In year one, our intention is to consolidate and integrate roles and responsibilities to further broaden the scope of the Integrated Care Model by combining care coordination and Guided Care functions. This will begin on a smaller scale to work through transitions, any constraints and unanticipated issues and to scale up the ICN to target population and spread thereafter. Over the course of Year One we will continue to redesign in concert with patients, caregivers and families as well as health and social service providers who consistently identify and share opportunity for improvement.

Frail Seniors
Identifying frail seniors or those at risk of frailty is not straightforward however a culminating event, such as a fall, may result in an ED visit. Along with already proven interventions for frail seniors the members will work together to identify opportunities to identify those older individuals at risk of becoming frail and look for opportunities to deliver preventative activities. Older adults who experience a fall are likely to have multiple conditions and complex health needs.

Preventing functional decline and further risk for falls requires an integrated coordinated approach to assessment and care. The team reviewed the Rehabilitative Care Alliance pathway to rehabilitative care for frail older adults presenting to ED post-fall (http://rehabcarealliance.ca/frail-seniors) and determined new work within current providers across the care continuum. Transitions of care may be exposed for consideration, particularly, to the Integrated Care Nurse team. This pathway can be applied in any/ all small and rural EDs plus the large community hospital with referral patterns to be established. The pathway leads the ED provider to determine follow-on services required including referral to Specialized Geriatric Services or Rehabilitative Services. In-year transferability to primary care will be determined. Early uptake in the EDs will ensure that patients receive the same pathway of assessment, care and access regardless of their primary care attachment status. Goals to minimize high-cost resources such as repeat ED visits and standardized access to specialty services will be considered success. Requests for community of practice models to support these priority populations arise. Partnership with existing primary care services and future implications for retirement home/ assisted living options were discussed. The need for interdisciplinary geriatric services to serve our priority patients was agreed.

Key to success for this priority population will be achieved through a simplified, comprehensive care pathway. This in turn will lead to improved patient and provider experience.

Setting the standard of work for both priority populations will enable the team to measure, monitor and advance performance objectives in the future.

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

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

3.3.1. How do you propose to coordinate care?

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

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

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether

your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.

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

Max word count: 1000

Care coordination for our priority populations have deliberate similarities: they serve complex patients in our communities; care models are deployed to ensure that patient information about their care is collected consistently and deliberately and, the patient and their caregivers are included in planning for transitions of care. Linking to reducing duplication, emphasis on service communication and visibility is highlighted for Year 1. The team is enthusiastic about utilizing all human resources to their full scope of practice.

Focusing on clinically high-risk patients or those with rising risk provides the greatest opportunity to improve health outcomes and lower costs. Services have been triggered historically by primary provider notification, high cost utilization including repeat ED visits or repeat hospitalizations. The team's performance improvement activities are specifically targeted to ensure that patients successfully mitigate hospitalization or transition from the hospital to their home and reduce readmission. Such activities as timely discharge notification, medication reconciliation and periodic follow up to ensure the patient understand discharge instructions, can recognize symptoms that might require immediate attention and that he/she attends scheduled follow up appointments can positively influence the patient's outcome (https://www.continuumhealth.net). The Integrated Care Nurse provides this care, reassurance and support while formalizing patient education and securing the interdisciplinary team, as required, to meet the patient's care needs.

Members of the current state Guided Care Nursing team and Specialized Geriatrics Service providers are all experienced care coordinators. In conjunction with specialty community providers and Home and Community Care Coordinators, the expertise exists within the OHT providers to focus and expand efficiently throughout the region.

Patients that present to the ED post-fall will have one assessment that determines their next steps for referral and service. Standardizing assessment and tools such as the Clinical Frailty Scale (https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html) ensure that all providers are reviewing the patient in the same manner and speaking a common language when creating care paths for patients. This will be achieved by consistent provider and patient education, creating care plans that are accessible to all health care providers and understanding the transparent next step so that providers know where the patient might next benefit most.

Referral and access to specialized geriatric services and rehabilitative care resources are processes and infrastructure designed to ensure the best patient outcomes including secondary fall prevention. Falls are multivariate and highly dependent on a

patient's polypharmacy, comorbidities, cognitive status and to some degree, socio-economic status such as nutrition, as examples. It is anticipated that patients that complete their referrals and consultations may be candidates for ICN care.

Attached patients with conditions better managed in the community will be prioritized for the ICN model. Primary care provider input is required to ensure no barriers exist to care for complex patient population. Frail seniors will be identified based on their ED visit and will follow a pathway that may be supported by specialized geriatric service providers at this time. By Year 2, there will be new opportunities for system development and Year 2 considerations for Algoma include unattached patients.

Our front-line teams will develop a standardized "toolbox" and each care provider will be equipped with clinical and technological tools that are culturally and linguistically appropriate to complete their work with accuracy and in a timely manner.

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

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

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

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

Max word count: 1000

Navigating the health care system requires organizations and services to standardize pathways, for example, patients receive care from similar organizations in a similar way and they receive similar interventions wherever they are. These aspects of navigation offer patients, caregivers and families reassurance and restores confidence in the health system and provider partnerships.

Organizations such as Home and Community Care, acute care and primary care have new opportunities to integrate and simplify their work to remove barriers and align to population needs. The Algoma OHT will focus on patient populations rather than historical models of care. Expanded scope of practice and a standardized "toolbox" will support the navigation for all patients, including those in remote areas. Models for in-person and digital outreach are available to ensure that all patients have access to the right service when they most need it.

The concept of “one assessment / one provider / one plan” comes alive in making our health system more effective at meeting the patients’ needs, such as:

• Establishing one point of contact for care plan development, care team and patient to eliminate duplicate work, improve inter-professional communication and improve trust and consistency

• Improving the patient experience by meeting the patient’s needs as they define them

• Simplifying the care coordination process with one assessment one plan

• Supporting providers to deliver services that are effective and reflective of best practice

• Promoting inter-professional teamwork to enable integration of care

Leveraging existing tools and the work of current integration projects such as the North East, One Client One Plan (OCOP) It will allow all care coordinators across sectors improve our patient’s journey. OCOP is focused on bringing together Home and Community Care and all 69 Community Support Services in the North East Region to act more cohesively and as one when supporting patients in navigating their care.

Some of the work mentioned above includes continuous and common education to all care providers about the services that are available to support patients in their community. Education will include how to access and use available information platforms that will be maintained with up to date and accurate information on services available based on patient needs and geography (examples: Caredove and Healthine.ca, etc.) These systems will have integration potential in order to improve efficiency and can be embedded within organizations’ health information systems for ease of access.

It will be important for patients in the care of the Algoma OHT to be directly connected to other organizations in our community. Identifying opportunities for electronic referrals and booking patients directly into intake appointments is a key factor in connected care and system navigation. This practice will decrease burden on patients and caregivers who may not have the capacity or knowledge to navigate their care.

By improving information sharing and access to patient information, care providers will be able to develop and contribute to well-informed care plans and referrals to all applicable health and social service providers. Care plans and Electronic Medical Record (EMR) systems will reflect all care being provided that address not only health, but also social determinants of health. This will reduce duplication in referrals to other providers.

Expanding current care coordination models (primary care embedment, neighbourhood

model, ICN) allows system navigation to happen with patient and caregivers where they feel most at ease. This could be in their home, in their neighbourhood or alongside their primary care provider.

Integrated Care Nurses and Care Coordinators will share patient navigation success stories and exchange knowledge in a community of practice. This will foster trusting relationships and provide an avenue for those providing care coordination in Algoma to exchange information on health and social services and best practice. Staying engaged in community, informed about best practice and having easy access to timely accurate information will be key system navigation success factors.

3.3.3. How will you improve care transitions?

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

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

Max word count: 1000

Early success from the work with Guided Care confirms that integrated care improves information flow and helps organizations work together as a team and as result break down the silos that exist in healthcare. With the ICN model and the Coordinated Care Plan we can simultaneously address multiple issues around the inefficiencies and fragmentation around transitions and move toward integrated care by:

• Bringing together providers and organizations

• Ensuring that services are coordinated and complement one another

• Sharing information between providers accurately, promptly and with a consistently high standard

• Collaborating to ensure that continuity of care is not “nice to have” but rather an obligation toward the individual who must manage chronic disease and illness

The ICN model will focus on supporting patients and health care providers through transitions between care settings by:

• Coordinating and facilitating referrals to specialists, homecare and community support services

• Reconciling medications at key transitions points

• Ensuring that the individual and their caregiver understand the care plan, therapeutic regimens, who to call for assistance and red flags to watch out for – complete engagement of the patient in his/her care.

The ICN model will also support seamless transitions as follows:

• Follow up with primary care within 48 hours of discharge from hospital

• Close liaison between the Case Reviewer role in the hospital and ICN in primary care will provide benefits for patients who have a high risk of readmission.

Transitions from hospital to home can be complicated. As they involve many health care providers across settings. Patients and caregivers report that communication is key to effective transition planning and that having enough time with their health care providers to ask questions and actively participate in the transition process. For patients with complex care needs or barriers to communication (e.g. learning disabilities; cognitive impairment, physical, sight, speech or hearing impairments; difficulties with reading, understanding or speaking English), members of the hospital and community-based interprofessional teams should be involved in transition planning and coordination. A member of the integrated care team as a single point of contact for transition planning and coordination can make the transition smoother for patients and their families and caregivers (https://www.hqontario.ca). Simplifying the journey for frail seniors ensures a transparent, logical and coordinated approach.

Another area that will improve care transitions, is when a patient moves to living in a Long Term Care (LTC) facility. "One assessment /one provider/ one plan" model would provide the LTC home the patient's full physical, psychosocial, emotional and spiritual plan which would then be shared with the resident's LTC interdisciplinary team. The team would subsequently be prepared to support the resident and their needs from admission.

The Algoma OHT will build upon and expand other programs and initiatives already taking place in the North East.

• eNotification – work to expand electronic notifications to our health service providers who provide Assisted Living and other personal support services is underway. These notifications will allow health service providers to know when services are required to resume or be placed on hold. Community health service providers to be informed when their patients:

- o present to the Emergency department
- o are admitted or discharged from an inpatient unit

• The PATH (Priority Assistance to Transition Home) program located within hospitals will be optimized as they provide a vital service that includes unique, patient centred solutions to overcome discharge barriers and assist patients with safe transitions back

to their home when they are ready to be discharged from hospital.

• Health Literacy – the Algoma OHT recognizes the importance of reviewing and continuing to implement health literacy strategies and provide health literacy education across the sector. When patients and caregivers are able to easily understand and verbalize care plan and discharge instructions this promotes safe and effective transitions from hospital to home and between points of care.

• Care Coordinators embedded within hospitals participate in discharge planning with hospital care teams, patients and families, make referrals and develop plans of care to support patient's needs in the community.

• Neighbourhood Model – Care Coordinators embedded in buildings and neighbourhoods are available to follow up with patients when they return home to ensure patient's discharge plan is met and that community services have been resumed or initiated.

Adopting the use of common interRAI assessment tools across the Home and Community Care sector in also underway as part of the One Client, One Plan project. When providers are using common assessments and sharing these assessments with applicable providers, this allows for timely intake to service provided by various organizations.

3.4. How will your team provide virtual care?

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

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

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

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

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

Max word count: 500

Patient self-management and health literacy are identified as key components of the work for our priority populations. These components will follow a standardized approach from the Integrated Care model whereby using the Coordinated Care Plan and other resources, the ICN with the patient will create a holistic, individualized plan for managing, monitoring and aligning with the patient's unique health care needs. The patient and his/her care goals are the primary focus, with the right care wrapped around them facilitated by the ICN in partnership and collaboration with the Primary Care Provider. The Action Plan is completed for conditions indicating "red flags" specific to the patient that should prompt the patient and / or caregivers to take Action as indicated on the plan. The ICN will use utilize principles of motivational interviewing to identify obstacles and develop strategies to empower patients to adapt to healthy behaviours and participate actively in their care. The ICN promotes health literacy and self-management by encouraging the patient to take ownership for his/her goals in the Coordinated Care Plan which is tantamount to good health care. Through proactive monitoring the ICN will evaluate adherence to the action plan to detect and address emerging problems and implement early intervention where appropriate. Shift from a system of dependency to one of empowerment and enable patient education of illness(s) and supports with simple instructions, clear language and easy to understand materials.

Our senior population will have a multifactorial evaluation including risk assessment for secondary falls, determination of level of frailty and conducting a fracture risk assessment. All domains are assess together to inform a comprehensive plan of care and complete the most appropriate referrals. There is an alignment to community assessment and intervention in Primary Care and to the Integrated Care Nurse, if appropriate.

3.5.2. How will you support caregivers?

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

Max word count: 500

In particular, patients transitioning from supportive or in-patient services require transition planning and written transition plans (https://www.hqontario.ca). The capacity of family members and caregivers to meet the patient's needs will be considered and additional resources or respite needs evaluated on a regular basis. Recent research indicates that 1 out of 4 Canadians aged 15-19 looks after loved ones.

We will ensure that the involvement of patients, family members and caregivers is culturally appropriate. Three process indicators will be considered in Year 1 and confirmed with our Patient and Family Advisors:

• Percentage of seniors in the care pathway, that report feeling that their family and caregivers were involved in decisions about their transition planning as much as they wanted to be (as measured by hospital Specialized Geriatric Services (SGS))

• Percentage of people discharged from Rehabilitative services to home for whom a caregiver report feeling prepared for the role of caregiving

• Percentage of people discharged from Rehabilitative Services to home who report feeling that they were involved in decision about their transition planning.

Caregivers will be assessed on an ongoing basis to see how they are managing. Caregivers often balance their caregiving with other responsibilities, such as their careers, family obligations and their own health needs. Supports such as training, support groups, home care and temporary respite care exist in Algoma for persons with dementia and should be augmented with respite care to ensure "breaks" from the caregiving routines.

The Integrated Care Nurse will work with families, caregivers and patients and by virtue of that proximity to the caregiver they are well positioned to identify and mitigate the risk of caregiver burnout.

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

Providing and expanding patients' digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity.

Please refer to *Appendix B – Digital Health* to provide your proposed plan for providing patients with digital access to their health information.

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

The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers,

implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.

Describe the mechanisms, processes, and/or tools that your team proposes to use to **collectively** identify, track, and follow up with Year 1 patients.

Max word count: 500

Patients will be identified by providers in Primary Care, hospital or Care Coordinators based on conditions better managed in the community, patient supports, care required and utilization patterns. Those working in the community may often have enough information based on their assessments to identify patients that fit this population. A Coordinated Care Plan (CCP) with the Action Plan will be created in conjunction with the patient, caregiver, provider and broader health and social service team to help individuals address all aspects of the care they are receiving. The ICN with the CCP will serve as a point of care coordination that enables shared planning, decision making and commitment to the patient by all care team members. The CCP is housed within both the primary care and hospital EMR systems and referenced upon admission to ED and / or a Unit with automatic notification to the ICN upon patient discharge for follow up care within 48 hours. In addition, patients would have secure online digital access to their CCP as well other medical records and health information via myCARE portal.

Establishing one point of contact for patient, caregiver, provider and health care team minimizes the duplication of work, improves inter-professional communication and improves trust and consistency through an ICN who serves as the “navigator”. Proactive monitoring sustains relationships while maintaining links and communication with the health and social service providers.

Identifying frail seniors can be a complex process. Evidence indicates that the older adult (65 years of age and older) attend the Emergency Department (ED) with higher frequency and subsequently have a higher propensity for admission. Preventing functional decline and further falls among high risk older adults requires an integrated, coordinated approach to care. Utilizing the expertise and skillset of Geriatric Emergency Medicine (GEM) RNs to educate ED nursing staff to employ the frailty secondary modifier, during the triage process, expedites frail seniors to the GEM nurse. This identification when the patient first enters the ED will improve the coordination of care and assist with admission avoidance. The GEM nurse can ensure the patient is linked into appropriate services and provide a warm hand-off to the next provider in the patient’s journey.

The GEM RN will ensure that staff education for frailty is consistent, patient care planning and pathway referrals are completed, patients have a point of contact waiting for SGS and that patient information is handed off in a comprehensive format.

3.7. How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve

care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

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

3.7.1. How will you work with Indigenous populations?

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

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

Max word count: 500

Published in 2016, the North East LHIN Aboriginal Health Care Reconciliation Action Plan supported the vision for indigenous health care and a commitment to work towards improving the health and care in the Indigenous communities.

The Algoma OHT is in early stages of collaboration and engagement with our First Nations communities in the area. We have overlap of patient populations as members of Indigenous communities utilize many of the services offered by our OHT partners. As well we have identified the need to plan to provide culturally appropriate care and support to communities and ensure smoother transitions in their return to their home communities and health services offered on reserve. Over 12.9 % of our Algoma sub region population self-identify as Indigenous, living off reserve in Sault Ste. Marie or on reserve in one of the surrounding communities.

Although the Algoma OHT does not yet have a plan in place, we have discussed with our Indigenous partners the need to co-create the plans. Algoma OHT has reached out to all surrounding communities and are in active discussion on their interest to be part of our OHT as a signatory member, or as advisors/collaborators to the OHT and all aspects of its evolution. We also have had Indigenous representation participating directly in the work of the digital health planning of the OHT. The Leadership of each community is assessing their preferred approach that works best for them and will be advising the OHT on next steps. In addition, we have received a letter of support from Maamwesying, who delivers a majority of provincially funded health services through partnership between seven (7) First Nations and the Indian Friendship Centre in Sault

Ste. Marie. Maamwesying is a key partner and submitted a recent OHT proposal that is “In Discovery”.
Through this process, and working with First Nation communities in the area, there is a commitment to work together to begin to address service planning, design, delivery, and evaluation. Early indications are that there is congruency around focusing on the identified populations of Year 1, namely the needs of clients accessing services at the Emergency Department, frail and elderly. Some of our OHT members are currently working together with the Indigenous community leaders on a plan to have a team in place that addresses culturally safe care, which can be adopted and spread within our OHT.
We have also had preliminary discussions around sharing data, self -identification, enabling technologies and holistic population based planning to better serve the Indigenous population in both the short and longer term.

3.7.2. How will you work with Francophone populations?

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

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

Max word count: 500
The Réseau du mieux-être francophone du Nord de l’Ontario (French Language Services Planning Entity) has been involved with the OHT since the very beginning and will continue to be a resource to our team in the planning, implementation and ongoing activities regarding services for Francophones.

The Algoma OHT is committed to complying with the French Language Services (FLS) Act by ensuring provision of service in French to our catchment area. The needs of the Francophone populations, as outlined in section 1 of this application, will be met by ensuring the following:

• Prioritize FLS services where gaps are identified.

• Implement and/ or improve the active offer of FLS-meaning services that are clearly communicated, visible, available at all times, easily accessible and equivalent to the quality of services offered in English.

• Develop and work toward an OHT FLS Human Resources recruitment strategy.

• Address issues specific to Francophone patients in service planning, design, delivery and evaluation by working in collaboration with the FLS Planning Entity.

• Develop policies, bylaws and requirements related to FLS with the FLS Planning Entity.

• Ensure information intended for patients and the general public is actively offered in French.

• Ensure Francophone patients receive information on services available in French.

• If services needed are not offered in French by certain OHT members, the OHT will offer virtual care solutions, interpretation services or ensure provision of French services by another health service provider offering FLS.

Improvement of the provision of FLS will be measured through the data collected in the FLS annual reports (OZi) and monitored by the OHT to ensure ongoing progress. Data collected will also be used to assist the OHT in the planning of the FLS.

Members of the Algoma OHT will engage the Francophone population by the following means:

• Evaluation of the quality and access of FLS through client and patient surveys.

• Inclusion of Francophones on committees.

• Collaboration with the Francophone community to seek input on how to offer services and programs that meet the needs and reflect their values, cultures and experience.

• Collaborate with the FLS Planning Entity on engagement and planning activities.

OHT members will have the opportunity to complete the online training on active Offer from FLS (www.activeoffertraining.ca/www.formationofffreactice.ca) to demonstrate their understanding and commitment to the Francophone population and to attest their willingness to enhance their working relationship with the Francophone community.

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

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

to expand or modify these activities in Year 1 or longer-term.

Max word count: 500

Historically, Sault Ste. Marie has been successful in meeting the needs of marginalized and vulnerable patient populations. Two programs within the city are worthy of particular mention here as their work will be monitored for sustainability and spread as the OHT work advances and are described:

1. Serving the area from Dennis to Huron streets, the Neighborhood Resource Centre (NRC) was established as a project of the Sault Ste. Marie Police Service's (SSMPS) community mobilization model of policing, a strategy that relied on community engagement as a means of deterring and preventing crime. The NRC provides the opportunity for community members residing in this downtown area to access social service agencies who deliver programming, referrals and resources within the center. Removing significant barriers to access services increases the opportunity for social development to occur within this community.

In analyzing the 2013 monthly statistics, the Sault Ste. Marie Police Service (SSMPS) determined that 30% of all calls for police service originated within 1000 meters from the intersection of Albert and Gore Streets, an area which comprises less than 10% of the city's population. With further analysis, over 75% of these calls were primarily "social disorder" types of calls which required a different approach to resolution. Serving the area from Dennis to Huron streets, the Neighbourhood Resource Centre (NRC) was established as a collaborative project of the SSMPS and several core partner health and social service agencies, with support from the city and neighbourhood businesses. The NRC has welcomed community members outside of its catchment area as well with access to resources and services.

2. The Superior Family Health Team established a walk-in primary care clinic in 2014 at the NRC to provide care to unattached patients or those who have difficulty accessing care. As of March 31, 2019 care has been provided to 1392 patients (2727 visits), most of which have no primary care provider or health card. Mental health and addictions continue to be the #1 reason for patients seeking care. The collaboration between social and health organizations to meet the health and social needs of this segment of the population at the NRC has been provincially recognized as a model that improves outcomes.

The new immigrant population, particularly young adult students, has presented new challenges for primary care particularly. These new residents often present to family medicine with very complex medical issues coupled with translation/ communication challenges. It is imperative that advances in culturally sensitive care are made to accommodate this new and growing population in Algoma.

We recognize the need to improve access to services and to promote the health of (LGBTQ) communities. The needs of lesbian, gay, bisexual, trans, and queer people are often overlooked in our health care systems, and there are gaps and inequities in services and in the health status of LGBTQ people. We will be looking to access the

expertise of programs such as Rainbow Health Ontario to support our work to improve services, increase knowledge, and ensure collaboration with our LGBTQ community.

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

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

Max word count: 1000

Following the submission of the Readiness Self-Assessment, the existing partners felt it was important to ensure that the patient perspective guided and grounded this work. A Patient Advisor was added to the Leadership Council and later became one of the Council's Tri-Chairs. Early in the planning process for the submission of a full application, the Algoma Ontario Health Team (OHT) recognized the need to involve patients, families, and caregivers in their care redesign planning. This realization resulted in the creation of a Patient and Family Advisory (PFA) group to establish the framework for the involvement of patients, families, and caregivers in our care redesign.

It is essential to the Algoma OHT that mutually beneficial partnerships among health care providers, patients, families, and caregivers are taken to ensure that our care redesign is grounded in a patient and family-centred care approach to the planning, delivery, and evaluation of health care in our community. The patient, family, and caregiver centred approach to health care will shape the policies, programs, facility design, and patient interactions leading to better health outcomes and wiser allocation of resources, and greater patient and family satisfaction for our community.

The Ontario Patient Declaration of Values for Ontario (https://www.ontario.ca/page/patient-delaration-values-ontario) asks that OHTs recognize the importance of patients, families and caregivers as partners across the entirety of the health care system. The Algoma OHT commits to the patient as a key partner and therefore observes the following values:

Respect and Dignity
The Algoma OHT expects patients, families and caregivers will be treated with respect and seen as valuable contributors to the care team recognizing their right to make choices in our care.

Empathy and Compassion
The Algoma OHT expects our health care providers will act with empathy, kindness

and compassion while working with patients to develop their individualized care plans that acknowledge their unique physical, mental and emotional needs.

Accountability
The Algoma OHT expects a health care culture that values the experiences of patient, families and caregivers and incorporates their knowledge into policy, planning and decision making.

Transparency
The Algoma OHT expects that patients will be proactively and meaningfully involved in conversations, considerations, and decisions about their care.
The Algoma OHT will ensure that patients records are accurate, complete, available and accessible across the health system at their request.

Equity and Engagement
The Algoma OHT expects that patients will have opportunities to be included in the health care policy development and program design, ensuring equal and fair access to the health care system and services for all.

To date, an inter-organization Patient and Family Advisory (PFA) group of seventeen self-identified individuals has been formed and is actively involved in all aspects of OHT development - spanning care redesign, decision-making, and governance. The Algoma OHT is co-designing our transformation of care with patients, families, and caregivers to ensure they are an integral structure with our planning, that will be operationalized as we develop our activities and governance structure in Year 1 and through maturity.

The Algoma OHT will establish a framework to leverage the initial consultative work of the Algoma OHT PFAs, and the embedded patient and family advisory mechanisms that exist within the partner organizations as we develop our year-one approaches. At present, the following activities are planned to ensure the involvement of patient, families, and caregivers.

Establishment of an Advisory Council
• The Algoma OHT will establish an Advisory Council that is developed through a robust call out to Algoma OHT catchment area to ensure wide-ranging, diverse community representation

• Advisors will be embedded in all aspects of the Algoma OHT work from governance through care redesign and will show commitment to improving care for all patients, families, and caregivers by ensuring that the patients and their families are the focal point of all discussions.

• The Algoma OHT will ensure patients, families, and caregivers can contribute ideas and suggestions that will enhance patient and public involvement in health service planning and decision-making so that the patient and their families have a voice in the

delivery of health care services.

Development of an Algoma Ontario Health Team Declaration of Values
• Once the Algoma OHT establishes an Advisory Council they will be asked to review the Patient Declaration of Values for Ontario along with other key patient and family centred care concepts to develop an Algoma OHT - Patient Declaration of Values; which will be shared with the broader community for public consultation.

• It will provide an opportunity for public engagement, clarify what our community can expect from the Algoma OHT, and highlight the importance of a patient-centred approach to health care.

Community Engagement Sessions
• The Algoma OHT held its first Community Health and Social Service Provider Engagement Session as part of its consultative work to complete the full application.

• The Leadership Council of the Algoma OHT has committed to continuing these engagement sessions regularly to ensure stakeholders are informed.
Partner Board of Directors

• The Board of Directors of many of the Algoma OHT members are representative of the patient, family and caregiver populations that will be served by the Algoma OHT; these board members will act as an additional resource to drawn insight, especially for partner organizations without an established PFAC.

To ensure these activities have been successful and are engaging patients, families, and caregivers appropriately in care redesign efforts, the Algoma OHT will establish a mechanism for regularly receiving feedback from our stakeholders.

The Centre of Excellence on Partnership with Patients and the Public (CEPPP) provides a Patient and Public Engagement Evaluation Toolkit (https://ceppp.ca/en/our-projects/evaluation-toolkit/) that has been designed for the health sector and provides a wide range of tools to assist in the evaluation of patient and public engagement initiatives. The Algoma OHT will use the tools available through CEPPP, along with other established partner evaluation practices, and the Patient & Provider Experience Metric (Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient-Reported Outcome Measures - under development) once it has been developed to ensure patient, families and caregiver involvement and engagement in the work of the Algoma OHT.

4. How will your team work together?

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

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

Max word count: 500

Our team is truly committed to delivering a care model that puts our patient first and ensures they receive the best care possible when and where they need it. Our team did a cross-walk of our strategic plans, vision, mission and values and found alignment that grounds us on the patient throughout the development and evolution of our OHT. Values and practices that are culturally sensitive are evident in all organizations include respect, compassion, accountability and the need for collaboration for our patients and each other as providers of care. Our team is committed to delivering integrated, coordinated care centered around our patients and in pursuit of the Quadruple Aim. Our team will evolve over time and will work together with our patients to a vision that focuses on defining what the 'care' in healthcare really means and feels like.

Our OHT is confident that we can achieve the targets we have set for Year 1, including the OHT candidate expectations of 24/7 patient care and no cold hand-offs.

Upon reviewing separate team missions and values a common theme emerged. These include excellence, respect, accountability and collaboration. There is a common theme of togetherness present in the visions and missions to provide patient centered care. Most of our organizations have worked together in the past to improve care pathways and ensure our patients get the care they need. Some examples include: Patient Centred Flow Redesign, COPD Care Pathways, Senior Friendly Work and Health Link to mention a few. The draft Vision and Mission statements are as follow:

Vision: An integrated health system focused on the unique needs of Algoma residents, where patients receive seamless, effective care where and when they need it.

Mission: The Algoma OHT will collaborate in a model of care that is patient-centred, efficient and simplified for both patients and providers.

As a team, we will continue to collaborate and create a shared brand and vision. Our

communications sub-team is working together to draft the Algoma Health Team (AHT) with the brand “Connected Care. Your Care Journey Simplified.”

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

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

Please describe below the governance and operational leadership structures for your team in Year 1 and, if known, longer-term. In your response, please consider the following:

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

Max word count: 1500

The Algoma Ontario Health Team (OHT) is committed, at maturity, to provide a comprehensive and collaborative team approach to ensure that the patient experience is a seamless transition across different care providers and settings, encourages involvement and participation of primary care providers throughout a person’s care journey, provides a holistic approach to health care including physical and mental health

needs, enables healthy lifestyles and patient education. The system will be designed to avoid service redundancy, repetition of health history and will provide accessible, appropriate, affordable, and efficient service to the attributed population.

The Algoma OHT has put in place an interim Leadership Council (LC) until a comprehensive governing body is struck. This team has representation from each member organization. The current decision making structure is consensus-based, to ensure all voices are heard. The LC includes leaders from the hospital, primary care, longer term care, home and community care and mental health representatives. This council meets weekly.

Physician involvement has begun such as through a meeting with the Medical Staff Association at Sault Area Hospital and the Board of the Algoma District Medical Group. Development of a Physician / Nurse Practitioner Advisory Committee (Providers) is underway, as well as a strong cadre of Patient Advisors. The broader health and services sector, as well as Francophone and Indigenous communities, are also being actively engaged. Algoma's vast geography, and the separate OHT submissions by East and North Algoma and Maamwesying OHTs allow for the partners to work together, including inviting the leads of these teams to the Leadership table.

As outlined in various Ministry communications, there will be no cold hand offs during the first year. As the Leadership Council develops over time, a Terms of Reference (TOR), bylaws, and new-participant orientation materials will be developed and evolve to support participation growth as the model matures. Legal implications will begin to be addressed during ongoing engagement sessions with existing Board members.

In late September, approximately 80 Board members from the signatory organizations met, and the majority agreed that a collaborative governance would be best suited for the initiation of the Algoma OHT. Current Boards, in Year 1, will be working at developing a collaborative governance model. The Boards will be kept involved and informed.

The creation of a Year 1 governance committee is underway, including the development of a Terms of Reference to guide it in supporting the first year deliverables of the OHT, and in discussions relating to longer-term collaborative governing structures. The collaborative model, for Year 1 and subsequent early years of the OHT, will be one whereby each organization will maintain its' own governance structure and participate in an overall governance body. This team-level governance body could evolve to a structure able to oversee local system performance, ensure appropriate funding is in place, and ensure quality of health care.

The OHT, when designated, will enter into an agreement with the Ministry to report on performance and service delivery. These performance measures will, at a minimum, mirror current performance obligations and quality expectations presently outlined in existing agreements.

The project will follow current methodology for program development including planning, execution, monitoring and controls and closure. For example, roles and responsibilities will be determined during the planning stage. After the first year, the OHT will explore how best to manage team-level funding. By maturity, various mechanisms will be developed and implemented including accountability and the identification of performance measures. To the extent possible, surplus funds will be kept in the area for reinvestment into front-line care in the local health system. The mature OHT governing body will determine where the funds would be best utilized.

A collaborative governance model is seen as the best way to start the journey toward an integrated health system. As teams develop familiarity and the sharing of common goals, we will further build trust.

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

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

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

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

Max word count: 1500

Going forward, the Algoma OHT will improve communication between our technologies and will enhance the sharing of information that supports our patients' needs. OHT organizations will consult with partners and make best efforts to ensure technology investment decisions support integration, collaboration, and sharing of information. Our OHT will share tools and resources to determine what would work best across our system.

As a mature OHT, we will build upon and support initiatives to improve care by having access to patient information that will drive integrated care plans centered on our patients. We will ensure that language and culture are respected in the information sharing practices.

Through various technical interfaces organizations will be able to access patient information to better serve patients. Where required, the Algoma OHT will share information by asking for patient consent and sign off. This will ensure that the patient fully understands their role in their care.

We will ensure there is consistent understanding of legal authority to collect, use and disclose personal health information across all organizations. To support this we will establish a collaborative privacy council that will help to inform and guide decision making in regard to sharing information and ensuring appropriate safe guards are in place. We will need to find innovative ways to work within existing privacy legislation and advocating for provincial supports in this area.

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

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

5. How will your team learn & improve?

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

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

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

Max word count: 500

A survey of our OHT partners revealed a strong understanding of the value of accountability to our individual agencies, larger partner groups and other stakeholders. Agencies are implementing quality improvement initiatives, and many of the OHT partners are currently accredited. Action plans are in place to address any identified improvement opportunities. Other agencies are keenly interested in attaining such recognition and there is openness to both sharing and learning from each other. Most OHT partners have annual financial audits conducted by independent auditors. Any issues identified are brought to the attention of the board and a mitigation plan is put in place.

The OHT Senior Leadership will ensure that there is a structure in place to ensure transparency and accountability between all members with regard to governance, financial management and compliance to performance or legislative regulations. Early and continued support through collaborative arrangements and organizational alignment with the OHT vision has set the foundation for the development of a broad skills- based quality improvement model.

By capitalizing on our community's history of strong partnerships and remaining committed to patient-centered care, our OHT members will see improved care and outcomes for our patients. This may look like enhanced processes for patients that may reduce wait times, improved/more streamlined communications for our patients resulting in fewer misunderstandings and less duplicated work for the front-line staff. Any savings will be reinvested locally to support the needs of our identified community and to evolve through quality improvement (QI) models/tools as required.

Our OHT is committed to collecting, sharing and reporting data through shared quality initiatives that integrate care and improve performance within the OHT. We will strive to understand our area’s unique needs through engagement strategies which will support the development of a clear accountability structure upholding the principles of patient-centered care. There is a need for broader consultation and engagement

sessions with partners within our OHT and other OHTs that provide care to the attributed population. It is imperative that we work together to ensure our patients needs are the fundamental driver of decision making within our OHT and between OHTs. There will be multiple reviews of the population, models, tools and results to ensure rapid transformation in year 1 and solid planning and learning to better define our path to maturity (multiple PDCA cycles).

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

Ontario Health Teams are expected to pursue shared quality improvement initiatives that help to improve integrated patient care and system performance.

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

Describe what experience each of the members of your team have had with quality and performance improvement, including participating in improvement activities or collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).

Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.

Describe your members' approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.

Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all member organizations/providers.

Max word count: 1000

There is significant talent within the OHT with respect to quality and performance improvement. We conducted a survey with all organizations within our OHT and used the responses to collect our information and data quickly. All organizations had experience with quality performance improvement. Some examples include: Quality Improvement Plans (QIPs), Patient Experience Surveys, annual review of clinical data, MoreOB - a program meant to keep all maternity team members engaged in

best practice.

A few examples of successful quality improvements related to integrated care include:
• Health Link (which includes connected linkages between primary care, mental health, palliative, acute care and community support services)

• Code Stroke

• Restorative Care at Sault Area Hospital

• Patient Centered Flow Redesign which involved working with home care services, palliative care, long term care and other hospitals.

• Senior Friendly Care which includes working and sharing resources with our NE LHIN and Health Sciences North.

Our OHT has significant experience in continuous improvement training including various levels (Yellow- Black) Lean process improvement and a Blackbelt Six Sigma practitioner that has assisted with certification of others in the community. The majority of leadership on our team has attended training and committed to a transformational leadership approach. In the past, Sault Area Hospital has hosted Leader Development Sessions which it has opened to other partners in the area. SAH Lean practitioners have facilitated internal and external employee events to share the concepts of Lean to front-line service providers throughout our area. This has led to aligned leadership style and coaching around quality and process improvement and a true people leadership focus around leading change for successes. In addition, our team has certified change management facilitators including the Prosci methodology and ExperiencePoint model. We have experienced project managers within our team to help us plan, execute, sustain and evolve our model. We plan to maximize our resources by sharing capacity throughout our partnership team. All organizations within our OHT have plans to enhance data/analytical capacity recognizing that having data driven decisions coupled with the passion for improved patient care and outcomes are key to a successful OHT and to support the Quadruple Aim principles.

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

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

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

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

operational aspects of your care, with examples.

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

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

Max word count: 500

Our OHT partners have had great success working with patients, families and caregivers in providing input and feedback to influence organizational strategies, policies and operational aspects of care. Some examples include:

• Patient Advisory Council in development and Patient representation seat on Board of Directors to ensure patient centered focus is always maintained throughout the strategic plan of the Algoma NPLC

• Sault Area Hospital Patient and Family Advisory Council has continued to be embedded in all areas of the organization including program development, recruitment, employee and leadership training, process improvement, project management and most recently sitting on our Senior Leadership Team

• Public Engagement Committee provides feedback for ARCH services and also social change in perspectives on death and dying

• ARCH uses experience-based design approaches to integrate feedback from clients, caregivers and family into process design

• Patient surveys are completed, annually and results reviewed to create an action plan to improve services in almost all OHT partner organizations

• Algoma Family Services is involved in youth and family engagement

The Patient and Family Advisors are supporting our OHT by working as part of improvement teams and sharing their firsthand experiences with providers to empower redesign of care pathways. We currently have 17 patient advisors on our OHT including one advisor sitting as a chair of our Leadership Council.

Annual Quality Improvement Plans (QIP) are a requirement of a number of our OHT partner organizations with alignment in common indicators which encourages evidence- informed care and best practice principles for patients at all points in the system.

The Quadruple Aim Framework highlights the importance of ensuring patient

experience is the top priority. Patient experience is a key performance indicator monitored by the majority of our OHT partners. Patient survey results are used to develop and implement action plans, develop annual goals and strategies to improve a patient's care journey. This is also reflected in a number of current organizational strategic plans.

Patient access is key ingredient to delivering an integrated continuum of care that is patient focused and in pursuit of the Quadruple Aim. As discussed in our Self-Assessment, the Neighbourhood Resource Centre is an excellent example of our OHT partners coming together to provide a truly patient centered approach in delivering accessible social and health services with front line care workers on site to improve access, care coordination, transitions and system navigation.

Another example of our local providers coming together to advance integrated care and provide better patient experience and outcomes is the Health Link where Home and Community Care seconded an employee to the Group Health Centre to take on the role of a Guided Care Nurse.

Our OHT is committed to continuing to work jointly to improve quality, engage in continuous learning and provide more integrated care to the patients we all serve.

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

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

Max word count: 500

Our OHT is focused on meeting the needs of our population and working together to address issues as they arise. This means ensuring everyone has a voice at the table and are able to influence decisions made within our organizations. We have seen an increase in individuals requiring mental health and addictions services over the last several years. Broader engagement has led to many initiatives to ensure patients and clients have access to the right services in a timely manner. Some of the initiatives resulting from consultation, engagement and strategic choices include:

• Neighbourhood Resource Centre to deliver accessible social and health services

• Mobile Crisis Response teams to provide a community co-operative response for individuals with a serious mental illness or who are in crisis

• Walk in Counselling-A Session at a time where five partners provide staffing to support this walk in service one day per week. This was developed out of a recognized need for quick access to counselling services and long wait list for traditional mental health and addictions counselling. This service is open to anyone for any issue.

• Rapid Access Addictions Medicine Clinic designed to meet the rising rates of opioid use disorder, accidental overdoses, hospitalizations, and hospital emergency room visits

• The Sault Ste. Marie and Area Drug Strategy Committee's "Call to Action" to develop a plan with 20+ community partners to address the substance use challenges within our community

• Community Treatment Orders Program which is a comprehensive plan of community based treatment, care and supervision for clients who suffer from a serious mental disorder

• East Street Residence complex for those struggling with mental health and addictions issues

Each of our organizations uses input and engagement to drive strategic planning, vision, mission and values, policies and operational planning. Other examples of how we have used local input to drive changes in practice include:
• Chronic Pain Program due to increased numbers of chronic disease/chronic pain patients in the community

• ARCH actively engages partners in co-designing care and services

• The North Channel Nurse Practitioner Led Clinic works with the municipality of MacDonald, Meredith and Aberdeen Additional to operate a satellite location in Echo Bay and conduct health events, programs and services

• Continued evolution of Patient and Family Advisory Councils and focus groups within the area

• SSM Innovation Centre works with many community agencies, including partners, to provide data analytics and information to support initiatives designed to improve services and population health

• Partnerships with both Sault College and Algoma University to enhance learning opportunities

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

Please describe whether your team has any experience in managing cross-provider

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

Max word count: 500

The partners completing this application are committed to delivering an integrated continuum of care that is patient focused and in pursuit of the Quadruple Aim. We have a demonstrated history of successful collaboration where local providers have come together to advance integrated care and provide quality patient experience and outcomes.

Some recent examples of cross-provider funding include:

• Sault Ste. Marie Integrated Care Nursing (based on former Health Link) where Home and Community Care seconds an employee to the GHC to take on the role of an ICN

• Memory Clinic co-located with the Superior Family Health Team and is staffed in collaboration with the team from the Alzheimer Society

• Mobile Crisis Team – a mobile mental health response team staffed with a city police officer and a Social Worker from Sault Area Hospital.

• Walk-In Single Session Counselling Service resourced by 5 community organizations that deliver mental health and addictions services.

• Neighbourhood Resource Centre – supported by primary care as well as multiple social service and healthcare organizations working together to reach some of our community's most vulnerable residents in their own neighbourhood.

• There have also been several examples across the Algoma district demonstrating the ability of partners to work with pooled resources to provide coordinated services.

• The Triple P Parenting program is a community-wide population health approach to providing support and education to parents of children up to the age of 16 years involving 18 agencies. Evidence-informed parenting programs are delivered with a combination of "pooled" funding as well as collaborative participation to deliver service. Pooled funds are used to support the purchase of materials, training and supports for parents to assist with program attendance. Collaborating organizations provide program space, and staff facilitators.

• An area-wide drug strategy was launched in May 2019, with support from 14 agencies including social services, health, mental health and addictions and community police and fire services. Partners have committed to work together on a population health strategy which will address prevention, harm reduction, enforcement, treatment and recovery.

OHT partner agencies have diverse experiences with cross funding models, change management, or alternate governance structures. We will share experiences among the partners to enhance the capacity of all. Specific, complex and sensitive subjects will be dealt with openly to build trusting relationships. Our OHT will invite experts as required to help our team execute our model.

Proudly, our OHT membership is growing as the existing partners reach out to other agencies or as we are educating others about the value of OHT partnership.

Our OHT will ensure resource capacity and expertise around funding models and our committed to sharing expertise and decision making as we move forward.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

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

Max word count: 1500

The ICN model implementation plan is grounded in transitions and culture change. There is signaled work from Home and Community Care to embed care coordinators in Primary Care and adhering to this implementation plan will ensure that work is completed in a standardized fashion that is successful and sustainable. Care coordinators are found across Algoma: in Home and Community Care, at the Group Health Centre, Superior FHT, ARCH connect, Algoma NPLC, Indian Friendship Centre and in the hospital, placed as discharge coordinators. In developing the ICN role and growing case load, the following plan may be considered:

30 days
• Resource realignment
• Orientation
• Education – 40 hours to GCN designation

60 days
• Transition current caseload and add new patients.
• Change management/ culture change work and education.
• Assess change for patients.

90 days
• Accept new patients.
• Work to expanded scope.

6 months
• Full scope of practice for the ICN.
• Full caseload.

Similarly, education and understanding of clinical frailty and geriatric syndromes will be integral to the work for Frail Seniors. We have access to regional resources e.g. Regional Geriatric Rehab Lead, Senior Friendly Quality Lead and Geriatric Knowledge Translator from the North East Specialized Geriatric Services team. They will play key roles in supporting ED teams to develop this expertise to ensure smooth transitions for seniors with falls. We are linking in Algoma to our Specialized Geriatric Teams, Rehabilitative Care and Convalescent Care Programming by our existing shared patient populations. These relationships, in the patient's interest, will support the new work ahead:

30 days
• Education and orientation

• Develop local geriatric “champions”
• Confirm relevant baseline performance data

60 days
• First patients are assessed and referrals made
• Chart audit and patient feedback obtained.
• PDSA.

90 days
• Referrals monitored for timeliness and access.
• Rehabilitative beds access monitored for access and clinical effectiveness.
• PDSA.

6 months
• Monitoring and follow up in Primary Care with links to ICN established.
• Consideration for small hospital EDs rollout.

During Year 1, we commit to activities to secure broader community engagement, including, provider consultation building on our relationships to complete this submission and further to our session with all Boards and a range of broader community partners. We will develop our Patient and Family Advisory Council and embed their voice and consultation in building the system in Algoma. We will evaluate our progress with patients, caregivers and providers to inform new practices and future planning. We will build on evidence informed care best practices, new knowledge and engagement opportunities with local and regional partners. As the Algoma OHT develops, a multi-year strategy must emerge to ensure that our population and practice assumptions are proven.

6.2. What is your change management plan?

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

Max word count: 1000

Developing an Ontario Health Team offers an opportunity for our regional health care partners to create an improved, people-centric health care model that transforms the way we care for our community. This work will:

• Demonstrate that health care partners can do change well and shift perceptions of bystanders/resisters

• Reinforce to our communities, patients and families that we are committed to provide the best possible people-centric care

• Demonstrate our ability to establish a new model of health care to serve our population

• Increase efficiencies and improve outcomes with a better approach to health care

APPLYING A CHANGE FRAMEWORK
Using a structured change management approach is best practice. A defined approach provides the structure necessary to stay on track, ensures time is spent on meaningful activities and allows the team space to identify and address gaps.

The ExperienceChange (EC) Model
We intend to use the Experience Change (EC) model as our change management framework. Sault Area Hospital has transformation specialists that can assist with training around the ExperienceChange model. This model has two phases ("Align Key Stakeholders" and "Engage the Organization") and seven distinct stages.

Key principles of the ExperienceChange Model include:
• Change is a process, not an event
• Change occurs at an individual and organizational level
• Stakeholder involvement is necessary, but not sufficient
• Urgency good, anxiety bad
• Communication is critical
• Walk the talk
• Make change stick

The 7 stages of the EC Change Model

"Align Key Stakeholders"
1. Understand the need for health care change ("why?").

2. Enlist the support of a core team of health care partners. This needs to include primary care providers and leverage clinician leaders to help their peers to embrace change.

3. Envisage the opportunities and implications of the OHT model to partners.

"Engage the Partner Organizations"
4. Motivate people and partners by connecting at an emotional level around the "why".

5. Communicate the vision and mobilize the stakeholders around "how" to roll out plan.

6. Act by aligning the partner organizations (people, processes, structures).

7. Consolidate by reinforcing which things which are working and not.

CHANGE CAPACITY

Navigating change requires partners to have time and energy to take action on change activities and adjust their future states. We recognize that partner organizations will need to be innovative to create capacity.

STAGE 1: UNDERSTAND the need for a change. This is the rational 'why'.

Partner organizations and workers need to understand how this change helps to serve and provide care to our population. Each organization will enable their teams to understand by:

• Providing quality information about proposed changes, addressing challenges, opportunities and benefits, and our readiness.

• Reviewing critical roles and analyzing how this change might unsettle key people.

• Reviewing what future roles might look like, policy and practice changes, training might be required and contingency plans needed to address increased demand on resources.

STAGE 2: ENLIST the support of a core team of stakeholders to work on an OHT plan and implementation.

During this stage we will ensure the right people are positioned in the right place to:
• Provide timely and detailed information

• Identify barriers to the change work and have the authority in place to make change

• Ensure the change effort is given the necessary priority to effectively support the success of the transformation

CHANGE GOVERNANCE
People are more inclined to engage in and support change efforts when they know how to contribute. Our governance structure will leverage current roles and structures, as well as, identify additional supports.

STAKEHOLDER MAPPING
We will assess how impacted partners are responding to the change initiative. This is critical to ensuring buy-in and avoiding community or partner doubt and mistrust in our ability to deliver change.

STAGE 3: As part of envisioning the opportunities and implications of the new model we will finalize a vision that connects the "why?" to the OHT mandate.

Partner Involvement
Partners will be encouraged to identify their own plan to get out in front of their teams and engage them in the OHT work and explain how they might be impacted and what benefit may come of the work.

Identifying Future State
We will undertake and involve people in ongoing communication about the continuous evolution of the OHT will be shared with all levels of each of the partner organizations identifying changes that will impact teams, individual roles and service delivery.

STAGE 4: We will motivate partners and their teams by connecting at an emotional level around the 'why'. We will identify strategies and tactics to motivate stakeholders to engage and support the OHT. This strengthens factors driving this change and mitigating forces restraining this change. We need to demonstrate how we are doing things differently and communicating that value. This shift has a direct and heavy impact on the culture, relationships, communications and health care workers and the community. We will:
• Communicate
• Advocate
• Coach
• Liaise
• Manage Resistance

STAGE 5: We will communicate the vision and mobilize stakeholders around 'how' to roll-out the solutions. As we develop the Algoma OHT a communications plan will built and implemented.

Our change communication approach will apply best practices, including:
• Repetition – Repeating key messages.

• Consistency in Message - Ensuring consistency in corporate communication. Walk the talk.

• Consistency Across Channels - Multiple communication tactics will be applied to ensure message is shared across our diverse health care organizations.

• Connectivity - As updates and clarity are provided, messages will address what will be the same and what will be different.

STAGE 6: We will act by taking steps to align the OHT (people, structures, processes) with the new approach.

At this stage, efforts will focus on a training plan and support, which are critical to acceptance and adoption. Training will be delivered in a way that allows partner participants to "digest" the information.

STAGE 7: We will consolidate by reinforcing which things are working and exploring which things are not. We will incorporate a "Plan Do Check Act" process to evaluate and improve partnerships.

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

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

Max word count: 500

Consideration for maintaining access and high-quality care for those patients that require our services have been made in choosing the priority populations and determining models that will improve the system while utilizing existing healthcare resources.

The Integrated Care Model calls for expansion of the existing resource by consolidating underutilized resources across Algoma OHT partner organizations. New access opportunities for additional patients will grow an existing model and match new complex patients to the appropriate care provider services.

Seniors having suffered a fall and presenting to the Emergency Department will receive a new care pathway to ensure that they are consistently evaluated for frailty, appropriately referred to specialized resources thereby ensuring that the patients most in need are identified early and consistently. With an expanding Geriatrics program we are poised to respond. Additional resources, e.g. Geriatric Emergency Medicine (GEM) nurse roles may expand to include particular attention to mobility and therefore all patients that they see will benefit. Spread to all Algoma Emergency Departments will be planned for Year 1. Spread and sustainability to primary care will be planned for Year 2.

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

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

Max word count: 1000

As part of the Algoma Ontario Health Team planning sessions we have identified some systemic barriers that need to be considered and reviewed during the development process of the Algoma OHT. Note: Some of these barriers appear in the 6.6 Risk Analyses (Risk Registry).

1. FUNDING

1.1. There are different funding approaches and levels at each of the partner organizations. The ways in which funding is allocated varies at each organization. There may be restrictions on how funding is used.

1.2. There will likely be some roadblocks if there is uncertainty on how to split or allocate costs between the partner organizations (who are funded differently

and are very different sizes with different scope).

1.3. Funding for things that are outside of health care are beyond health care's reach. For example IT Infrastructure in rural and remote locations in Northern Ontario is a challenge. Without certain infrastructure, specific opportunities might not be available in all areas creating equity issues for providing health care across Algoma.

1.4. Funding varies in First Nations communities within our catchment.

2. LEGISLATIVE

2.1. We have identified that there may be conflict between what is considered "best practice" for a common OHT and the legislative bodies that oversee the work at different organizations. Partner organizations may also be at different stages of implementing "best practice" at their organization meaning that there may not be a consistent approach and these gaps will require further development/consideration and education.
An example: the Complex Continuing Care and Rehab area at SAH utilizes best practice as identified in the Rehab Care Alliance. Are we sure that these standards are being used by partner organization? Or does it still make sense that we are using this as our standard at all. We would need to ensure alignment in the understanding of best practice.

2.2. Accreditation Canada has somewhat different standards and expectations from different types of health care organizations. If we are working as one team, there could be misalignment between the expectations and best standards.

2.3. Ontario College of Nurses has specific expectations that might not apply at all the partner organizations.

2.4. There may be specific legislative requirements for First Nations communities within our catchment.

2.5. There may be restrictions on the sharing of information between partners due to healthcare privacy legislation.

3. GOVERNANCE

3.1. There may be challenges that the Board of Directors or governance bodies at partner organizations may have competing priorities that may not be aligned with the OHT vision.

3.2. There may be interest within First Nations communities within our catchment for self-governance when it comes to health care.

4. UNION

4.1. Many of the partner organizations have different unions and therefore different collective agreements that might create some challenges in the creation of new approaches to care, new roles and duties for workers, for a grievance process that crosses partner organizations, etc.

5. POLICY

5.1. There may be barriers in aligning policy between the partner organizations.

6. TECHNOLOGY

6.1. There are challenges with physical IT infrastructure that need to be improved. Certain assumptions about virtual care opportunities may not represent the cell phone and IT infrastructure/capacity in a rural Northern environment. Rural IT and cell service infrastructure is often not available, and therefore certain parts of the catchment may not have all of the same opportunities.

FACILITATORS OF CHANGE

As part of the Algoma Ontario Health Team planning sessions we have identified some facilitators of change that will help with the process of developing the Algoma OHT.

1. FUNDING

1.1. The Government of Ontario funds most health care related organizations and therefore can help address funding issues.

2. PATIENT AND FAMILY ADVISORS

2.1. The Patient and Family Advisors coming from the partner organization can help us to ensure we are on the right path and keep our focus on patient-centric care in the community. They will approach their task without the systemic barriers in mind and push the OHT to keep focus on care in the community.

3. TECHNOLOGY

3.1. If leveraged properly, technology could be a facilitator of change when overcoming the challenges of geography.

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

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

Max word count: 1000

Our team has considered this thoroughly and believes that non-financial resources and supports that may be helpful include:

1. New and ongoing change management support, education and training. Facilitated work that is meaningful to the team should be explored to support adult learning methods. Partner organizations will pool their training and education resources to utilize internal resources and to further to support the development of the local context.

2. Monthly performance data will ensure that the teams are on track and can course-correct if required without significant lag-time.

3. All care coordination staff will require motivational interviewing for patients and staff, to ensure best practices and positive approaches to patient self-management are undertaken. The rollout of training programs is required to support approximately 150 care coordinators.

4. Access to Indigenous cultural sensitivity training that is multimodal and endorsed by our Local Aboriginal Health Advisory Council.

5. Access to on-line training on Active Offer of French Language Services.

6. Consideration for maintenance of the current infrastructure specific to Home and Community Care transitions (e.g. technology, human resources and physical environments).

7. Access to gender diversity expertise such as Rainbow Health Ontario.

8. The Algoma OHT requests early consideration and support for the elimination of legislative and regulatory barriers identified to be impeding our vision of modernizing Home and Community Care.

9. Information about innovation successes from other OHTs.

6.6. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe

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

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

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

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

6.7. Additional comments

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

Max word count: 500 Nothing to add

7. Membership Approval

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

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

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

APPENDIX A: Home & Community Care

Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.

In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.

Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team's proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.

Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

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

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care.

Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

Max word count: 1500

To inform our vision of the redesign and future delivery of home and community care services to our patient population we invited frontline care coordinators from various organizations to participate in a co-design session.

The objectives of the Kaizen (improvement) event were to understand:

• Current activities of the care coordination role within the sector
• Current opportunities for improvement (e.g. reduced duplication)
• The key tools used in carrying out the role (e.g. assessment tools, IT systems)

The outcome of this session identified that there were several areas with existing opportunities for improvement. The key takeaway was that to best serve the patient's needs the care coordination team should have one system, one tool (assessment) and one person to help guide the patient through their journey.

Taking these results into consideration means that modernizing the delivery of home and community care will be achieved through a multi-faceted, multi-year approach. Our plan is to leverage the strength of the existing team, evolve the model and create capacity by reducing duplication and eliminating low value work. Utilizing the existing human resources we will start working to evolve to a 'full scope' model of practice, commencing with the registered nursing staff.

The current model of care coordination is not patient centred nor is it connected to primary care. Care Coordinators (CCs) are assigned patients based on their 'complexity' or by geography. This means that patient whose conditions change or deteriorate might be served by several different Care Coordinators over the course of the time they are receiving service. The first step we will implement will be to move from a 'specialized' to a 'generalist' model of coordination in which care is patient focused.

A second opportunity will be to accelerate the embedment of CCs into primary care practice. In the initial stages of embedding the care coordination role into primary care work will be undertaken to realign the case load of each CC to incorporate the patients of a particular provider(s') practice. This process will facilitate the development of a better understanding of a particular provider's population needs and lay the foundation for increased accountability between the CC, patient and provider. Trust will develop as the relationship between the provider and CC evolves.

As part of embedding the role, additional opportunities will be explored to optimize alignment between caseloads and care setting where patients are currently being served. Care coordination services are currently being delivered in some non-traditional settings such as the Indian Friendship Centre where an Indigenous primary care team provides services to the urban Indigenous population or the Algoma Geriatric Clinic which services the frail elderly population. The recently launched Neighbourhood Model aligns coordination resources, caseload and service provider organizations within a geographic area where significant utilization occurs. Lessons learned from the evaluation of these embedment activities will be used to inform Year 2 opportunities.

We will begin to leverage the role of the embedded CCs by removing barriers and

duplicative work to create capacity and maximize their roles to evolve into the role of an ICN over time. Currently, the Home and Community CCs are regulated health professionals with a background in nursing, social work, occupational therapy, physiotherapy or speech therapy. They complete assessments to determine client eligibility and coordinate ongoing services with service providers to address client needs and ensure the most effective use of resources.

Integrated Care Nurses (ICN) are specially educated registered nurses who work in partnership with primary care physicians, patients, health care professionals and caregivers to provide comprehensive, actively coordinated, continuing patient-centered healthcare to patients in need. They will provide support over the patient's care journey and disease trajectory by: assessing the patient, creating a coordinated care and action plan, promoting patient self-management, proactively monitoring patients, coordinating care between multiple providers, smoothing transitions from hospital to home, educating the family and caregivers, and accessing community resources.

Elimination of duplicative work across the sector, maximizing scope, utilizing virtual care options where possible (e.g. PC/VC), creating standardized tools (e.g. Clinical Frailty Scale), standard work and a 'common language' as well as fostering a collaborative culture with PCPs will all support efficient and integrated service delivery. By removing barriers/waste and moving to a patient focused generalist model of care coordination, aligned with providers, we will create capacity and opportunity for care coordinators to work at full scope.

Our team recognizes that technology, facilitated system navigation, enhanced care coordination using an integrated care model, expanding scope of practice and patient/peer support are all essential elements in transforming home and community care. We recognize the need to establish a common patient identifier to determine the linguistic identity of our Francophone clients from the very first point of contract. By removing barriers and duplication across the broader sector we will achieve efficiency that will result in capacity within the system.

We will expand access to virtual care which is currently provided through home and community care's Tele-homecare program. This technology is maximized to support patients in accessing clinical expertise and support. ICNs will optimize the use of PC/VC to connect patients from their home directly to their PCP via an iPad. Additional opportunities are also being explored to provide virtual care through the utilization of e-Shift type technology solutions.

Within the geography covered by the Algoma OHT the NE LHIN has a staffing complement of 77 (6 supervisory staff, 51 Care Coordinators, 2 Rapid Response Nurses, 1 Nurse Practitioner and 17 administrative staff) engaged in the authorization and delivery of homecare and long-term care placement services. Algoma had 7,071 active patient referrals for home care in 2017/18 and the 8th highest utilization rate (69.2 per 1,000) of all Sub-Regions in Ontario. We are mindful

that as we move forward to operationalizing our vision of modernizing homecare we cannot jeopardize service to the patients who rely on service each day.

Transforming from the current system will take time. The capacity gained through the elimination of waste and duplication will be 'reinvested' initially into education to support expansion of scope and updating of clinical skills. We propose starting to move from a pure CC role to an ICN role with seven FTEs from the existing home and community care program. Three additional FTEs have been identified by member agencies and they will also transition from their existing roles to an ICN. At maturity, the vision is that the entire workforce of care coordinators would transition to a model of integrated care. Administrative functions of a non-clinical nature would be considered for realignment to administrative staff allowing capacity for front line patient care.

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

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

- What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.
- Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives.
- Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the **optional** table below to describe the delivery model.

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

Add functions where relevant		
See supplementary Excel spreadsheet		

Max word count: 1000

The team is comprised of multi-sector organizations that will work together at combining health and human resources and knowledge sharing to create a cohesive team. Efficiencies within our partner organizations will be identified and maximized to create fiscal resources that will be reinvested in patient care.

We anticipate that between 90-100% of our identified Year 1 target population of 1,500 will require some degree of home care. Patients in our Year 1 population have been identified as frail elderly or as patients with complex needs better managed in community. They will require connection with out-patient or in-home services to manage their chronic disease trajectory and care. These patients often have socioeconomic factors that limit their access to care, maintenance of care needs, or they may struggle to understand how to manage their conditions. Our Year 1 population will benefit from early identification and the specialized basket of services that ICNs can deliver to ensure that the whole patient is cared for and not just the symptoms.

The vision is to evolve the role of the existing CCs to an integrated care model which will reduce costs, improve the experience of both patients and providers and support a preventative approach to population health. For example as earlier identification of frailty occurs in the community strategies can be developed with system partners to mitigate risks and support patients and caregivers at home longer.

The ICN model will use technology to share patient information, video conferencing, education, and apply common tools to maximize the care experience. Team members within care coordination who have not transitioned into the ICN role will have the autonomy to develop ICPs that best meet patient goals. We are adapting the Guided Care model based on previous success. Our first priority for transformation into the new model will be the transition of registered nursing staff.

Rationale for Nurse in the role:

• Nurses have the clinical assessment skills to manage this complex chronic patient population

• Can complete medication reconciliation

• Are skilled at health teaching and can identify and communicate targets/flags

• Use of medical directives for managing chronic diseases

• Trust and respect from PCPs based on established relationships

• As a generalist model this would reduce the number of providers in the patient's circle of care

ICNs will be able to assess patients for home care services using the standardized tools (RAI). As the ICN monitors the patient, changes that may need to be reflected in the home care service can be implemented in a more timely fashion.

Using the ICP tool, the ICN will:
• Ask patients to identify their goals of care

• Assess medical, functional, cognitive, affective, psychosocial, spiritual and environmental needs

• Identify family, caregivers, specialists, physicians, pharmacy, and involved community agencies

• Review medical chart for supplemental information

• Secure patient consent

Using the ICP and other resources, the ICN will create a holistic, individualized plan for managing and monitoring the patient's health care needs. Once the ICP is created, the ICN will:
• Review and discuss the plan with PCP to make modifications to align the plan with the patient's unique care needs

• Complete an Action Plan for conditions, indicating "red flags" that should prompt the patient and/or caregiver(s) to call the ICN or go to the hospital

• Review the ICP with the patient

• Provide a copy of the ICP to the patient, caregiver(s) and any other health care professionals involved in the individual's care

Monitoring patient proactively
• Monitoring the patient by telephone, home visit, and/or My Care at a minimum of once a month

• Evaluate adherence to the Action Plan to detect and address emerging problems

• Communicating back to the patient and caregiver(s) on updates pertaining to their care

• Communicating back to PCP when any health concerns emerge to facilitate and implement appropriate actions

Empowering the patient, encouraging self-management

The ICN will utilize principles of motivational interviewing to identify obstacles and develop strategies to empower patients to adapt healthy behaviours and participate actively in their care. They will promote health literacy and self-management while encouraging patient ownership for his or her goals in the ICP, which is paramount to good health care.

Coordinating providers of care will:
• coordinate efforts of other health care providers and support services using the ICP

• update the ICP as necessary to reflect the changes

• provide an updated ICP to all members of the individual's care team (with consent)

• inform PCP of changes regarding the individual's health as required

To ensure a smooth transition into and out of the hospital or other facility, the ICN will:
• Encourage patient and caregiver(s) to contact them before and during all admissions to emergency and/or the hospital

• Provide providers in the inpatient setting with up-to-date ICP within 24 hours of admission

• Prepare the patient and family for transition out of hospital in collaboration with hospital staff

• Visit the patient 1-2 days post-discharge to evaluate their recovery, medication reconciliation, and to ensure the patient and caregivers know the plan

• Brief PCP about the patient's hospital course and ensure an appointment to see PCP soon after discharge

The ICN will educate and support patients and caregivers with education, caregiver information and additional resources.

In addition to coordinating health care services, the ICN will:

• Be aware of current resources that may be available for patients with chronic conditions

• Provide the patients and caregiver(s) with information about community support services and resources that may benefit them

• Assist the patient and caregiver(s) in accessing community resources

The Year 1 target population will be identified by primary care, front line providers and existing CCs. Community dwelling patients 65+ who present to ED post fall will be screened for frailty and based on the assessment be routed into an evidence based care pathway. Where services are required CCs or embedded ICNs will conduct an assessment of the patient to determine their eligibility, needs, and coordinate the services required.

As ICPs are developed, a common consent will be secured from the patient that represents all partners in the circle of care, eliminating repeated messaging and streamlining the patient journey.

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

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

Max word count: 1000
In outlining our transition plan we will bucket activities out over 3, 6, 9 and 12 month timeline frames:

Embedded CCs Transition to ICN Role:

<3 months
• Provider satisfaction survey is administer as initiation of change

• Caseloads are realigned for the appropriate PCP(s) and move is completed to a generalist model

• Relationship building with the PCP and patients, trust is developed

• Skill development training provided on Guided Care Nursing (40 hours) and the Clinical Frailty Screening Tool

3-6 months
• Duplication of ICN/Family Health Workers role (if in place) is eliminated

• Removal of 'non-clinical' administrative tasks as Team Assistants expand role

• Evaluation of duplication between Access Coordinators and ICN role is undertaken

• Development of clear criteria of ICN services and care pathways

6-9 months
• Work to full scope and with a mix of patient need levels, towards a full caseload of 80-100 (e.g. 30 complex patients, 60-70 chronic/community independent patients)

9-12 months
• Continue to refine and evaluate. Utilize learning from the initial transition to inform future staff transitions

• Administer provider satisfaction survey

GCN role to transition to ICN role:
<3 months
• Administer provider satisfaction survey

• Training on role and requirements of existing care coordination function and the Clinical Frailty Screening Tool

3-6 months
• Realign caseload to allow embedding into PC as with CC embedding into PC settings

6-9 months
• Work to full scope with a full, mixed caseload of 80-100 patients

9-12 months
• Continue to refine and evaluate. Utilize learning from the initial transition to inform future staff transitions

• Administer provider satisfaction survey

Palliative Outreach Nurse transition to ICN:

<3 months
• Administer provider satisfaction survey

• Skill development training provided on Guided Care Nursing (40 hours) and the Clinical Frailty Screening Tool

• Training on role and requirements of existing care coordination function

3-9 months
• Work to full scope with a full, mixed caseload of 80-100 patients

9-12 months
• Continue to refine and evaluate. Utilize learning from the initial transition to inform future staff transitions

• Administer provider satisfaction survey

The Integrated Care Nurse model implementation plan is grounded in transitions and culture change. Education and understanding of clinical frailty and geriatric syndromes will be integral to the work for Frail Seniors and completion of the clinical training on Guided Care will be required.

Caseloads will be re-aligned to ensure that workload is manageable during transition. The initial 30 days will see resource realignment and education designed for advanced clinical assessment for the Integrated Care Nurse. The initial 60 days will see transitions in caseloads to realign FTEs and begin and sustain cultural change

work and education. Within 90 days, we will begin identifying patients from Year 1 target population. At six months, the ICN will maintain full caseloads and work within their full scope of practice.

Existing Home and Community Care resources including: human resources (e.g. FTEs in Care Coordination, Team Assistants) existing facilities; IT tools and resources and management support will be required to transition fully over time. As the Algoma OHT matures, we fully conceptualize the transition of all HCC staff to support Algoma patients.

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

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

Max word count: 1000
Possible barriers to realizing the vision of home and community service modernization include:
• Provisions in Community Care Access Centres (CCAC) Client Services Policy Manual which outline two key responsibilities of CCAC (now LHIN) as the provision of home care and managing the placement process into long-term care (LTC) homes. The CCAC manages these key activities through case management services, a core service of the CCAC.

• CCACs (now LHINs) are the designated placement co-ordinators under the Nursing Homes Act (NHA), Charitable Institutions Act (CIA) and Homes for the Aged and Rest Homes Act (HARHA), and are therefore required to comply with the relevant provisions of these statutes and their regulations. As placement co-ordinators, management of admissions to long-term care (LTC) homes is one of the key functions of the CCAC (now LHIN).

• Under the Long-Term Care Homes Act, 2007 40 (1) The Minister shall designate one or more persons, classes of persons or other entities as placement co-ordinators for the long-term care homes in specified geographic areas. This designation currently resides with the CCAC (now LHIN) role of Care Coordination

• Provisions of the existing collective agreements that outline the schedule/hours of work of the team within home and community care as seven hours per day or 35 hours per week would be inconsistent with most other organizations within the system, the majority of which work 37.5 total hours per week. As CC roles come together within the OHT provisions will need to be made to allow for the harmonization of numerous employment terms.

Ontario Health Teams
Full Application Form

APPENDIX B: Digital Health

Experience from other jurisdictions suggests that digital health is a powerful tool for advancing integrated care, shared accountability, value-based health care, and population health management approaches.

In this section your team is asked to assess its current digital health capabilities and propose plans for building off this existing capacity to meet the minimum readiness requirements and Year 1 expectations set out by the Ontario Health Team Guidance Document. Responses provided in this section will be evaluated based on the degree to which your team seeks to integrate already existing infrastructure and improve disparities in digital capacity across the members of your team. Responses will also help the Ministry understand what supports teams may need in the area of digital health.

By completing this section, the members of your team consent that the relevant delivery organizations (i.e., Cancer Care Ontario, Health Shared Services Ontario, Ontario MD, Ontario Telemedicine Network, and/or eHealth Ontario) may support the Ministry of Health's (Ministry) validation of claims made in the Current State Assessment by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

Virtual care is an area where we have seen some good success on connecting local patients with specialists or consultants in other areas. In 2018/2019 Sault Ste. Marie hosted 4786 virtual visits of this nature. Understanding that we are 300+ kilometers from the next largest center means that our patients have a long way to go for appointments, patient monitoring or to receive patient education. We also understand that our attributed population can also live 300+ kilometers so we have been providing 1800-2000 annual virtual visits with our consultants in Sault Ste. Marie and the patient is elsewhere. The virtual visits have been done using the OTN services and range over the following care areas:

- Oncology
- Mental Health
- Child Psychiatry
- Cardiology
- Rheumatology
- Thoracic Surgery
- Gastro-Enterology
- Nephrology (includes Dialysis)
- General Surgery
- Neurology

• Neurosurgery
• Bariatrics
• Hematology
• Urology
• Primary Care (family medicine & general practice)
• Cardiovascular Surgery
• Endocrinology (includes diabetes)
• Other

The majority of e-visits in Sault Ste. Marie are still occurring from room based (studio) systems or from personal computers (98.4%). Only a small number of visits are happening into the home at this time (209 home visits from 2017-2019). This is an area that we plan to target and see expansion in Year 1 continuing to maturity. Currently the OTN system is available on PC/laptop, iPad and iPhone however there is a plan to implement and test on Android systems as well to expand the options for use. Some of our attributed population is in areas where access to data networks may be restricted so when video capacity is limited or not required, we will focus on virtual visits through phone calls. Currently we have 416 users with OTNhub accounts within our partner agencies (94 physicians, 81 nurses and 241 allied health, admin staff or other accounts).

We are currently providing Telehomecare, a digital self-care program utilizing peripheral equipment to remotely support and monitor Chronic Heart Failure (CHF) and COPD patients via OTN. This allows for less hospital visits and more closely monitoring of these patients. The Algoma Regional Renal Program (ARRP) also has a remote dialysis program in place to reduce patient trips to the hospital, and allows for more treatment options at home.

A wonderful local example of how OTN is beginning to be used in Algoma is when a patient was nearing readiness for discharge and the occupational therapist was able to setup a virtual visit with the patient's family. The occupational therapist was able to use the digital technology to do a walk-through of the patient's home and set up additional supports without having to leave the hospital. This was more convenient for the patient's family member and it was able to save the occupational therapist from driving to and from the patient's home resulting in more patients being seen throughout the day.

Our plan would be to have additional acute, primary and community care capacity done virtually through the OTN platform as it is currently available to all of those individuals who register for a ONEID account. This would allow us to start

increasing virtual visits in the home immediately using this available technology without any additional systems or platforms required, especially in Year 1. Since many of the organization are already using OTN to some degree, we believe that we would be able to meet the target of 2-5% of Year 1 patients having a virtual encounter within Year 1.

Our team will include opportunities for FLS through virtual care with Francophone professionals.

2.2 Digital Access to Health Information

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

Max word count: 1000

Currently the Group Health Centre has a patient portal with their MyCare system with approximately 10,000 patients having access to this portal. The Group Health Centre currently provides primary care for approximately 80,000 patients within the community. This number expands when you add in all of the patients being cared for by specialists that see any patient within the community. All of these individuals would be able to be setup with a patient portal. The MyCare portal allows for patients to access their medical history, communicate with their provider and coordinate appointments. MyCare functionality includes:

• Messaging your provider's office
- With a medical question
- To request a prescription refill

• Visits/Appointments
- Patients can see a list of upcoming appointments
- Patients can schedule appointments and cancel appointments
- Patients can also view a summary of past appointments

• Medical Record – specific parts of record can be viewed including:
- Test results
- Health summary
- Current health issues

- Medications
- Allergies
- Medical history
- Immunizations
- Administrative information e.g. demographics
- Patient can download personal health summary to a PDF

The Group Health Centre is continually growing the patient portal annually with expansion of providers and their patients being added. In current state this is the only patient portal that is utilized in our area, however there are additional patient portals that are in the planning or execution phase within the next year or two. We plan on leveraging these available assets for our year 1 population. We are examining our current platforms and patient access with a long term goal of enabling patient access for the entire population.

Sault Area Hospital is currently working on the ONE Initiative where 24 hospitals in North Eastern Ontario will be working on the same instance of Meditech Expanse. This will allow for a greater flow of patient information and data as they move to different facilities or specialists within this hub. SAH will be live with Meditech Expanse on October 29th, 2019, moving to a fully digital electronic medical record in all inpatients areas, the emergency department, diagnostic imaging, lab and pharmacy. The next phase (phase 2) of Meditech Expanse will be focused on outpatient areas and will have a patient portal for all SAH patients. The planned rollout of this is 2020-2021. SAH is currently contributing patient data to the Connecting Ontario Clinical Viewer for other providers to view and access relevant patient health information for continuity of care and follow up.

The Superior Family Health Team has the ability for patients to send in requests via their website. The Sault Family Health Organization is launching a patient portal via Health Myself in October 2019 which will allow patients to book and manage their appointments as well as exchange messages with their providers.

Algoma Family Services is currently using EMHware which has capacity for client portal, and text message appointment reminders, in addition, to self and provider referrals through the website. They are currently in the process of getting this set up for client use and will also be available for Year 1 patients.

Caredove is currently being adopted and is a platform for home care and community services that provides access for patients to manage their referrals and appointments online. They also use OCEAN which enables patients to review pre-

visit information and complete forms, confirm their appointment, and update contact information.

Health Line is being used and is a public-facing online tool to share a directory of available health care services within the Algoma area.

There are many examples through the different organizations of using technology to help better educate and inform the patients. This is done in many different ways through resources on websites, wait time clocks, digital applications and digital health teaching. In the Algoma District Cancer Program, they are using internally developed videos to explain treatment processes to patients. Patients will come in for their initial consultations and be given an iPad to show them what to expect and how the treatments are designed. They are able to see how the treatment or procedure is performed and the equipment and rooms that will be used. Another digital feature being used in the cancer program is a virtual self-assessment. When patients arrive to their appointments, they are able to perform the "Your Symptoms Matter" self-assessment on a computer workstation and this information is used both for that specific appointment and to see trending for a patient as it transitions into their health record. They are able to see for instance if an oncology patient's pain is being managed or if there are opportunities to provide better care.

By October 2019, the two largest primary care providers in Sault Ste. Marie (Group Health Centre and Superior Family Health Team) will have patient portals in use. Our plan will be to leverage these assets and others currently in existence (or planned) within home and community care to connect patients to their digital records. This will allow us to meet the target that 10-15% of Year 1 patients can digitally access their health information in Year 1.

2.3 Digitally Enabled Information Sharing

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

Max word count: 1000

As previously mentioned, Sault Area Hospital is contributing discharge summaries and hospital reports to the Connecting Ontario Clinical Viewer in order to share this information with the patient's primary care provider. The Group Health Centre and Superior Family Health Organization are also able to access hospital discharge summaries and hospital reports for their patients through the Physician Office Integration (POI) reporting system. Although many primary care and home care providers are using electronic systems, there is some variation in different systems being used and their functions. Some

providers are using electronic systems for booking and documentation while others are only using electronic booking and continuing to use paper charts. Respecting the autonomy of the various electronic systems chosen at the different organizations, we can start to more broadly use the existing provincial platforms (Clinical viewer, eNotification, eConsult, eReferral) to share information and work more efficiently together in Year 1. These platforms can be utilized very quickly by setting up providers and organizations with ONEID and ONEMail while we look at developing a long term plan on becoming more integrated.

Health Link is a great example of how our partner organizations were able to work together and share patient information with those involved in caring for specific patients. Using the integrated care model, an interdisciplinary team from many organizations came together to wrap care around the patient and it was important that all parties had access to the care plan in an electronic format. The teams worked together to find a solution to be able to have this care plan available on all of the different electronic platforms. The one struggle with this electronic care plan was in the updating and contributing to the care plan. If an interdisciplinary team member wanted to add or modify anything in the plan, they would have to send the changes to the integrated care nurse to complete the edits. It was important to implement version control and to regularly send the updated care plans to all care partners.

In the Algoma area we are using the Health Partner Gateway (HPG) to securely exchange information with home and community care providers. Care Coordination Tool (CCT) – CHRIS/HPG is being advanced to support the sharing of Health Link Care Coordination Plans within the circle of care.

Algoma Public Health (APH) is a public health agency committed to improving health and reducing social inequities in health through evidence-informed practice. They have been working with the Innovation Centre and other health and community partners to map out the Algoma area. Acorn Information Solutions (formerly known as the Community Geomatics Centre) is a division of the Sault Ste. Marie Innovation Centre, a not-for-profit organization dedicated to promoting and establishing the means to share data, knowledge and tools among organizations to create healthier, safer and more prosperous communities. Declared to be the most comprehensive Geographic Information System (GIS) solution in the world, AIS is the first true information utility and is the best example of leveraging public data for public good in North America. In this endeavor they have been able to work with 50-60 different organizations to provide data. Their team has been able to push/pull data from all individual partner programs and overlay this data together to see trends, patterns and opportunities. Our OHT digital working group had the opportunity to meet with the Sault Ste. Marie Innovation Centre and they are excited to partner with us to help enable an integrated digital health system to better share information to provide better integrated care delivery and planning. They fully support our full application and are committed to

working together to find solutions that work within the community.

The Sault Ste. Marie Innovation Centre also has a mandate to build bandwidth capacity within the Algoma region. This was identified as a barrier for virtual care and digital access for patients in the rural communities surrounding Sault Ste. Marie where cell service and internet connections aren't currently available or aren't reliable. The Innovation Centre is focused is on improving the economics, health and safety of our region. They are currently working on a plan to improve the infrastructures within the rural communities.

We also discussed the use of data (or big data) that we all have within our separate systems to start to better understand our population health and opportunities that exist. We have segregated data analytics, some even built into the electronic medical records (such as in Epic and in Meditech Expanse). By looking at all of this data from a community perspective, we can overlay more information and start to think about using artificial intelligence to find patterns or trends within that data. There have been many small scale projects, such as one on falls where we used digital tools (sensors and apps) to improve patient health. These types of projects will continue to occur within our OHT and working with partners like the Innovation Centre, we can increase the scale and spread of the benefits to additional patients and the support of integrated care pathway design.

2.4 Digitally Enabled Quality Improvement

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

Max word count: 500

All of the partner organizations have experience with quality performance improvement and key metrics. We are using patient experience surveys and clinical data to drive these plans and develop priority initiatives focused on continuous improvement. Digital tools are being used to capture this data and to ensure the quality of the data. Many of the organizations have some level of decision support with larger organizations having dedicated decision support resources. Partners are using the data that is captured electronically for corporate reporting and to create smart goals. By focusing on these key metrics, they can identify when something is off track and develop a recovery plan. Some are also moving towards case costing to identify efficiencies and become more fiscally responsible. Evidence based care is important in ensuring that patients receive the most efficient care to improve patient outcomes. Implementation of Meditech Expanse brings a quality transformation by embedding evidence based practice into order sets and standardized care pathways. Use of Quality Based Procedures have been implemented within Sault Area Hospital and will be transitioned to digital form

in Meditech Expanse. This will ensure the highest level of care and best practice for all patients while making it easier to capture the data going forward.

Best care practices are being built into the EMR systems by implementing modules such as Computerized Physician Order Entry (CPOE) and digital (barcode) medication administration. This is improving the care that we are delivering to patients and ensuring better quality with fewer errors. Assessments are moving to a digital format where higher risk patients can be identified and monitored on an electronic status board.

Improvements to EMRs are continuous to ensure that the best data is being captured to improve data analytics and patient trending. This data is currently used to better care for the patient and to improve population health. Using available data to map out areas for improved community supports and neighborhood resourcing based on patients presenting to ED with addiction related conditions was recently completed. This improved the quality of the support provided to these patients through community programs such as United Way and access to social and health resources.

Digital access to patient portals and digital self-management tools are providing more information and education to patients. This allows them to work together with providers to create goals within their health care plan and share this information with their families and caregivers. These digital tools are helping to create a more structured support network to improve the quality outcomes for the patient. We will see continued quality improvement as we leverage these digital assets and continue to create more sophisticated digital tools with the goal of the Quadruple Aim.

2.5 Other digital health plans

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

Max word count: 500

Our team has been highly engaged and actively involved in coming together to plan our vision of an integrated digital health system among all partners. We share the common vision of a patient focused platform with the patient at the centre of their own health data. We strongly believe that we need to work together to provide the patient full access to their health records and access to digital and virtual tools to help them to manage their own health. All of the community partners have been actively moving to more technologically advanced platforms over the last several years. Most of the paper charting and documentation has already been replaced by electronic systems. Systems with a lot of “free text” or “narrative” dictation have evolved to discreet documentation where standardization and data capture is now allowing us to see and

trend the patient's vitals, labs and health issues. Analytics and reporting have been built into these systems to more easily pull information to make quicker, more informed decisions. There has been a strong focus among all partners to improve the quality of the data that they are capturing.

We conducted a team webinar with Dr. Alexandra Greenhill of Careteam to see what a digital integrated tool could look like. Careteam is a healthcare-grade team collaboration platform which brings together health care professionals, the patient and personal support team with an integrated care plan, instant communications, and population analytics to enable transitions, complex chronic care, and innovation in a fragmented health care environment. Careteam creates an ecosystem of data, integration and security on which healthcare apps and Artificial Intelligence (AI) are built. Careteam is unique in bringing together four key features:

- Flexible teams that include patients, families and health professionals
- Care plans, integrated across different health teams and settings
- Privacy and security compliant, 3rd party app and technologies integration
- Prediction - patient/caregiver activation and population health

This was important in bringing the team together to see how our vision could start to come to life and how innovation could close the gap between providers and facilitate the sharing of information. Leveraging integrated solutions from innovative patient-focused vendors and our Sault Ste. Marie Innovation Centre, this vision of community care is not only possible, but exciting. Putting the patient at the centre of their care and truly working together as one integrated team at maturity will ensure the best outcomes for patients and create efficiencies for all health care providers and organizations. This will also lead to improved population health and data analytics. Our high level concept for this integrated digital health care is included in the supplementary documentation.

In order to achieve this concept barriers that would require assistance were identified. These include:

- Improved infrastructure (cell service and bandwidth capacity, remote communities)
- Privacy legislation and requirements streamlined
- Improvements to billing codes
- Improved data quality (both within individual organizations and at the provincial/ministry level)
- Change management support

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

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

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