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Type:	Managers' Reports

Request for Decision

Ontario Health Team

Resolution

THAT the City of Greater Sudbury endorses the application for the formation of an Ontario Health Team service model substantially in the form presented in Appendix A to this report.

Signed By

Report Prepared By
Ed Archer
Chief Administrative Officer
Digitally Signed Nov 27, 19

Financial Implications
Liisa Lenz
Coordinator of Budgets
Digitally Signed Nov 27, 19

Recommended by the C.A.O.
Ed Archer
Chief Administrative Officer
Digitally Signed Nov 27, 19

Relationship to the Strategic Plan / Health Impact Assessment

The recommendations in this report directly relate to Council's "Healthy Community" goal in the 2019-2027 Strategic Plan. Specifically, these recommendations respond to Action 6.4, "Work with Health Stakeholders to Determine Appropriate Role in Local Health Team Development".

Report Summary

The purpose of this report is to endorse the application for an Ontario Health Team (OHT) service model for the City of Greater Sudbury. If approved as presented, the OHT anticipates its member organizations will further develop this service delivery model and strengthen service coordination efforts so that a full and coordinated continuum of care will be provided to patients within the Greater Sudbury service area.

Financial Implications

There are no direct financial implications associated with the recommendations in this report. As the OHT model evolves, further reports will be prepared to describe strategic and financial implications for the corporation and, where required, seek Council's further direction.

BACKGROUND

Earlier this year the Ministry of Health (MOH) launched a low rules and self-organizing process to create OHTs. The purpose of OHTs is to deliver an integrated and coordinated continuum of care and facilitate information sharing so that patients, families and caregivers have a seamless service experience when they access health services. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions between service providers will be seamless.

OHTs will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care. They will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.

It is reasonable to anticipate the transition to this service delivery model will take several years. Health care services are complex and there are many stakeholders' views that need to be addressed when designing a new service delivery model and during the related transition process. Therefore, each OHT will determine its own governance structure(s).

Over time, each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls. Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations. OHTs will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with – and be driven by the needs of – patients, families, caregivers, and the communities they serve.

Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators will measure performance and evaluate the extent to which Teams are providing integrated care, and there will be accountability reporting. Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

ANALYSIS

The OHT Application Process

The application presented in Appendix A reflects coordination among over 36 local health and social services providers. Since the province's announcement in the second quarter regarding the formation of OHTs, these organizations have been meeting to understand the nature of the potential changes offered by the OHT model, apply context based on their experience providing care in the Greater Sudbury area, and design an approach for introducing the OHT model here.

In May, local health care providers began meeting and indicated their interest in the formation of an OHT to the province. The province then invited the group to make a full application for an OHT. Appendix A reflects the results of their efforts, using the province's prescribed format for OHT applications.

The application would be submitted by December 19 to the Ministry of Health for further consideration. Applications will be evaluated by third-party reviewers and the Ministry of Health according to standard criteria that reflect the readiness and ability of teams to successfully

implement the model and meet Year One expectations for Ontario Health Team Candidates. 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'.

In addition to the application, the OHT is proposing a memorandum of understanding (MOU) to summarize the commitment of members, followed by an Interim Collaboration Agreement. The MOU is expected to be signed when the application is submitted, with the agreement following in the first quarter of 2020. Further, a Steering Committee would be co-designed and appointed by OHT Members in the first quarter. It would consist of approximately 12 members who would serve as an interim non-binding governance arrangement of the OHT activities between April 1, 2020 and the end of the first year of operation of the OHT. That Steering Committee would include primary care providers and patient and family advisors, among others.

Opportunities Presented by Participating in an OHT

OHTs are expected to improve the experience of care, health outcomes, system sustainability, and provider experience. They expect providers will find new ways to share information and work together to deliver a modern and high functioning health care system. In Year One, the expectation is that persons living with dementia (PLWD) and their caregivers will experience better linkages between their primary care providers and other health services, as well as better coordination and navigation of those services. Generally, this segment is estimated to be approximately 1,655 individuals in the City of Greater Sudbury, plus their caregivers, but not all are expected to access the "integrated care" proposed in Year One.

This population segment was chosen because of the high degree of complexity inherent in the dynamics of a diagnosis of dementia and the impact of that care journey on one's family and loved ones. The OHT recognizes the demographic imperative for improving "senior friendly care" strategies across our system and ensuring older adults are able to age in their place of choice for as long as they choose. In addition, the OHT identified PLWD as its Year One focus because it is confident about its ability to develop system improvements to better support the experience of care for individuals, their families, and health care providers.

There are other opportunities that, with time and experience, the OHT will produce. For example, purposefully integrated and team-based models of care that are linked to one's primary care provider have the opportunity to improve health outcomes. By removing barriers and silos that have traditionally separated some health care services, there will be greater abilities to develop coordinated care plans, wrap care around individuals and their families, and complete "warm hand-offs." Further, integrated pathways and information systems will ensure that navigating the system is easy and straightforward, and that one's information is always up to date and available.

Additionally, digitally enabled models of care and virtual services have the opportunity to dramatically improve access to care. This opportunity is especially impactful given that travel distances in Greater Sudbury are significant—and further exacerbated for those who rely on transit—and that winters are often long and marred by treacherous weather and driving conditions. Expanding these capabilities will drastically improve the ability of caregivers to monitor individuals' health status and to support virtual visits, where appropriate.

The City of Greater Sudbury's Role

As a provider of Long Term Care, Paramedic service and social services the City of Greater Sudbury has been an active participant of the OHT development from its outset. This is particularly important given the year one population of people living with dementia and other conditions where the City of Greater Sudbury already plays an important role through programs such as the 32 bed secured dementia unit at Pioneer Manor and the community paramedicine program.

Next Steps

If approved as presented, staff will continue collaborating with health care sector colleagues to finalize the OHT application and establish a memorandum of understanding and subsequent Interim Governance Agreement for the OHT. Subject to the province's disposition of the application, staff will continue participating on working groups designed to advance the OHT's development in Greater Sudbury.

Ontario Health Teams
Full Application Form

Appendix A: OHT Application

I PREFACE

The following document is a first draft. It reflects a robust, yet highly distributed collective effort that relied on subject matter experts from across our community and agencies. Indeed, many participants dedicated enormous amounts of time that were otherwise unscheduled in their calendars before September and October. This is especially true for physicians and clinicians who made themselves available with little advanced notice and during clinic hours.

The text below is a product of these collaborations—many of which are new and brought together leaders and agencies with little-to-no previous experience working together. Consequently, what follows is already a celebration of our collective intent and commitment to working together, and the work group participants and chairs should be thanked and celebrated for their efforts thus far. Thank you!

II NOTE TO READERS

As a draft, we recognize there will be many opportunities for improvement, and indeed corrections. In some cases, there are known and intentional gaps that require the project team to know exactly whether agencies intend to be members or collaborating organizations in Year 1. The project team is aware of these gaps and will close them in time for a rigorous application. Additionally, the distributed nature of our work groups does increase the likelihood that inconsistencies are present; these will be addressed through finer refinement and editing of the text, as well as continued leadership and collaboration among the work group chairs.

As readers—and leaders of our respective future members and collaborating organizations—the request to you is: *can you live the ideas, suggestions, and recommendations presented?* Recall, the content below is the distillation of input provided by participants from across all participating agencies who wished to be involved. Therefore, please consider the following when reviewing the document and formulating questions and suggestions:

- Content: If something is untenable for your agency, why, and what can be done to address barriers to gaining your support? Or, if something was missed and should be added, please highlight this;

- Style: please share your feedback with the Secretariat;

- Spelling, grammar, and word counts: this is a draft; consider ignoring the urge to correct for these knowing revisions will occur and fine editing has not yet occurred; and

- Please ensure all feedback is constructive and supportive of Équipe santé Sudbury and District Ontario Health Team beginning a significant system transformation process and engaging in its own rapid learning and improvement.

On behalf of the Secretariat, thank you. With gratitude,
adam

Ontario Health Teams
Full Application Form

Introduction

Thank you for your interest and effort to date in becoming an Ontario Health Team. Ontario Health Teams will help to transform the provincial health care landscape. By building high-performing integrated care delivery systems across Ontario that provide seamless, fully coordinated care for patients, Ontario Health Teams will help achieve better outcomes for patients, improved population health, and better value for the province.

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

Ontario Health Teams
Full Application Form

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

[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.

networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

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

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

Participation in Central Program Evaluation

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

Additional Notes

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

clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

In addition, the Ministry may disclose the names of any applicants for the purposes of public communication and sector awareness of prospective teams.

- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name:
	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.

[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.

Ontario Health Teams
Full Application Form

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

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

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

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

Maximum word count: 1000

I ACKNOWLEDGEMENT

Équipe santé Sudbury and Districts Ontario Health Team (our OHT) acknowledges that the City of Greater Sudbury is settled on the ancestral lands of the Anishnaabe peoples, and within Robinson-Huron Treaty Territory (Treaty 61, 1850). We recognize these lands as the traditional territory of the Atikameksheng Anishnawbek and Wahnapitae First Nation. Further, we acknowledge the harms of colonialism and are committed to learning from, and working with these communities to improve reconciliation. We recognize that First Nation, Metis, and Inuit are distinct cultural groups, and have elected to use the term Indigenous to encompass these populations.

Additionally, our city and the surrounding areas are designated areas under the French Language Services Act, and we affirm the inclusive definition of Francophone (IDF). We are proud and privileged to live in and serve a community with rich cultural histories. We are committed to equitable access to culturally safe health care services, and being socially accountable to the population we serve, their experiences of health and well-being, and the realities of living in northern Ontario.

II ATTRIBUTED POPULAITON

Our OHT is based in the City of Greater Sudbury and is comprised of X members and supported by *Y* collaborating organizations. Greater Sudbury is located in the Sudbury-Manitoulin-Parry Sound (SMPS) sub-region and is the largest city in Ontario by land area, yet has low population density (50 individuals/km^2),[3] with some areas continuing to lack coverage for cellular connectivity and robust broadband internet access. The distances required for travel are often exacerbated by the demanding geography and sometimes dangerous winter weather, meaning timely and equitable access to care is a perennial challenge.

Our readiness self-assessment described that we would deliver care to the City of Greater Sudbury and its surrounding area. At that time, we were aware of neighbouring communities that were either developing their own self-assessments or not yet ready to commit to our OHT—choices that our OHT continue to respect. Our OHT is committed to collaborating with these communities and the ministry to ensure that all individuals and families in our region receive high quality integrated care from an OHT. In this application we continue to plan for Greater Sudbury and the surrounding areas. We recognize that there are many surrounding rural and unorganized communities that will be attributed to our OHT, and we are committed to supporting them.

The attributed population data provided by the ministry describe 181,376 individuals, 86.2% of whom are residents of Greater Sudbury.[4] These data indicate that no other community has more than 2% of its residents attributed to our OHT and, in fact, the next cumulative 4.8% of our attributed population is live across four communities—each of which is more than a 30 minute drive from Health Sciences North. The remaining 9.1% live across more than 16 communities, some of which are not located in our sub-region. Additionally, care type costing data describes OHT localization percentages for “GP physician fees” and “acute inpatient expenses” as 91% and 85%, respectively, with “physician specialist fees” being 76%,[5] suggesting that relatively high alignment with utilization. Therefore, we believe there is a high degree of alignment between our self-assessment and the attributed population data provided by the ministry.

III OPPORTUNITIES

[3] "Population and dwelling counts, for Canada, provinces and territories, and census subdivisions (municipalities), 2016 and 2011 censuses – 100% data". Statistics Canada. February 6, 2017. Retrieved February 8, 2017.
[4] Ministry data file for attributed population
[5] OHT Costing by care type for 65. Sudbury and Districts (.pdf)

We recognize the opportunity before us to improve the experience of care, health outcomes, system sustainability, and provider experience, and we are committed to working together to deliver a modern and high functioning health care system. In Year 1, we expect that persons living with dementia (PLWD) and their caregivers will experience better linkages between their primary care providers and other health services, as well as better coordination and navigation of those services.

We believe that future opportunities to improve the pillars of the quadruple aim are real and attainable. For example, purposefully integrated and team-based models of care that are linked to one's primary care provider have the opportunity to improve health outcomes. By removing barriers and silos that have traditionally separated our services, we will be better able to develop coordinated care plans, wrap care around individuals and their families, and complete "warm hand-offs." Further, integrated pathways and information systems ensure that navigating the system is easy and straightforward, and that one's information is always up to date and available.

Additionally, digitally enabled models of care and virtual services have the opportunity to dramatically improve access to care. This opportunity is especially impactful given that travel distances in Greater Sudbury are significant—and further exacerbated for those who rely on transit—and that winters are often long and marred by treacherous weather and driving conditions. Expanding these capabilities will drastically improve our ability to monitor individuals in their homes and to support virtual visits, where appropriate.

IV CHALLENGES

Fundamentally redesigning and modernizing our health care system will present real challenges to the full operationalization of the ministry's vision for OHTs. In the short term, many of these challenges will relate to improving trust, developing new ways of working together, and sharing information. For example, rearranging and redeploying resources to support our Year 1 goals will present challenges to maintaining existing levels of care outside our Year 1 population. Additionally, care pathways and processes will need to be revised to account for expanding teams, continuous improvement, and standardization. And, enhancing existing digital capabilities to enable cross-provider sharing, coordinated access and referrals, coordinated care plans, and patient portals will take time and require resources. Moreover, sophisticated population health initiatives and models of care will take time to develop, refine, and implement across our membership.

Long-term, we anticipate challenges endemic to system. For example, cascading new organizational cultures and ways of working together will require significant effort and support. As well, maintaining commitments and engagement throughout a long change management process will challenge our team's ability to onboard new members, as well as ensure comprehensive coverage of primary care for our attributed population. We further anticipate challenges collaboratively deriving a future end state governance structure that enables clinical and fiscal accountability for our attributed population. We recognize that robust change management and risk mitigation strategies will be required to support the journey towards maturity.

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

I YEAR 1

It is our plan in Year 1 to focus on persons living with dementia (PLWD) and a significant comorbidity. Generally speaking, this segment is estimated to be approximately 1,655 individuals, plus their caregivers.[6] This population segment was chosen because of the high degree of complexity inherent in the dynamics of a diagnosis of dementia and the impact of that care journey on one's family and loved ones. We recongizine the demographic imperative for improving "senior friendly care" strategies across our system and ensuring older adults are able to age in their place of choice for as long as they choose. In addition, we identififed PLWD as our Year 1

[6] Attributed population data file via MOH—CIHI health profile groups and costs.

focus because we are confident about our ability to develop system improvements to better support the experience of care for individuals, their familes, and health care providers.

II DEMOGRAPHICS

Of the total attributed population for Équipe santé Sudbury and Districts OHT (our OHT), individuals 65 years and older account for 19.4% of the population, with 86.2% of them living in the City of Greater Sudbury.[7] As the primary risk factor, age is a strong predictor of a diagnosis of dementia, and this risk is estimated to double every five years after the age of 65.[8] Recent prevalence estimates based on data from 2014 suggest that approximately 2.8% of females and 1.9% of males (ages 65 – 74), 11.6% of females and 10.4% of males (ages 75 – 84), and 37.1% of females and 28.7% of males (age 85 and older) live with dementia.[9] In fact, between 2010 and 2015, the prevelance of PLwD in the Sudbury-Manitoulin-Parry Sound (SMPS) sub-region increased grew by 16.5%.[10] Practically speaking, data provided by the Ontario Ministry of Health (ministry) estimate that approximately 2,342 individuals within the attributed population lived with a diagnosis of dementia in 2017[11] and, further, that approximately 1,655 of those live with "significant comorbidities".[12]
Therefore, we are presented with a clear imperative to design a seamless, integrated, and robust continuum of care that supports our aging population and their families.

III COSTS AND COST DRIVERS

Data provided by the ministry identify the most costly health profile group for our OHT to be individuals living with "dementia with significant comorbidities"—with annual costs estimated to be $68M.[13] These data also summarize that 79% of individuals in this profile group access hosptial services at Health Sciences North.

[7] Attributed population data file. Ministry of Health
[8] World Health Organization. Dementia: a public health priority [Internet]. Geneva, Switzerland: The Organization; 2012 [cited 2017 April]. Available from: http://apps.who.int/iris/bitstream/10665/75263/1/9789241564458_eng.pdf
[9] Alzheimer Society of Canada. Prevalence and monetary costs of dementia in Canada. Toronto. Alzheimer Society of Canada, 2016.
[10] Dementia Capacity Tool. (2018) Ontario Ministry of Health. Accessed October 17, 2019.
[11] Ministry of Health Attributed Population Data
[12] CIHI grouper data and costs estimates
[13] Population costing profile for 65. Sudbury and districts: Most costly population groups (2019). <pdf peach and blue>

IV HEALTH CARE STATUS AND NEEDS

Persons living with dementia and their caregivers are known to experience a fragmented health care system that complicates their journey and is frought with barriers and poor outcomes.[14] What is more, the number of caregivers of PLwD who experience distress is nearly twice that compared to caregivers of other odler adults (45% vs 26%, respectively), and when they present to hospital they "wait longer in emergency departments, are more likely to be admitted.[15] Worse, hospital admissions for older adults are associated with elevanted risks of poor outocmes, including falls <REF>, delerium <REF>, and deconditioning <REF>, among others.

Data compiled by the ministry to produce its dementia capacity tool estimate that nearly 62% of individuals in the sub-region live with at least one co-morbid condition, and that 1,120 receive "long-stay homecare" services. It is estimated that 48% of individuals have a distressed partner, [16] which is known to predict presentations to the emergency department and potential health events for the caregiver. <REF NEEDED>. As such, we know that high quality care for individuals living with dementia includes care and support services for their caregivers. [17] It has also been reported that dementia is underreported among community-dwelling older adults. [18] Therefore, although 1,655 is the best estimate currently available to our team, we know this number is higher than reported, and that a significant proportion of them have caregivers experiencing distress.

V SOCIAL DETERMINANTS OF HEALTH

People living in northern Ontartio experinece health inequities compared to the rest of Ontario, including: lower life expectancies, higher premature death rates, poorer access to primary care, higher unemoployment, and lower levels of education. These inequiteies are exacerbated for Francophone and Indigenous peoples.[19] In the SMPS sub-region, it is estimated that 11.3% of individuals 65 and over are living below the low-income measure (LIM-AT)[20], and further that 27.3% of older adults live alone.[21] Together, these realities further complicate barriers to access and navigation of health

[14] North East Dementia Strategy Final Report. (2018). Lough Barnes Consulting Group.
[15] Dementia in Canada: Summary (2018) Canadian Institute for Health Information
[16] MOH dementia capacity tool. (2018)
[17] Quality standard: Dementia – care for people living (2018) Health Quality Ontario (link)
[18] Sternberg et al. (2000). Undetected dementia in community-dwelling…
[19] Northern Ontario Health Equity Strategy (2018) Health Quality Ontario.
[20] NE LHIN Profile (2089). <confirm reference with Joan -> populatin profiles from BI site>

[21] <confirm title/reference with J Tonon> North East LHIN Environmental Scan. (2018).

services, which in turn increase challenges for PLwD and their caregivers.

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

I OVERVIEW

People living in Northern Ontario experience poorer health and greater health inequities compared with the rest of the province. Overall life expectancy is lower in the North[i],[22] and mental health and addictions, diabetes, and parental and child health are of particular concern[ii].[23] Poor health outcomes in the North are influenced by limitations to social and economic opportunities – income, housing, food security, education, childhood development, social supports, access to services in general, and access to services that are linguistically and culturally appropriate[iii][24]

People living in this region have shorter life expectancies and lower rates of health literacy. As a population, we demonstrate poorer health behaviours compared to the rest of Ontario—including higher rates of obesity (33% vs 20%), smoking (19% vs 12%) and consumption of alcohol (23% vs 18%). Additionally, we experience poorer health outcomes compared to the rest of Ontario, including higher rates of chronic diseases, such as COPD (7% vs 4%), diabetes (10% vs 7%) and high blood pressure (24% vs 18%).

II. INDIGENOUS PEOPLES

Approximately 12.5% of individuals living in the Sudbury-Manitoulin-Parry Sound sub-region identify as Aboriginal (i.e., First Nation, Metis, or Inuk)[25], and there are two First Nations that neighbour the City of Greater Sudbury: Atikameksheng Anishnawbek and Wahnapitae First Nation. Équipe santé Sudbury and Districts Ontario Health Team acknowledges that First, Nation, Metis, and Inuit are each distinct cultural groups—we have elected to use the term Indigenous to encompass these populations. Our OHT affirms Indigenous Peoples' rights to

[22] Statistics Canada, Canadian Vital Statistics, Death Database and Demographic Division, CANSIM table 102-4315. CANSIM table 102-4307.
[23] Booth, G.L., Lipscombe, L.L., Bhattacharyya, O., Feig, D.S., Shah, B.R., Johns, A., Degani, N., Ko, B. & Bierman, A.S. (2012). Diabetes. In A.S. Bierman (Ed.), Project for an Ontario Women's Health Evidence-Based Report, vol. 2, Toronto. Retrieved from http://www.powerstudy.ca/power-report/volume2/diabetes/; Institute of Clinical Evaluative Sciences (2015) The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Retrieved from https://www.ices.on.ca/Publications/Atlases-and-Reports/2015/Mental-Health-of-Children-and-Youth; Ward M.S., Sahai, V.S., Tilleczek, K.C., Fearn, J.L., Barnett, R.C., & Zmijowskyj, T... (2005) Child and Adolescent Health in Northern Ontario: a quantitative profile for public health planning. Canadian Journal of Public Health 96(4): 287-290;
[24] Health Quality Ontario. (2018). Northern Ontario Health Equity Strategy
[25] Environmental Scan (2018). NE LHIN.

self-governance and self-determination, as well as the First Nations Principles of Ownership, Control, Access, and Possession (OCAP™), and we support the principle of Indigenous health being in Indigenous hands.

We recognize that colonial practices have racialized and inflicted trauma upon Indigenous Peoples, and that this trauma has echoed through generations in First Nation communities causing the loss of culture and language, and driving severe health inequities.

II.a Wahnapitae First Nation

III FRANCOPHONE POPULATIONS

Our OHT is proud to work with—and learn from—the Réseau du mieux-être francophone du Nord de l'Ontario (Réseau), who has been a partner throughout our OHT's development. According to the 2016 census, and using the inclusive definition of Francophone (IDF), 23.1% of the population in the Sudbury-Manitoulin-Parry Sound sub-region are Francophone, totalling approximately 51,110 people. Importantly, 30% of these individuals are age 65 and older, compared to 20.7% for Non-Francophones population.

Francophones living in northern Ontario experience barriers to accessing care in French, and report feeling that they are in very good or excellent health less than Francophones in other parts of Ontario (45% compared to 62%, respectively).[26] Further, Francophones in our region have a poorer health status than Non Francophones, including a higher prevalence of arthritis (26.6% vs 22.9%, respectively), diabetes (11.4% vs 8.6%, respectively), heart disease (8.6% vs 7%, respectively), living with at least one chronic condition (48.7% vs 42.6%, respectively), and living with at least two chronic conditions (23.9% vs 20.5%, respectively).

IV MARGINALIZATION

Marginalized individuals living in poverty and precarious or unsafe housing often do not have good access to primary care. Many also have multiple, complex health and social care needs – making it challenging for them to manage their own health and well-being. In 2013, the Sudbury & District Health Unit (SDHU) published its report, Opportunity for All: The Path to Health Equity[v].[27] Drawing from 2006 Canadian Census data, results of the Canadian Community Health Survey and hospital utilization data, SDHU was able to demonstrate significant health inequities experienced by residents of Sudbury's least advantaged neighborhoods (including Sudbury's downtown core). Most significantly:

- The rate of emergency department visits (all causes) was 71% (or 1.7 times) higher than in less deprived areas;
- The annual rate of emergency department visits for mental health was 341% (or 4.4 times) higher;
- Infant mortality rates were 139% (2.4 times) higher;

[26] Northern Ontario Health Equity Strategy. (2018). Health Quality Ontario
[27] Opportunity for All: The Path to Health Equity. (2013). Retrieved October 17, 2019 from: https://www.phsd.ca/resources/research-statistics/health-statistics/opportunity-path-health-equity-highlights/opportunity-path-health-equity-report

- The rate of hospitalization due to intentional self-harm was 242% (3.4 times) higher.

Additionally, people residing in Sudbury's most deprived areas were less likely to have access to a regular medical doctor and less often rated their own health as excellent or very good. The Community Mobilization Sudbury (CMS) partnership also collects and regularly reports data related to the health and well-being of residents in the City of Greater Sudbury. Specifically, CMS data enables us to better understand the risk factors present in situations involving significant and imminent risk of harm. Between May 6, 2014 and December 21, 2017, the CMS Rapid Mobilization Table responded to 343 situations of "acutely elevated risk", (i.e. a situation where there was an imminent and significant risk of harm that required the support of three or more agencies/sectors).

People living in Northern Ontario face significant challenges to their mental health. A variety of factors are understood to contribute to this, including economic barriers, geographic isolation, cultural and language barriers for Francophones, and for Indigenous people, intergenerational and current trauma due to discrimination and discriminatory policies[iv].[28]

[i] Statistics Canada, Canadian Vital Statistics, Death Database and Demographic Division, CANSIM table 102-4315. CANSIM table 102-4307.
[ii] Booth, G.L., Lipscombe, L.L., Bhattacharyya, O., Feig, D.S., Shah, B.R., Johns, A., Degani, N., Ko, B. & Bierman, A.S. (2012). Diabetes. In A.S. Bierman (Ed.), Project for an Ontario Women's Health Evidence-Based Report, vol. 2, Toronto. Retrieved from http://www.powerstudy.ca/power-report/volume2/diabetes/; Institute of Clinical Evaluative Sciences (2015) The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Retrieved from https://www.ices.on.ca/Publications/Atlases-and-Reports/2015/Mental-Health-of-Children-and-Youth; Ward M.S., Sahai, V.S., Tilleczek, K.C., Fearn, J.L., Barnett, R.C., & Zmijowskyj, T... (2005) Child and Adolescent Health in Northern Ontario: a quantitative profile for public health planning. Canadian Journal of Public Health 96(4): 287-290;
[iii] Health Quality Ontario. (2018). Northern Ontario Health Equity Strategy.
[iv] Northern Policy Institute. (2015). Access to culturally appropriate care for physical and mental health. http://www.northernpolicy.ca/healthpolicypriorities2
[v] Opportunity for All: The Path to Health Equity. (2013). Retrieved October 17, 2019 from: https://www.phsd.ca/resources/research-statistics/health-statistics/opportunity-path-health-equity-highlights/opportunity-path-health-equity-report

[28] Northern Policy Institute. (2015). Access to culturally appropriate care for physical and mental health. http://www.northernpolicy.ca/healthpolicypriorities2

Ontario Health Teams
Full Application Form

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[29]	Number of Physicians	Number of Physician FTEs	Practice Size	Other
*Provide the name of the participating physician or physician group, **as registered***	*Please indicate which practice model the physician(s) work in (see*	*For participating physician groups, please indicate the number of*	*For participating physician groups, please indicate the number of*	*For participating physicians, please indicate current practice*	*If the listed physician or physician group works in a practice*

[29] 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.

with the Ministry. *Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table.* *Physician* ***groups*** *should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire group practice is not, then provide the name of the participating physician(s and their associated incorporation name).*	*footnote for list of models)*	*physicians who are part of the group*	*physician FTEs*	*size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.*	*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).*
See supplementary Excel spreadsheet -					

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

Name of Organization	Type of Organization[30]	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

I DEVELOPMENT AND MEMBER IDENTIFICATION

Our OHT has been inclusive and welcoming to agencies across the health system and across our region, and we have strived to be purposeful and transparent in our communication and planning. The development of our OHT began with a broad invitation to participate initiated during the self- assessment process. Following the self-assessment, # organizations who had signed on as "members" or "informants" met again in August 2019 and through a plenary discussion began to draft guiding principles, a project structure, and determined that it was critical to confirm the Year 1 population as an initial step. Doing so would allow each agency to better understand their role as either a "member" or "collaborating organization" in the Year 1 service redesign and implementation.

A second plenary event on August 26th resulted in # collaborating organizations prioritizing Year 1 population options and deciding to focus on integrated care for PLwD. This process also provided guidance on future populations for development of integrated care beyond Year 1. The year 1 population definition and determination of the change to how care is delivered provided the basis of determining whether membership gaps existed for year 1. Next, a survey in early October provided

[30] 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

collaborating organizations the first opportunity to self-identify as members or collaborators for the full application. This was cross-referenced with the members from the self-assessment, and membership or collaborating organization participation was confirmed at a final plenary event on November 25th.

II INDIGENOUS AND FRANCOPHONE PEOPLES

Our OHT's attributed population includes a significant Indigenous population, and Greater Sudbury neighbours two First Nation communities: Atikameksheng Anishnawbek and Wahnapitae First Nation. Both communities participated in the process to complete our readiness self-assessment, and Wahnapitae First Nation has actively participated throughout the development of the full application. Our OHT recognizes the right to self-governance and self-determination of Atikameksheng Anishnawbek and Wahnapitae First Nation, and their right to define their relationship with Équipe santé Sudbury and Districts OHT. We acknowledge that this relationship building will require ongoing dialogue with our OHT's leadership and for the communities to determine the approach best-suited to developing a relationship with our OHT. Many of our OHT members and collaborating organizations will continue to develop and maintain strong working relationships with First Nation and Indigenous communities and service providers.

Additionally, it is important to note that our OHT serves a significant Francophone population. Two Francophone primary care organizations, the Centre de santé du Communautaire du Grand Sudbury and Centre de santé de Sudbury-Est, have participated throughout our OHT's development. These organizations remain identified as collaborators. Among our members, X are designated and Y are identified under the French Language Services Act, and we are committed to improving equitable access to services and improved outcomes for Francophones.

III CHALLENGES TO MEMBERSHIP

The main challenges to membership lie in primary care participation beyond the three large primary care organizations, one urgent care group, and two Nurse Practitioners Lead- Clinics (NPLCs). Smaller primary care groups have been more difficult to engage in OHT development given the number of individual providers. Our OHT has therefore focused its initial effort on larger groups of physicians. This gap in primary care participation translates to approximately 40% of the attributed population and will require focused attention to close in future years to achieve comprehensive primary care coverage at OHT maturity. Delaying this recruitment of primary care beyond Year 1 will provide the opportunity to demonstrate to primary care providers the value proposition of the OHT through positive outcomes.

Overall, our team is well positioned to care for the Year 1 population with primary care coverage of approximately 60% of the attributed population ~60%, however the gap in

primary care coverage at maturity will need to be closed to ensure comprehensive coverage. Despite this gap in primary care membership it is anticipated that many of the care integration improvements will be transferrable to patients of non-member primary care providers.

The OHT has the advantage for the Year 1 population of significant proportion of primary care involvement, and a broad representation of relevant specialty services. For the population at maturity, the main advantage is a significant population with little out migration to other locations and providers, other than for some subspecialty care.

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

Examining our relationships through the lens of integrated care, shared accountability, and value-based health care and population health, we have gathered close to 100 examples of collaboration. All of our team members have worked with at least one other member and some dozens of other members. Besides specific projects, many of our team members also sit on local and regional planning tables including ones focused on palliative care, long term care, home and community care, mental health and addictions, rapid access medicine, non-urgent patient transportation, patient-flow through acute care hospitals, rehabilitation care, falls prevention, dementia strategy, diabetes care, and stroke care.

Below are some examples of our work together to improve the patient and client experience:

I HOME AND COMMUNITY CARE PROJECTS

I.a ONE CLIENT ONE PLAN (OCOP)

PARTNERS: 69 NE LHIN-funded providers, including members: Alzheimer Society, Independence Centre and Network (ICAN), March of Dimes Canada (MODC), Victorian Order of Nurses (VON), Canadian Red Cross (CRC), as well as the North East Local Health Integration Network (NE LHIN) Home and Community Care (HCC), and RMEFNO

ABOUT: Started in 2018, the purpose of OCOP is to transform community support services (CSS)_and NE LHIN HCC into one cohesive home and community care system that enables a “no wrong door” approach to accessing services and supporting cross-provider information sharing, communication, and referrals. Once fully implemented, an individual will tell their story once and add to it as their needs change over time. Further, OCOP will enable individuals to make informed decisions about their care and improve the overall client experience. Its scope includes developing a single point of contact and single assessment, standard processes to navigate and coordinate services.

OUTCOMES: This project is currently being implemented, with a targeted “go live” date of <Month/Season YEAR>.

I.b NEIGHBOURHOOD MODEL OF CARE:

PARTNERS: NE LHIN HCC, VON, MODC, CRC, Manitoulin Sudbury District Services Board, Capreol Non Profit Housing Corporation

ABOUT: This initiative will support older adults to age in place by embedding care

coordinators from both NE LHIN HCC and the host in a seniors' social housing building. Across the region, both urban and rural models have been implemented, with one coming to the community of Capreol in the City of Greater Sudbury by <DATE>. Once operationalized, both clients and non-clients of health services will receive health literacy supports, as well as help accessing and navigating the health care system.

OUTCOMES:

I.c REGIONAL ASSISTED LIVING STANDARD OPERATING GUIDELINES

PARTNERS: VON, Aide aux Séniors / Sudbury East Seniors Supports (SESS), MODC, CRC, NE LHIN HCC, ICAN, Finlandia, Ukrainian Seniors Center

ABOUT: Published in 2019, the standard operating guidelines (SOG) articulate the best practices for the delivery of assisted living services. These SOG summarize standards for LHIN-funded agencies and include compliance check resources to support agency audits.

OUTCOMES: The finalization and implementation of the SOG occurred in 2019, with compliance checks now completed and services developing work plans to ensure compliance. The SOG are expected to standardize access to and delivery of assisted living services, including funding and performance levels.

II PRIMARY CARE COLLABORATIONS

II.a DIABETES CARE

PARTNERS: Health Sciences North (HSN), Sudbury District Nurse Practitioner Clinics (SDNPC), NEOMO, City of Lakes FHT, Capreol NPLC

ABOUT: Delivering diabetes care program a shared care model with the HSN diabetic care services nurse providing care in the primary care setting on a monthly basis or through consultation to manage complex diabetic patients.

OUTCOMES: # of clients have received care through this model since ??

II.c PRIMARY CARE MEMORY CLINICS

PARTNERS: North East Specialized Geriatric Centre at Health Sciences North (NESGC), Alzheimer Society, NE LHIN HCC, <list participating primary care providers>

ABOUT: Primary care memory clinics are a shared care initiative that build capacity among primary care providers to better support PLwD in primary care The physicians that attend the training, dedicate 1-2 days per month to completing these memory clinics. In 2018, the Memory Clinic model shifted to Multi – speciality INterprofessional Team-based (MINT) memory clinics . The two existing Primary Care Collaborative Memory Clinics in Sudbury ended service. MINT clinics are embedded them within North East Specialized Geriatric Centre. MINT clinics consist of an expert team of trained primary care physicians as well as clinicians from Specialized Geriatric Services, Alzheimer's Society and NE LHIN Home and Community Care. This team works closely with specialists in geriatric medicine, geriatric psychiatry and cognitive neurology.

OUTCOMES: This MINT model delivers early assessment, diagnosis and treatment to 180 patients with cognitive impairment per year within the Sudbury area. Additionally, this decreases the demands on the NESGC Geriatric Medicine Service (redirecting 25% of referrals) and allow high risk vulnerable patients to be seen sooner.

II.d PRIMARY CARE AFTER HOURS COLLABORATION

PARTNERS: Physicians participating in the NEOMO and Dr St.Martin groups collaborate to provide rostered patients with after-hour care in one centralized location.

OUTCOMES: The goal is to reduce the duplication of work, walk-in clinic access and non-urgent emergency department visits.

II.e CARE COORDINATOR EMBEDDMENT AND OPTIMIZATION

PARTNERS: NE LHIN HCC, City of Lakes Family Health Team (COLFHT), NESGC, Northeastern Ontario Medical Offices (NEOMO)

ABOUT: Since January 2012, the NE LHIN has strived to forge stronger collaborations between NE LHIN HCC care coordinators and primary care teams to better support efficient care coordination and improved navigation and transitions with other health services. The COLFHT was one of the early adopter teams, and the model has since spread to several other primary care teams across the NE LHIN region, including embedment with NESGC in 2013 to support older adults with complex health needs.

OUTCOMES:

II.f GREATER SUDBURY HEALTHLINK
PARTNERS: Canadian Mental Health Association-Sudbury Manitoulin, Centre de santé

communautaire du Grand Sudbury, Greater Sudbury Paramedic Service, City of Lakes Family Health Team, Community Living Greater Sudbury, Greater Sudbury Police Services, Health Sciences North, Monarch Recovery Services, North East LHIN Home and Community Care, North East Behavioural Supports Ontario, North Eastern Ontario Medical Offices, Northern Initiative for Social Action, Réseau ACCESS Network - HIV/Hepatitis Health and Social Services, Sudbury Community Service Centre, Sudbury and District Health Unit, Sudbury District Nurse Practitioner Clinic

ABOUT: The Greater Sudbury Health Link (GSHL) sought to improve the well-being of Sudbury residents who require a wide range of services and supports. This includes individuals who are challenged by multiple chronic conditions, mental illness, addictions, developmental disability and poor access to the social determinants of health, (e.g. income, housing, social supports). The Greater Sudbury Health Link brings individuals together with their full team of health and community service providers. They work together to identify each individual's unique care goals and make plans to achieve them. Members of care teams may include primary care providers, specialists, allied health professionals, community health and social service providers and other informal caregivers.
Lead Care Coordinators were established as the first point of contact for individuals who have questions about their care plans. Coordinated Care Plans were developed so that all providers had access to the most current information about an individual's health, treatments, care team members and goals.

OUTCOMES:

III ACUTE CARE AND CHRONIC CARE

III.a COMMUNITY PARAMEDICINE PROGRAM
PARTNERS: City of Greater Sudbury Emergency Medical Services; HSN; NE LHIN HCC

ABOUT: The Care Transition Program is a partnership designed to help patients who have been discharged from the hospital and have a high probability of being readmitted live independently and retain their quality of life. As part of the program, community paramedics visit patients in their homes to help them manage their health. Most participants have one or more chronic diseases that they need help managing, and paramedics support education and health literacy, care plan reinforcement, and medication compliance. Remote monitoring is a keystone of the program and paramedics are able to conduct unscheduled visits when patients' symptoms worsen and provide them with treatment that can decrease visits to the hospital.

OUTCOMES: The Community Paramedicine Care Transitions Program showed to be highly cost effective reducing the total cost per care per patient by 50%. Statistically significant reductions in the number of admission and hospital bed days at 3, 6, and 12

months. Statistically significant reduction in emergency department use in the 3 month intervention period

III.b PRIORITY ASSISTANCE TO TRANSITION HOME (PATH) PROGRAM

PARTNERS: HSN, Canadian Red Cross

ABOUT: Path supports older adults being discharged from hospital with the transition back to their home. The scope of services offered include transportation from hospital, assistance acquiring prescriptions, settling in at home, preparing meals, housekeeping, and additional referrals to other home and community care services.

OUTCOMES:

III.c JOINT ASSESSMENTS AND BUNDLED CARE
PARTNERS: HSN, NE LHIN HCC, St Joseph's Continuing Care Centre of Sudbury (SJCCC).

ABOUT: HSN has led the north east in the implementation of the bundled care model and the management of its resources by promoting greater integration in care delivery. This program drives high-quality, efficient care, and improves the experience of care and clinical outcomes throughout the individual's journey, from the decision to treat to the end of the post-acute rehabilitation phase. The model utilizes gain/risk pricing to ensure quality care is delivered to patients undergoing total joint replacement and, as a result of this experience, HSN is in a strong leadership position to implement the bundled care models for both the stroke and coronary artery bypass graft pathways, as well as developing future models.

IV MENTAL HEALTH FOCUSED PROJECTS

IV.a MENTAL HEALTH AND ADDICTIONS SYSTEM PRIORITY ACTION TABLE
PARTNERS (*OHT Year 1 members): Behavioural Supports Ontario – Seniors Mental Health (North Bay Regional Health Center), Canadian Mental Health Association-Sudbury/Manitoulin, Centre for Mental Health and Addiction, Child and Family Centre, City of Greater Sudbury, Conseil scolaire catholique du Nouvel-Ontario, Conseil scolaire public du Grand Nord de l'Ontario, Espanola Regional Hospital and Health Centre, Greater Sudbury Police Service, Health Sciences North*, Human Services & Justice Coordinating Committee, Manitoulin-Sudbury District Social Services Administration Board (MSDSAAB), Ministry of Children and Youth Services, Ministry of Children and Youth Services Youth Justice, Ministry of Education, Monarch Recovery Services, Noojmowin Teg Health Centre, North East Local Health Integrated Network*, Northern Initiative for Social Action, Public Health Sudbury & Districts, Rainbow District School

Board, Shkagamik-Kwe Health Centre, Sudbury Catholic District School Board, Sudbury Counselling Centre, Centre de santé Univi Health Centre (CSUHC)

ABOUT: Formed in 2017, the table brings together health care, police, education, social services, the municipality, mental health advocates, addiction services, justice, people with lived experience, and others to put real issues on the table and take concerted actions to address them. One example of success is how the table worked with HSN to reduce mental health-related emergency department visits by implementing revised work standards enabling a simple pathway to a key community's rapid mobilization table led by CMHA.

IV.b RAPID MOBILIZATION TABLES

PARTNERS: Alzheimer Society, BSO, Children's Aid Society, City of Greater Sudbury, CMHA-S/M, CGS Paramedic Services, Greater Sudbury Police Service, HSN–MHAP, Homelessness Network, MSG – Adult Probation & Parole, Monarch Recovery Services, NE LHIN Home & Community Care, N'Swakamok Native Friendship Centre, MAG – Office of the Public Guardian & Trustee, MCCSS – Ontario Disability Support Program, Réseau Access Network, SACY, Sudbury & Area Victim Services, Sudbury Community Service Centre, Sudbury Counselling Centre, Sudbury District Nurse Practitioners Clinic, MCCSS – Youth Probation, RDSB, CSCNO, CSPGNO, Sudbury Catholic School Board

Sudbury East Partners: Some of the same agencies at RMT, and includes OPP, Centre de Santé Univi Health Centre, Aide aux Séniors de Sudbury East/Sudbury East Seniors Support

ABOUT: GREATER SUDBURY-Community Mobilization Sudbury (CMS) is a partnership representing over 25 agencies from diverse community sectors – health, children's services, justice, education, mental health and addictions, and social services. Working together, our Mission is "leading and connecting for improved community well-being through proactive collaboration and response." One aspect of the CMS program is the Rapid Mobilization Table (RMT). Representatives from partner agencies meet twice each week to collaboratively identify situations that place Sudbury residents at high risk of harm. All necessary partners then plan and participate in a timely, coordinated response – connecting those at risk with the services and supports that can help. Data collected at the RMT is used to identify trends, common risk factors and potential gaps in community services. This information is shared with leaders and stakeholders in order to inform community planning and decision-making.

SUDBURY EAST: recently launched in fall 2019, the Sudbury East Mobilization Table has developed an ad hoc model based on key learnings from Greater Sudbury to provide the situation table model of care to residents in Sudbury East. Canadian Mental Health Association-Sudbury/Manitoulin is lead agency for both Greater Sudbury and Sudbury East situation tables.

OUTCOMES: 253 referrals brought forward in 2018 and 244 (96%) met the threshold of acutely elevated risk. An average of 10.8 risk factors were identified per discussion, with an average of 8 agencies involved in response. Mental Health was the most frequently identified risk category, occurring in 96% of discussions, followed by Antisocial/negative behaviour (75%), Drugs (64%) and Basic Needs (62%). 201 individuals were identified to have been helped by RMT interventions. Between May and August of 2018 33 referrals from HSN resulted in a 68% reduction in ED visits, 71% reduction in Community Mental Health Crisis Visits and 56% reduction in Withdrawal Management service visits.

IV.c HARM REDUCTION HOME

PARTNERS: CMHA, Sudbury NPLC, Centre de santé communautaire du Grand Sudbury, City of Greater Sudbury

About: A program of the Canadian Mental Health Association-Sudbury/Manitoulin, the Harm Reduction Home (HRH), has been operating for two years and supports individuals who are homeless or at risk of homelessness and who are also impacted by alcohol dependence. The HRH Residential Program provides access to a managed alcohol program (MAP) where individuals are supported with housing and addressing primary care and mental health needs. Individualized care planning assists individuals to work towards personal goals and enhanced overall wellbeing through a person-centered approach that meets them where they are at. The HRH employs a multidisciplinary team which includes Nursing staff, Residential Workers, an Indigenous Social Worker, a Case Manager, and a Life Enrichment Worker. The HRH will be moving to its permanent location at 200 Larch St. in the new year. The completed building will provide a permanent location for the Off the Street (OTS) Emergency Shelter, Harm Reduction Home, Sudbury District Nurse Practitioner Clinics' third location.

OUTCOMES: The Harm Reduction Home began as a day program and transitioned to a residential program in April 2018. In 2016, comparing the nine months before and after HRH admission, ED visits dropped from 215 to 32, this is an estimated cost savings to the system of $50,000. The rate of hospitalization for the individuals utilizing the program also declined going from 32 times admitted to 15 times and mental health outpatient presentations from 390 visits reduced to 32 visits within this same timeframe. Additionally, there was a 41% decrease in police encounters from 2015 vs. 2016 and a 38% decrease in arrests. The HRH currently houses 7 individuals and has the capacity for 8. Once construction at 200 Larch St. is complete, the program will be able to accommodate 15 individuals

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

There is high alignment between the current membership and existing provider networks and care patterns that were reinforced in the attributed population data. The data described in Section 1.1 reveal that the attributed population data provided by the ministry describe a total attributed population of 181,376, of which 86.2% are residents of Greater Sudbury.[31] Additionally, the data describing OHT costing by care type describe OHT localization percentages for "GP physician fees" and "acute inpatient expenses" as 91% and 85%, respectively, with "physician specialist fees" being 76%,[32] suggesting that relatively high alignment with utilization patterns and proportions of our attributed population already receiving these services from our members.

This high alignment applies to both the Year 1 population and the population at maturity. This is largely driven by a geography where out-migration to other primary care, home care, community care, rehabilitation, long-term care and acute care is limited by distance to the nearest available alternative. The data provided support a focus on the population of people living with dementia which may have resulted in some self-assessment members choosing not to participate in the OHT as actively in the Year 1 development due to limited relevance to their focus of services. Comparing the final application to the self assessment there are x members who are no longer members and Y members who have been added.

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

[31] Ministry data file for attributed population
[32] OHT Costing by care type for 65. Sudbury and Districts (.pdf)

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 – populate from survey; cross reference to self-assessment;			

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 – populate from survey; cross reference to self-assessment;		

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

The Year 1 population of 1,655 will be limited to Y% service to align with current primary care membership. Of the population served by the primary care members we anticipate that 90% of these patients—approximately XXX PLwD—will receive the planned integrated care services by the end of Year 1. This will be achieved by existing care coordinator capacity being associated with each primary care organization. It is expected that this level of uptake of integrated care will take time to achieve over the course of the first year as processes are refined, and providers and PLwD and their carepartners become accustomed to the change in approach to service provision.

Efforts will be made to make participation in the integrated model as seamless as

possible by reducing administrative barriers and supporting shared resources. In particular, maintaining as much consistency as possible with respect to care coordination will be pursued. Where this is not possible, warm handoffs between coordinators will reduce information transfer breakdowns. It is important to note that participation in elements of the integrated service model by PLwD and their caregivers is open to choice and a small percentage of the population may choose not to actively participate in the integrated model of care. Eligible PLwD and carepartners will be introduced early to the model of care and encouraged to actively participate through as few points of care coordination as possible.

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

Timing of phasing for expanded populations will be dependent upon progress with the Year 1 population. Priority populations for future years include people in the Year 1 population who may be underserviced as described in section 3.1. This includes Francophone, Indigenous, 2SLGBTQ and those unattached to a primary care provider.

In year 2, we will consider expanding an integrated and coordinated continuum of care to all individuals 65 and over living with comorbidities, such as congestive heart

failure (CHF) and chronic obstructive pulmonary disorder (COPD). The rationale behind this decision is to expand on the processes developed and key learnings from Year 1. In doing so we will continue to focus on a high priority population with high resource and acute hospital utilization that could be better served in the community. Expansion will require detailed assessment of readiness to expand based on capacity and progress in Year 1 to ensure a purposeful and iterative expansion of integrated care services.

Future members, collaborating organizations, and services that would need to be involved with the year two population include additional primary care capacity, as well as the HSN heart failure program, pulmonary function lab, pulmonary rehabilitation, respiratory therapists, cardiologists, respirologists, as well as community home oxygen companies.

In year 3 and beyond, we have identified adults with mental health and addictions as a key priority. The demand on our local system and poor outcomes for this population present a clear imperative for us to improve the health and well-being of our community and for making significant gains against the quadruple aim. In Year 3, we anticipate challenges expanding the number of our partners to include a significant number of new members, collaborators, and services that are not involved in Years 1 and 2. The rationale behind this decision is that this group has high acute hospital utilization and complex system navigation needs—inclusive of social services—and would be better served in the community. Our OHT anticipates the opportunity for significant improvements in experiences of care, health outcomes, and provider experiences. It is noted that ongoing work to improve the continuum of care for mental health and addictions will continue through Years 1 and 2, including current networks of providers, some of which are also Year 1 OHT members.

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

Our OHT has strived to include primary care providers throughout our readiness self-assessment and full application process. Ontario Medical Association (OMA) communication routes have been utilized by our OHT to reach primary care providers who have not yet been involved in the OHT development. Despite these efforts uptake from the full network of primary care providers has primarily been through large family health team (FHT), family health organizations (FHO) and nurse practitioner-led clinics (NPLC). Among primary care providers in Greater Sudbury, there are a number of solo physicians and smaller physician group within the larger network. It is anticipated that these providers will only be likely to join the OHT as the value proposition is demonstrated and governance is more clearly defined.

Primary care involvement will be expanded through purposeful engagement and meaningful opportunities for participation and leadership, and reinforced through demonstrated success

in each year of the maturing OHT. Success will be defined as improved access, ease of navigation, decreased hospitalizations, and overall satisfaction for patients and caregivers. For primary care providers, success is defined as improved workflows supported by care coordination and navigation, improved health outcomes, and improved provider experiences. As the model of care is developed and demonstrates success, continued connection to interested primary care providers will be achieved through our OHT's physician leaders and champions, as well as via OMA communication routes.

2.10. How did you develop your Full Application submission?

Describe the process you used to develop this submission. Indicate whether it was a 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/ontario32ollabo-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

I OVERVIEW

A plenary session in August 2019 with all organizations who participated in the self-assessment was used to develop the approach to managing completion of the full application. This led to formation of a temporary group of volunteers from collaborating organizations (the "planning team") who developed a project structure consisting of eight working groups—one associated with each section of the application which would report to a planning committee consisting of the working group chairs and ultimately to the collaborating organizations. Over ## people

participated in working groups from ## organizations. The work groups and their were supported by a secretariat consisting of an administrative lead (the local NE LHIN Director of Planning and Integration), a project manager (NE LHIN Project manager), communications lead (Alzheimer Society), and an administrative support staff member (Canadian Shield Health Care Services).

Collaborating organizations were asked to nominate members from their organizations to the working groups including identification of patient and family advisors and primary care providers. Patient and family advisors were considered critical in development of the application through a process of co-design. Additional patient and family consultation occurred through focus group session where members of the Alzheimer's Society <Family Council?????> provided advice on the design of the change to the model of care proposed in section 3. This information and feedback was provided to all working groups to consider in the development of their respective sections of the application. (insert summary as an appendix).

II COMMUNITY ENGAGEMENT

The participation of the Agente de planification et d'engagement communautaire, région de Sudbury Manitoulin Parry Sound Elliot Lake / Planning and Community Engagement Officer, Sudbury Manitoulin Parry Sound Elliot Lake region of the Réseau du mieux-être francophone du Nord de l'Ontario in several OHT working groups ensured that the needs of the Francophone population were being considered. Other working groups used a guide to developing OHT's provided by the Réseau du mieux-être francophone du Nord de l'Ontario aimed at ensuring
That French Language Services were being considered in planning by the OHT. (appendix FLS guide)

As a provider of Long Term Care, Paramedical services and social services the City of Greater Sudbury has been an active participant and member of the OHT development from its outset. This is particularly important given the year 1 population of people living with dementia and comorbid conditions where the City of Greater Sudbury already plays an important role through programs such as the community paramedicine program.

III FIRST NATIONS ENGAGEMENT

Our OHT affirms Indigenous Peoples' rights to self-governance and self-determination, as well as the First Nations Principles of Ownership, Control, Access, and Possession (OCAP^{TM}), and we support the principle of Indigenous health being in Indigenous hands.

Approximately 12.5% of individuals living in the Sudbury-Manitoulin-Parry Sound sub-region identify as Indigenous (i.e., First Nation, Metis, or Inuk)[33], and there are two First Nations that neighbour the City of Greater Sudbury: Atikameksheng Anishnawbek and Wahnapitae First Nation. Both Firest Nations have participated in the OHT self assessment and Wahnapitae First Nation has remained a participant in the full application development.

Member and collaborating organizations had the opportunity to comment of the final draft through a plenary presentation of the full application leading to a final signoff by collaborating organizations.

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

[33] Environmental Scan (2018). NE LHIN.

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

I OVERVIEW

Throughout the course of the dementia journey, people living with dementia (PLwD) and family caregivers[34] will need access to different health and community services at different times, and with varying intensity and frequency. Recognizing that care coordination and social service supports are critical to supporting PLwD and their caregivers, we are committed to defining new philosophy of care supports better experiences of care and outcomes. This new model is one of integrated, shared care and coordinated service delivery that promotes informational, care management and relational continuity. This is summarized as One Patient, One Record, One Number. As part of Year 1, we will start with two site team approaches (demonstrated pilots) leveraging existing best practices to test the model.

Implementing this change will require that:

[1] A clearly defined OHT care coordinator is identified for each patient and that this OHT care coordinator remains attached to the PLwD and their family through the duration of their journey.

[2] Roles and responsibilities, and news ways of working together are clear and respected among team members. To support this new model, OHT care coordinators will be embedded and empowered in the primary care system to further develop and deepen their relationships with primary care providers and the families they support. Functioning as empowered members of the primary health team, OHT care

[34] We will find an appropriate way include the following:
Here is the caregiver/care partner terminology content in the dementia care in the community QS (page 2):
In this quality standard, the term "caregiver" refers to an unpaid person who provides care and support, such as a family member, friend, or anyone identified by the person living with dementia.
In choosing this term, the lived experience advisors on our Quality Standard Advisory Committee also considered a number of other terms currently being used to describe this role locally, provincially, and internationally. These included "care partner," "informal caregiver," "family caregiver," "carer," and "primary caregiver."
We acknowledge that not everyone in this role may identify as a "caregiver." In addition, their role may change over time, especially as the person's dementia progresses and they require more assistance. Our choice to use "caregiver" does not diminish or negate terms that an individual may prefer.

coordinators will take on an enhanced role to support and coordinate the individual's experience across health services.

[3] Consistent and reliable methods of communication and collaboration will be established with PLwD and their caregivers and the health team to promote informational, care management, and relational continuity throughout their journey. We expect this new model of integrated care will reduce the incidence of "orphaned patients"—which often occurs when their primary care provider retires—because they will be connected with our OHT.

II PRIORITIES

Our priorities for Year 1 were determined by reviewing existing planning documents, including the North East Dementia Strategy and ministry's dementia capacity planning tool. The OHT work group that developed the content for this section included primary care providers and patient and family advisors, as well as health service providers from across the continuum of care who participated in visioning, theming, and systematic priority setting. Additionally, we engaged with a focus group including 17 PLwD to further inform the priorities we have defined for Year 1.

In Year 1, our OHT has identified four key performance improvement opportunities, including:
[i] Improving Care Transitions
[ii] Timely Access
[iii] Care coordination
[iv] Patient and family engagement, and partnership

To support the achievement of these priorities, we have planned a three-phase approach to implementing of this model, which is described below.

Phase one will include:
a) improving transitions and streamlining collaboration;
b) improving timely access to care;
c) improving care coordination, dedicated resources, best practice, and learning;
d) improving engagement with people with lived experience and PLwD; and
e) improving access for Francophones.

Phase two will include:
a) improving health literacy;
b) acute care;
c) electronic health records and a patient portal; and
d improving access for Indigenous Peoples.

Phase three will include:
a) improving transitions and coordination with long term care;

b) Mental Health and addictions;
c) primary care and orphaned patients,
d) 2SLGBTQ community; and
e) improving access for new immigrants.

<Reference PRIMARYCARE – HCC DIAGRAM as Appendix XX>

II.a Phase One

II.a.i IMPROVING CARE TRANSITIONS

We understand both the opportunity and imperative to improve care transitions for PLwD and their caregivers, and we are committed to improving this experience. The team will embrace emerging best practices[35] to support improving care transitions. Further we will examine the literature (Fancott[36], for example) to identify an experience of care tool that has been validated to measure care transitions from the perspective individuals and their families. Individuals and families will be engaged throughout health care planning, service delivery and throughout the care journey as partners in care. The expected outcomes from this will be streamlined transitions across all care services and services providers, leading to individuals receiving care at the right time in the most appropriate setting.

We plan to measure:
[i] Individual experience with care transitions. Our target will be 85% satisfaction with care transitions.

[ii] Proportion of individuals in Year 1 connected with in-home services within 24 hours following discharge from hospital. Our target is that 100% of our Year 1 population accessing integrated care will receive a phone call within 24 hours of discharge.

[iii] Proportion of OHT individuals in Year 1 who are reassessed by their primary care provider and care coordinator within 7 days of discharge from hospital. Our target will be a 15% increase from baseline. Baseline data will established via primary care providers, NE LHIN HCC, and Health Sciences North (HSN).

[iv] Utilization of respite services to support caregivers. Our targets include:
- 15% increase in referrals for respite care, from baseline.

[35] Quality standard: Transitions between hospital and home [Draft]. (2019). Health Quality Ontario. url: https://hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/transitions-between-hospital-and-home

[36] (Change Foundation 2011) that reviewed "Interventions and measurement tools related to improving the patient experience through transitions in care: A summary of key literature"

- 15% increase from baseline in referrals used.
- 15% decrease in cancelled/missed referrals, from baseline.

[v] We expect caregivers to feel better supported and less overwhelmed in caring for their loved ones. Caregiver distress will be measured using the Zarit Burden Interview. This will be measured at the beginning of an individual's OHT journey and again at 6 months. The target will be that caregivers report less distress.

<Reference NE Dementia Strategy Model of Care as Appendix XX>

II.a.ii TIMELY ACCESS

Our OHT is committed to timely access to the right care at the right time for the right purpose. Through improved role clarity, well-defined care pathways., and dedicated coordination resources for each individual, we expect to improve access to needed supports for PLwD and their caregivers. Expected outcomes from this are that patients will receive timely access to the right care, promoting optimal outcomes. This will be measured and monitored using the following indicators:

[i] Proportion of individuals who have access to same day/next day primary care appointments to address acute or escalating issues. The target is that 100% of patients will have access to same day/next day appointments.

[ii] Proportion of individuals receiving nursing and personal support services. The current goal is that individuals receive nursing and personal support services within 5 days 98.19% and 88.6% of them time, respectively.

III.a.iii CARE COORDINATION

We will improve care coordination through dedicated coordination resources, adopting best practices, and learning through continuous improvement. OHT care coordinators will be embedded with primary care providers to support the development of transdisciplinary teams and integrated care. Expected outcomes include dedicated care coordination resources that use best practice guidelines and learnings to provide care coordination that benefits the providers as well as the PLwD and caregivers. Our success will be measured using the following indicators:

[i] Proportion of individuals in the Year 1 population receiving services within the OHT care coordination model from any of the following team members: a care coordinator, system navigator, or primary care provider, depending on the individual's complexity. Our target is 100%.

[ii] Improved experiences of care for providers. We expect care provider satisfaction will increase as our team fully implements new models of when compared to current arrangements. Our target will be 80% satisfaction.

III.a.iv ENGAGEMENT WITH PLwD AND THEIR CAREGIVERS

Our OHT is committed to engaging with individuals and families, including as partners in care, partners in system planning, and partners in governance. Throughout their care journey PLwD and their caregivers will be equal members of the care team. We expect to improve experiences of care and health outcomes by demonstrating:
- 85% patient satisfaction with care transitions;
- 15% increase from baseline in referrals for respite care and referrals used;
- 15% decrease in cancelled/missed referrals; and
- a decrease in Zarit burden score between pre-post survey.

The expected outcomes are that PLWD and their caregivers will be engaged throughout health care planning, delivery, and throughout their care journey as an equal member of the care team (involved at all levels of OHT as a partner).

III.b PHASES TWO AND THREE

Once progress is made in Phase One, the team will shift its attention to further improving the health literacy of the individuals and caregivers it serves. Health literacy will be improved by embracing best practices and sharing learnings in the acute care environment, while collaborating with all efforts associated with advancing a region-wide Electronic Medical Record and patient portal (under development). The team has clearly indicated that there will not be a deliberate focus in the long-term care setting or with orphaned individuals who sit outside of the OHT in year one, or during the first few years of development.

<Reference to Appendix for phases>

We expect to leverage our current assets and service delivery features that are currently available in the Sudbury area through streamlined pathway development. In appendix XX is a more comprehensive list of all services available for this population.

All care and service arrangements are expected to be coordinated through the efforts of OHT Primary Care/ Care Coordinators. These include:

- Primary Care Collaborative Memory Clinics,
- Complex Care Coordination, currently embedded in Specialized Geriatric Services

and limited Primary Care settings,
- Adult Day and First Link® programs offered by the Alzheimer Society,
- Assisted Living for High Risk Older Adults
- Direct Access Pathways to the Geriatric Rehabilitation Unit at St. Joseph's Health Centre, and
- Respite Care provided in the community through in-home, short-stay and long-stay arrangements.

Sudbury's community paramedicine program pioneered the use of community paramedicine to provide outreach and acute care symptom management and will continue to be part of the service model in year 1. Community Support Services will contribute in the form of:
- Red Cross' PATH program (a priority assistance transition- to-home program),
- Transitional care beds provided by March of Dimes and ICAN,
- Home & community care coordination and rapid response nursing.

Where appropriate to match needs in the context of mental health comorbidity, Canadian Mental Health Association's (CMHA) case management and transitional support services and Northern Initiative for Social Action (NISA) older adult peer service will be leveraged. (NESGC) providing specialized geriatric services, are part of our current state assets and service-delivery model and will be engaged by OHT primary care and OHT care coordinators when appropriate, including:
- Regional Outpatient Geriatric Medicine clinics,
- Geriatric Outpatient Rehabilitation services (STAT),
- Geriatric Inpatient Consultation services (COACH),
- Seniors Mental Health Outreach Program and
- Geriatric Emergency Management (GEM) Nurses.
- Nurse-led outreach teams
- Primary care collaborative memory clinics
- Community-based Behavioural Support Ontario (BSO) Outreach workers
- Long Term Care BSO knowledge workers
- 8 Behavioural specialized support beds/units
- 15 Regional Specialized Dementia beds

Please refer to one page Outcomes, Priorities and Targets in Appendix XX

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

Our OHT believes in "the power of one," meaning that each individual will have one primary caregiver, one OHT care coordinator, one patient identifier, one care plan, one assessment, one data set, and one system. To support this transition, monthly case conferences will be scheduled to bring together OHT clilnical team members to review processes and engage in rapid learning and improvement. These case conferences will be an opportunity to review the care plans, as well as celebrate successes and re-evaluate care needs along the dementia journey. We will embed this case conferencing process witin our change management strategy to support the creation of new paradigms and support our new models of care.

In addition to these monthly case conferences, PLwD will have clinical reassessments according to Health Quality Ontario's (HQO) Dementia Quality Standards for People Living in the Community, which will inform the next steps in the care plan. As per HQO, "given the ongoing cognitive decline associated with dementia and the increased risk of people with mild cognitive impairment developing dementia, a comprehensive assessment should be performed when a person first exhibits or experiences changes in cognition, behaviour, mood, or function, and on a regular basis afterwards. The person and ideally their family, caregivers, and/or substitute decision-makers should be included in the assessment. The assessment should be culturally appropriate—respectful of diverse cultural, ethnic, and spiritual backgrounds—and in the person's language. A person living with dementia should receive a comprehensive assessment every 6 to 12 months, or sooner according to clinical need."[37]

PLwD and their caregivers will have access to a health care team with expertise in dementia. OHT clinical teams will be multidisciplinary and embrace the opportunity to draw clinicians and resources from across our members to support the goals of the care plan. Recognizing that the OHT is person-centred, PLwDs and their caregivers will also be treated as important members of the OHT health care team. This means all questions, concerns, observations and goals are discussed and will be incorporated into the care plan, and PLwD and their caregivers will be supported to play an active role in their own care. This means duplication will be eliminated and where possible, standardized tools put in place that will incorporate clinical judgment.

Each PLwD will have their own individualized care plan, giving careful consideration to the current state of care, which will determine where change needs to occur while also ensuring that we are leveraging existing programs utilizing best practice guidelines. We will ensure there are systems, processes, and resources in place to

[37] HQO Quality Standard url: https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/dementia

support clinicians to develop and regularly update individualized care plans, as well as to communicate care plans to others within their care team.

This team recognizes that the approach for the first year needs to be simple, utilizing a step cared approach so that we can ensure we are goal oriented and meeting the needs of our target population. We agree to be humble, honest and transparent. We will be data driven,utilizing both qualitative and quantitative data, meaning we will analyze the data collected to help us determine what is working and what potentially needs modification. We agree that accountability of performance is to be shared amongst all members of the OHT and look at how this accountability can impact equity. See attached Appendix XX for the agreed upon outcome measures and refer to outcomes listed in 3.1.

A key success factor of this program is to focus on providing support in navigation to PLwD and their caregivers. Programs such as the “Community and Health Services Navigation Program” (Cambrian College) become integral partners in supporting our target population. In addition, understanding the social determinants of health and wellness in partnering with the City of Greater Sudbury’s housing, social services, homelessness network and Public Health.
Our plan for Year 2 and 3 is to provide increased focus on Indigenous, Francophone and marginalized populations, bringing together health services providers and leaders in these areas to provide support to the OHT. It is believed this model of care is scalable for multiple populations especially as we embed the new philosophy of care.

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 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

I OVERVIEW

Équipe santé Sudbury and Districts Ontario Health Team (our OHT) recognizes that improved and redesigned care coordination is one of the key improvements required to deliver the quadruple aim for our system and attributed population. Notably, primary care providers will be crucial to implementing integrated care coordination that ensures health services needed to support one's care plan are customized and wrapped around PLwD and their caregivers. As our OHT matures and scales to deliver integrated care to our entire attributed population, embedded integrated care coordination will become the new standard. In fact, two examples of integrated care coordination already exist among our members/collaborating organizations: two care coordinators are embedded at the City of Lakes Family Health Team (COLFHT), and one care coordinator is embedded with North East Specialized Geriatric Centre (NESGC; a program of Health Sciences North [HSN]).

(reference NESGC Integrated model of care in Appendix XX.

II CARE COORDINATION IN YEAR 1

A demonstration of successful care coordination is when primary care providers take a leadership role in endorsing and advocating for this new philosophy of care. Indeed, it is our vision that care coordination will become an extension of primary care.
Our OHT has determined that the dementia service model for patient-centred care developed through the creation of the North East LHIN Dementia Strategy aligns well with the model we are working to develop for PLwD (see appendix X). PLwD will be

identified by their OHT primary care providers who will then connect that person to an OHT care coordinator. The OHT care coordinator will then meet face-to-face with the PLwD and their caregiver to review their care needs and define goals for their unique care plan. OHT care coordinators will arrange services to wrap care around the PLwD and their caregiver, as well as help navigate the dementia journey. As our digitally-enabled tools come online and our e-health strategy mautres, OHT care coordinators will also ensure all team members are informed, and that one's care plan and health status are up to date. Recognizing that the needs of PLwD and their caregivers vary throughout the dementia journey, OHT care coordinators will be aware of what resources and supports are available to PLwD and their caregiver during the span of the disease. The new pathway being desicribed to support our Year 1 population is depicted in Appendix X.

III CARE COORDINATION RESOURCES

As of November 2019, the number of individuals 65 years and older with a diagnosis of dementia and two or more comorbidities, and who are actively receiving NE LHIN HCC services is estimated to be 642. As PLwD with complexity require more services and time and attention to serve, current individual caseloads for existing NE LHIN HCC care coordinators range from 30 – 50 PLwD. Based on the North East LHIN Dementia Strategy, as well as consultation with PLwDs and recommendations from our OHT, we anticipate that each OHT care coordinator manage a caseload of approximately 40 PLwD to support achieving our desired outcomes. Consequently, we estimate that 16 OHT care coordinators will be required to support our YEAR 1 target population. However, consideration also has to be given that support for weekend, evenings and backfill for vacations is also required. Thus, additional CC resource will be required to maintain this level of coverage.

CURRENT HCC CC RESOURCES: (please refer to Chart XX in Appendix XX)
There are currently 2,925 adults and older adults on care in the Sudbury community (not including the Short Stay team). In addition, there are 163 palliative/End of Life (EOL) patients. Excluding this specialized palliative population, thus there are a total of 2,762 individuals being supported on a daily basis by Sudbury Community CC's.

There are a total of 39.5 HCC CCs in community. This number is excluding the 5 palliative specialized CCs. However, it is inclusive of our support CC resource such as our FT Mentor CCs, 3 "In person" CCs who are always in office and available for patient and service provider calls, as well as 2 Direct Referral CCs who see complex patients urgently and without and intake assessment. As well it also includes 3.5 FT Float CC resource who are available to patients for urgent face to face home visits.

Total 44.5 HCC CCs in Community	**44.5**
Less Palliative Specialized CCs	-5
Less Shared Support CC resources:	
FT Mentor CCs	-2
"In person" CCs	-3

Direct Referral CCs	-2
Float CC resources	-3.5
Available CCs	**29**

If we consider the total of active community patients: 2,762 minus the dementia population of 642, this would leave a total of 2,120 patients to be managed by the remaining 13 CCs. Current caseloads range from 80 – 120 patients per CC with an average caseload of 90 patients per CC. Without adding any additional CC resource and with significant caseload restructuring required, each CC would support approximately 163 patients each. This is not manageable nor realistic.

Also, in order to provide the CC team ongoing support, education and promote flexibility, it is recommended to continue to have 2 Mentor/educator CCs, 2 direct referral CC and 3.5 Float resource. However, the requisite resources to support the OHT CCs should be reviewed at maturity to ensure appropriate support is in place to ensure the proposed level of care for this target population is well supported and managed.

Today's Client Population (2762) less Dementia Patients (642)	**2120**					
Available CCs (29 – 16 to OHT team)	13					
New Caseload	**163**					
Resources Required @ 90 caseload (2120/90)	23.5					
Resource Gap (short term)	**10.5**	**Supports OHT Proposal + Continuity of Care for frail/elderly**				
Resources Required @ 40 caseload (2120/40)	**53**					
Resource Gap (long term)	40	**Supports OHT Proposal + Longer Term Population**				

		needs				

The above-noted estimate is based on the ability of each CC to manage a total of 90 patients each. NE LHIN HCC currently has 29 CCs available, but when taking into consideration the resources allocated to the OHT, this then decreases to 13. In turn this would increase their caseload to an unmanageable 163 patients each. Thus, to ensure we meet OHT expectations as well as continue to service existing demands for other populations served, the immediate resource gap is 10.5 resources.
It should be noted that this pertains to the existing overall target population being served by HCC, additonal work needs to be done to determine which new paitents will be added to phase one and which patients would be included in phase two. and beyond. It is expected as our OHT progresses with the inclusion of other older/frail patient populations, and with the goal of modelling our pilot population size of 40 patients per caseload, we would need significantly more CC resource (2,120 patients would need a total of 53 CCs).
At OHT full maturity, we estimate the need of approximately 29.5 more (40 less 10.5) OHT CCs. Thus, it will be imperative to explore alternative and supportive CC resources elsewhere within our partner organizations such as the Alzheimer Society First Link Care Navigators, Behaviour Supports Ontario (BSO) coordinator, and our Assisted Living providers care coordination resource.

Another resource is the Sudbury Access Team which has a total of 26 FT CCs who complete hospital resumes and new hospital and community referrals. As we transition to achieve the full benefits of our OHT, there will be less demand for embedded CCs in hospital, as resumes for active patients would be managed by their assigned Community or OHT CC. There are on average 300 hospital resumes monthly for active HCC patients. Thought has to be given that with our proposed model, there will be potentially 53 community CCs who will visit the hospital, transitional care, and slow paced rehab facilities at one given time. Logistics around parking, workspace etc. also should be considered and explored.

Lastly, there are on average a total of 1500 new community and hospital patient referrals received by HCC per month. Access CCs complete on average 3 new referrals per day, or 15 per week. However this may vary depending on complexity of the referral. Also on average, there are approx. 685 discharges monthly-this which is inclusive of all community home care patients (includes Short Stay and palliative). Reasons forThe patient discharge can include: completion of service plan, admission to LTC, dieddeath, client/family preference, etc. Thus, on a net basis, an average of 815 additional individual case files of varying complexity are opened per month. Furthermore, our population of older adults with frailty in the City of Greater Sudbury is estimated to be XXXX. Capacity planning for this population is imperative. Our conclusion is that while staff could be re-assigned, to serve our aging population, significantly more resources will be required over time.

Success of the coordination of care will be monitored closely to help us determine what is and is not working and determined by not only quantifiable statistics like key performance metrics but also through qualitative data like direct feedback from individuals receiving care and the staff providing the care.
The focus of care coordination for Year one1 population, persons living with dementia (PLwD) and their caregivers is focused on an integrated community model with primary care taking a leadership role in design and implementation. PLwD and their caregivers will be at the centre of the model with customized programs and services to meet their needs. The customized programs and services by multiple providers that have experience in the areas needing to be addressed, I.e Assisting, Living, Respite, Adult Day program, income support and more) Out of scope for Year 1 is long term care.(please refer to 3.1 for additional out of scope activities).

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

Patients should never feel lost in the health care system hey should be able to easily understand their options for accessing care and know where to go for the services required. 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

Persons living with dementia (PLwD) and their caregivers will have access to specialized and personalized system navigation services integrated with OHT care coordinators. This will provide PLwD and their caregivers with more comprehensive services to support them throughout their journey. There will be a suite of programs, that individuals will access based on their assessed needs. These programs will be adapted as PLwD progress on their journey. PLwD and their caregivers are provided with essential support services to assist them in navigating the health care system. Specialized system navigation further coordinates and integrates supports and services around the PLwD and their caregiver using a basket of services and community resources. Connecting Year 1 individuals between community and primary care will be an essential part of the design of evidence-based care pathways that will be used. System navigation also focuses on providing warm handoffs between agencies to better support those living the dementia journey.

The OHT care coordinator is a direct client service role—the key "go-to" person for families after a dementia diagnosis. Working with PLwD, coordinators will help identify needs, support self-management goals, and strengthen the communication and care planning linkages between services along the continuum of care. Care coordinators are experts at developing care plans, and they will support navigation by:

• Understanding the different stages of dementia and the appropriateness of related programs and services; (see diagram in Appendix XX)

• Having sound knowledge of available services within the OHT, including inclusion and exclusion criteria for services;

• Support the identification and delivery of culturally safe services for Francophone and Indigenous PLwD;

• Be an advocate for the target population;

• Determine the care needs, supports, and identify services required to support the care plan and the individual's wishes and goals;

• Monitor and adjust the care plan, as required, ensuring the clinical team are provided with up to date information on the individual's status; and

• Understand the social determinants of health and know how to work with marginalized populations.

PLwD will access the health system from any point, such as OHT primary care coordinator or other service providers. Therefore, one key to our success will be development of one record for every PLwD. We believe that by removing barriers and silos, integrated pathways, and information systems, with information that is update to date and readily accessible, will lead to a significantly improved experience for the PLwD, their caregiver and primary care providers. Further digitally-enabled models of care and virtual services will dramatically improve how care is accessed and delivered to individuals that are homebound and living in rural communities. Coordinated care plans are unique and evolve over time as one's health status and needs change. Providing comprehensive system navigation 24/7 will require that our OHT builds on systems already in place, including:

• Telehealth Ontario – a free, confidential service that connects persons with a registered nurse who can direct them to the most appropriate level of care or connect someone with a health professional who can advise on next steps; and

• North East Healthline – an online platform available to all that summarizes information about services available across the region.

Indeed, keeping individuals connected to their primary care providers will be an

essential part of our redesign. Evidence based care pathways will be used and alerts will be set up within the system (which is still to be determined) to ensure that all those involved in the care of the PLwD are kept up to date on the progress of the individual. The coordinator will focus on providing warm handoffs between agencies to better support PLwD and their caregivers to ensure seamless transitions throughout the dementia journey. Success will be monitored closely by relying on key performance metrics and feedback from PLwD and their caregivers to support rapid learning and improvement.

(see appendix XXX for targets and outcomes)

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

In order to improve care transitions, it is imperative for the OHT care coordinator to build a trusting relationship with the PLwD and their caregiver. While at times some of the discussions will be done via telephone, we will strive for each first meeting to be completed face-to-face, and that the coordinator and PLwD, as well as their caregiver meet physically at least annually. Care plans will be developed to meet the needs of the individual and reflect their health literacy, and be responsive to the moment, yet also be proactive to better support transitions in care.

Additionally, OHT care coordinators will have access to health records across systems to ensure care plans are current, and to further support warm handoffs, referrals, and supported transitions. Moreover, we are committed to implementing a portal where PLwD and their families can access their own health information and care plans, as well as self-management and education tools to support their own understanding and navigation of their care journey. Further, best practices identified for improving care transitions—quality standards[38], for example—will be embraced and implemented to support exceptional experiences of care and improved outcomes.

Regardless of where the person is along their journey or which service is required to meet their needs, our OHT is committed to “warm” handoffs to support PLwD’s care transitions. OHT care coordinators will work with PLwD and their caregivers to update care plans to revise goals of care, when required to ensure each person’s care plan is current, comprehensive, and reflects their current health status and place along their

[38] QHO Draft standard for transitions

journey. All services, both private and non-private, will be reviewed to ensure that adequate care is wrapped around the PLwD and their caregiver.
Currently in place, the OHT will have access to several different mechanisms already in place including the home and community care CHRIS system and Meditech to help with care transitions. However not all OHT partners have access to these systems. The team is currently reviewing options to determine a system that will best suit our needs. Finally, monitoring our performance supporting successful care transitions will be a focus of our performance measurement strategy.

3.4. How will your team provide virtual care?

The provision of one or more virtual care services to 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

Our OHT is committed providing health services and supports that are inclusive, respectful, welcoming, and culturally safe to meet the unique needs of PLwD and their caregivers. Currently there are several programs and services that are available in the community to support self-management and health literacy, and we intend to integrate and expand upon these

options. We have identified the HQO Quality Standards – Dementia Care for people living in the community[39] as a key resource to inform the improvement and evolution of our self-management and health literacy supports.

For example, one approach to self-management and health literacy improvement will be to promote the chronic disease self-management program to PLwD and their caregivers. This program provides a coordinated approach to support people living with chronic conditions with self-management education. In the program, workshops are provided in a standardized way following the best practice established by Stanford University. Further, we will also promote access to existing programs such as Mount Sinai's CARERS and TEACH programs that support co-creating with caregivers a solution-oriented care plan that facilitates the ability of client self-management where possible.

Other educational programs, will be incorporated int our suite of supports for self-management, health literacy, and group support, including:

• Alzheimer Society's First Link® Learning Series;

• Virtual dementia support offered by the Reitman Centre;

• Support groups for PLwD as well as for caregivers, and other peer-to-peer support and connections; and

• Educational training, such as the "Living the Dementia Journey" can enhance self-management and health literacy.

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

Équipe santé Sudbury and Districts Ontario Health Team (our OHT) recognizes the overwhelming contribution of informal caregivers to the health system, and that they deliver a significant proportion of care and services to their loved ones. We are committed to supporting caregivers. Indeed, well-informed and supported caregivers are not only to better able care for their loved ones, but also ensure their own health and well-being is not at risk.

Caring for a loved one living with dementia often results in the need for emotional

[39] HQO standard

support, strategies for care, and education, especially as many caregivers experience high levels of stress and the demand on their own health often becomes cause for concern. In Year 1, OHT care coordinators will work with caregivers of PLwD to ensure they receive timely access to, education, services, and supports. The OHT care coordinators will support warm handoffs for caregivers and will encourage self-management, where appropriate, and our future portal will provide navigation information about programs and services that caregivers can access.

In addition to individual education and support, caregivers will be provided with customized services that provide respite from the constant demands of providing care to a person living with dementia. Respite services provide assistance to both the PLwD as well as their caregiver(s), treating both as individuals who require their own unique support. The opportunities for physical activity and social stimulation made available through respite programs allow caregivers to focus on their own health and well-being, while connecting with others in similar situations and building an opportunity for shared experiences, thus creating a support network in their community. These services address a gap within our health-care system, assisting caregivers who are able and willing to support people living with dementia residing in their homes, but require occasional support. These services will include options, such as:

• Adult day programs;

• Recreation therapy;

• Support groups;

• In-home activation

• Health promotion programs; and

• Community-based activation.

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

In Year 1 we will assign a unique identifier to PLwD as they are identified, which will be shared among service providers to ensure that existing records are updated to flag these individuals as receiving integrated care from our OHT. In this way, clinical team members can work towards common care goals and support the care plan, regardless of where the individual presents for care. We expected that a common unique identifier will support creating electronic system alerts to notify providers about care transitions (e.g., visits to the emergency department, hospital admissions and discharges, and referrals to specialists). Each PLwD receiving integrated care will have a clear and documented plan of care that will be housed within their primary care provider's EMR and updated by the OHT primary care provider-care coordinator dyad. OHT care coordinators will play a central role maintaining the integrated care plan to minimize overlaps and duplication, and streamline the delivery of services to individuals. Building upon processes developed for HealthLinks, OHT care coordinators and OHT primary care providers will be given access to HSN's Meditech to attach relevant dictated notes and update care plans.

Currently, the HSN's Meditech system is due for a considerable upgrade including a patient portal. It currently interfaces with primary care EMRs through a physician office integration (POI) connection and also connects to NE LHIN Health Provider Gateway (HPG). In the next three years, it is expected that the HSN Meditech system will include ambulatory care and primary care modules, as well as a patient portal, providing the opportunity for all OHT care providers to come together into a single EMR. Until this time, however, OHT care coordinators will monitor the care journey of PLwD across these multiple systems to ensure a single plan is updated and available to all clinical team members. Furthermore, robust communication methods between providers such as secure texting and secure email will be used to keep care plans updated. Also, OHT clinical team members will identify Francophone clients from the very first point of contact to ensure services are actively offered at the initial greeting and at each subsequent point of contact. Data sharing agreements between all parties, including PLwD and their caregivers, will be developed to support new digitally-enabled models of care. Last, it should be noted that further discussion is required on how best to serve clients in the short term, overcoming privacy concerns until the EMR is available.

3.7. How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

Considering your response to question 1.3 and according to the health and health care needs of

your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

3.7.1. How will you work with Indigenous populations?

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

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

Max word count: 500

The City of Greater Sudbury is settled on the ancestral lands of the Atikameksheng Anishnawbek and Wahnapitae First Nation. These two First Nation communities neighbour the city, and we are confident that the population attributed to our OHT includes Indigenous Peoples living both within and outside these two First Nations.

Our OHT is committed to being socially accountable to the people that make up our attributed population, and we are committed to delivering culturally safe care to those people that access care. Further, we are equally committed to seeking and valuing community engagement and stakeholder participation to address the priority health concerns and health equity gaps of our attributed population and across our health system. This approach has underpinned the planning associated with our OHT, and local Indigenous health leaders have been invited to participate throughout our development. Both Atikameksheng Anishnawbek and Wahnapitae First Nation have attended a planning meeting, and Wahnapitae First Nation has participated across our work groups and in subsequent planning meetings.

In addition to these two First Nations, there are also two local Indigenous-led health services that receive funding from the NE LHIN and Ministry of Health: Shkagamik-Kwe Health Centre, an Aboriginal Health Access Centre, and N'Swakamok Native Friendship Centre. Each of these services have been invited to participate in the development of our OHT. Our OHT respects the rights to self-governance and self-determination, and we respect the involvement of these providers and communities. At the time of writing, each provider and community have expressed they are involved to the degree they wish to be.

Our OHT is committed to delivering culturally safe care, and all members are expected to participate in cultural safety education and training. The development of sharing circles with Elders and other learning forums will help influence and shape this work. Moreover, our OHT is committed to building trust with First Nations and Indigenous health providers to realize strong and robust partnerships that support Indigenous health. To foster this goal, we expect to learn by listening. We recognize that building relationships with Indigenous communities and organizations is best done from a position of humility. We express a genuine interest in working with First Nations communities

and their Elders learn how best to design and improve services for Indigenous persons living with dementia, particularly in the palliative phase of the dementia care journey. Finally, our OHT will:

• Provide the opportunity for individuals to self-identify as an Indigenous person and explore cultural offerings with them that meet care and treatment needs from a bio-psycho-social-spiritual approach framed by Medicine Wheel teachings

• Treat individuals and their care givers by respecting their wishes and preferences. This may include traditional healings and the involvement of large and extended families in their treatment plans

• Embed OHT care coordinators who possess specific Indigenous health and service system knowledge with primary care providers, and assign them to individuals and caregivers seeking culturally directed care.

•Ensure Indigenous PLwD care plans are culturally adapted to meet expressed preferences and needs.

• Involve Indigenous leaders and communities in the development and review of OHT policies and processes to ensure cultural relevance.

• Include Indigenous leaders in OHT governance.

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

Our OHT is embraces the strategic goals of population health and social accountability, and we are committed to seeking and valuing community engagement and stakeholder participation to address the priority health concerns and health equity gaps of our population. This approach has underpinned the planning associated with our OHT and, from the beginning, we have invited and involved broad participation from Francophone health leaders, including:

• Centre de santé communautaire du Grand Sudbury (Francophone community health

centre);

• Centre de santé Univi Health Centre (community health centre with a very high proportion of Francophones receiving care);

• Réseau du mieux-être francophone du Nord de l'Ontario (the French Language Health Planning Entity [Réseau]); and

• Francophone physicians, patients, and caregivers in work groups and planning meetings.

The City of Greater Sudbury and its surrounding communities are designated areas under the French Language Services (FLS) Act, and many OHT services and organizations are also designated, including 11 "designated" providers and 17 "identified" providers currently offering services within the Sudbury Manitoulin Parry Sound sub-region. Several of our members are already offering FLS following the active offer principle, and working diligently at identifying their Francophone clientele, engaging Francophones on committees—as well as on their board of directors and management team, monitoring the quality of their FLS through client survey and their FLS report, and working closely with the Réseau. Proudly, the proportion of bilingual employees within the NE LHIN-funded organizations (including designated, identified, and non-identified HSPs) in the catchment area exceeds the proportion of the Francophones in our attributed population.[40] Our OHT will leverage the existing capacity, tools, and resources among members to ensure that FLS are better integrated, coordinated, and made available within the integrated care model to ensure PLwD and their caregivers are supported throughout their journey.

We are committed to continued partnership and collaboration to improve actively offered, quality health services to Francophones. Our Ontario Health Team expects to:

• Ensure the capture of the linguistic identity of Francophone individuals from the very first point of contact and match them with health and social service offerings that meet care and treatment requirements in their language throughout their journey;

• Ensure that Francophone individuals are matched with care coordinators who serve them in French;

• Provide active offer of FLS that go beyond registration and reception, which functions and extends into all roles on the health team. that support Francophone

[40] Annual FLS reporting data. Réseau du mieux-être francophone du Nord de l'Ontario

PLwD and their caregivers to ensure access to quality FLS throughout the continuum of care;

• Development of an OHT FLS HR strategy;

• Ensure access to communications and documentation at a Grade 6 French level and check with PLwD and their caregivers regarding their comprehension of spoken interactions and written material;

• Adapt to new immigrant's Francophone linguistic needs (French as a second language);

• Use existing resources to improve active offer of FLS such as the Translation Network Program and the French Language Training Reimbursement Program;

• Complete the training on Active Offer of FLS;

• Involve Francophone leaders, PLwD, caregivers and communities in the development, implementation and review of OHT activities, policies and processes to ensure linguistic and cultural appropriateness;

• Ensure a representative proportion of Francophone leaders on OHT committees, governance and management; and

• Measure and monitor the improvement of the provision of actively offered FLS through the data collected in the FLS annual report (OZi) to ensure ongoing progress.

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

Given the social accountability and population health focus of the Greater City of Sudbury, Health Sciences North, Public Health Sudbury & District, the Northern Ontario Medical School, Canadian Mental Health Association, Francophone and Aboriginal community health centres (AHACs), and other community support services, significant work has occurred already in strengthening relationships among each other and with sub-populations, in particular the two-spirited and LGTBQ population, those with mental health and addictions issues and new immigrants.

Our OHT will not have exclusion criteria. Any person who meets criteria for the Year 1 population will be served by the OHT. This means the team will strive to recognize early, the diverse social determinants of health that OHT PLwD and their caregivers face and use existing data collection tools to assess the social determinants of health and socio-demographic factors. OHT Care Coordinators will be expected to identify all health and social barriers and work with existing community partners to address them. We currently have strong linkages for vulnerable populations through the following pathways:

1. Centre de santé Communautaire du Grand Sudbury serves many newcomers and immigrants who are French speaking as a second language after their mother tongue.
2. The Sudbury & District Nurse Practitioners Clinic works with unattached patients in the downtown core who are marginalized, including those with mental health and addictions challenges.
3. Health Sciences North, Reseau Access AIDS and the Canadian Mental Health Association (CMHA)have strong linkages with the LGBTQTBQ community.
4. Health Sciences North offers Rapid Access Addictions clinics and an Addictions consultation team.
5. Sudbury Multicultural Association.

Access to translation services (beyond French translation) will occur through existing channels in our post-secondary institutions as well as through the health and social service community of caregivers. Use of multi-lingual apps to assist with translation will support the OHT's work. Where possible, an effort will be made to match patients with resources that address their linguistic needs. Please refer to Chart of phase one, two and three in Appendix XX.

a. 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

The ESSD OHT believes patients and family advisors are integral to the success of this new model of care, and both were actively engaged in the development of this application. The partnership with patients, families and caregivers has been demonstrated through the membership and leadership on committees and through target focus groups. Throughout this whole OHT journey, we have been asking PLwD and their families and caregivers to provide input into each step we have taken knowing that we want to keep the PLwD at the forefront of this care. Our OHT will entrench the "Patient Declaration of Values" developed by the foundational Minister's Patient and Family Advisory Council. PLwD, their families and caregivers are partners and advocates, as such they will provide input in the development of our policies,

programs and hiring.
Many individual organizations already have in place Patient and Family Advisory Councils, thus we will establish one for the entire OHT. The PLwD and their caregiver(s) will be active members within our structure, from governance to program development and will be present as a partner throughout the organization from day one. Individual engagement will follow a defined framework that includes partnership on system level decisions, organizational improvements, and clinical care.

<Diagram. patient engagmenet XXX) Please refer to our Patent Engagement Diagram in Appendix XX.>

We will develop a local OHT Ombudsman who will be responsible for investigating, helping to resolve, reporting on and responding to complaints about the health care system made by PLwD and caregivers beyond the scope of care coordination. This position, reporting to the governance and advisory council, will make recommendations following investigations on a quarterly basis, thus ensuring continuous quality improvement.
By adopting one patient survey which crosses all sectors, we will embed quality improvement across our OHT.
As we move forward, we will remember “Nothing about me, without me.“
We have already started this process by partnering with PLwD, their Caregivers and families in the development of this OHT application. In addition, a focus group with PLwD and their caregivers was conducted to provide feedback on the Year 1 focus of this OHT application. Their feedback was incorporated in our submission.

Ontario Health Teams
Full Application Form

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 Ontario Health Team is committed to working together to improve the health and well-being of its attributed population and to build upon existing successes to forge new partnerships. Together, we recognize that each member and collaborating organization has its own raison d'être and, collectively, we are proud of both our unique and shared histories. While each organization has its own mission and values, we are united by a commitment to high quality patient care and improving health outcomes, and it is under these auspices that we are collaborating to develop an Ontario Health Team.

We recognize that "collaboration" underpins the processes required to develop and manage our OHT. We know that trust is the foundation of true collaboration and that developing trust requires both time and energy. Consequently, our OHT is committed to an inclusive and transparent process for developing relationships that welcomes members and collaborating organizations that have different histories of working together. It is also why we collectively chose in early August to submit our Full Application in December rather than October, enabling more meaningful and thoughtful engagement in the process. This approach serves as one of our first steps in building trust among our members; and it will lay the foundation for our journey towards maturity. In addition, while there are differences between our members, we will endeavor to eliminate the real or perceived silos that serve only to disconnect the local healthcare system.

We acknowledge that this journey will be iterative, and that our practices and processes will evolve in step with the maturation of our OHT. Collaborative governance and leadership will be the first version of an eventual formalized OHT structure, which will be supported by an Interim Collaboration Agreement currently in development. Our OHT has affirmed Ontario's Patient Declaration of Values, and we are committed to the tenets of the Quadruple Aim- population health management, integrated care, shared accountability, and value-based care. Furthermore, we have established a set of guiding principles that are intended to support our collaborative efforts and maturation process, including: uninterrupted care, one team, co-design and partnership, respective autonomy, open communication, transparency, centres of

excellence, comfort with discomfort, equity, collaborative leadership, innovative thinking, and building trust and ownership. Our team is committed to the Ministry's vision for OHTs and, in Year 1, we will be honing a shared vision and strategic plan that addresses the unique profile and needs of our patient population.

Finally, it is important to note that differences do exist among our members in how their core services are conceptualized, developed, and managed. Further work will be required to better understand how these differences might either strengthen and improve out OHT or, conversely, where differences need to be addressed to ensure standard processes and approaches to care. We understand that there are different ways of knowing and doing, and that these approaches to healthcare need to be respected, such as with Indigenous, Francophone or LGBTQ populations. These models of care will be derived from purposeful, culturally safe approaches. Furthermore, we will be respectful of the Catholic Health governance and ethical framework. We are committed to learning from, supporting, and strengthening services for these and other unique populations.

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?

Ontario Health Teams
Full Application Form

Max word count: 1500

I OVERVIEW

Our team recognized that transparent and purposeful engagement were important considerations as we came together to develop this application. We are focused on creating an inclusive environment in which all potential partners have an equal voice, and are given the opportunity to be an architect of our OHT. Our governance efforts at this point are concentrated on designing a process that builds trust, ownership and, eventually, a formal governance structure. We recognize that governance will evolve as the team matures, and that "end-state" governance could take different forms. The potential end-state models that were identified within the Rapid Improvement Support and Exchange (RISE) resource on collaborative governance are worthy of exploration by the team. We believe this exploration must be a journey that the team takes together over time, and we are committed to developing a thoughtful process that will allow us to achieve an end-state model that best suits the needs of the team and those we serve and reflects our collective values and vision. We have experienced this challenge when discussing our plans for leadership and governance, and we have identified purposeful, yet pragmatic approaches to establishing leadership structures that will support the needs of our developing OHT.

II GOVERNANCE AND SHARED DECISION MAKING

Our OHT has agreed to an interim, transitional governance structure represented by a temporary Steering Committee and supported by an Interim Collaboration Agreement. This agreement is being developed to articulate the intentions of members and collaborating organizations and reaffirms the commitments each member agency makes with respect to Year 1 deliverables, the long-term maturity of the team, and the foundational tenets of the OHT model described by the Ministry. This agreement will describe a collaborative leadership and consensus-based approach to leadership for Year 1 and provide a guiding framework for core processes including decision-making and conflict resolution. The agreement will task the Steering Committee with oversight of the future accountability agreement. The agreement will be non-binding and protects the current governance status of participating members. We are committed to endorsing an Interim Collaboration Agreement and Steering Committee by March 2020, and that the temporary Steering Committee will continue to operate until the end of Year 1. During that time, the governance structures and mechanisms will be reviewed and a more permanent governance structure will be implemented at the end of Year 1. Our OHT anticipates membership growth in the future and will invite and/accept new members who are prepared to endorse a Collaboration Agreement and contribute to the OHT with an equal voice and shared accountability.

We have agreed to embrace the Canadian College of Health Leaders' "LEADS in a Caring Environment Framework" to orient our leadership philosophy. The framework includes the following five domains: Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation. Our OHT will develop mechanisms to embed the tenets of the LEADs framework into our governance and leadership practices, including the concept of distributed leadership, as well as using it to support leadership development for leaders across our membership.

We acknowledge that redesigning the way care is delivered to our attributed population will

require members to share accountability, as well as infrastructure, financial, and health human resources in new ways. We understand that our OHT will enter into an accountability agreement with the Ministry, and we expect the agreement to articulate performance management responsibilities and targets that will fall under the general direction and oversight of the Steering Committee. Our team understands the importance of creating a shared clinical and fiscal accountability framework. Our intention is to create a horizontal accountability framework that holds the members accountable to each other, instead of a vertical accountability framework in which accountability occurs within a hierarchical structure. Furthermore, we want the collective creative energy of the partners to drive a process of innovation and transformation. The identification of a single fund holder will be finalized within the deadlines that may be set by the Ministry, building on the trust, shared ownership and collaboration that have increased between partners since the beginning of the work towards an OHT initiated in April 2019.

If the full application is accepted, a working group will be established to explore a more formal "governance" structure as well as a transitional timeline. As the governance model is developed, it will be essential to ensure it reflects the needs and values of our community while developing a governance model that is built on a collaborative and distributed leadership model, not a hierarchical model.

III OPERATIONAL MANAGEMENT

The operational leadership and management structure of our OHT has not yet been established, but will be developed and directed by the Steering Committee. Defined within a collaborative agreement as the "Operations Committee," this group will support the delivery the OHT's Year 1 targets by bringing together subject matter experts, leaders, champions, and change agents to support the identification and removal of barriers to support integrated care delivery. We will develop a robust change management strategy to support the ongoing transformation process.

Our OHT has been supported by a secretariat and project team that have been given mandates to support the coordination of our OHT and delivery of our full application, respectively. These two bodies are representative of our developing OHT and are directed by the collaborating organizations participating in the work groups support the completion of this application. Key human resources in this process have included staff of the Northeast LHIN. Moving forward, we see an opportunity to leverage existing human resource funding associated with the Northeast LHIN and using those resources to create an administrative infrastructure to support the work of the OHT. This will be augmented by leveraging current resources of OHT members to identify shared service opportunities such as IT support, procurement and data privacy.

IV PATIENTS, FAMILIES, AND

Since coming together in early 2019 to complete the readiness self-assessment our OHT has welcomed individuals with lived experience to participate in our development. When our collaborating organizations reconvened to discuss the full application and work groups were formed, individuals with lived experience were identified as subject matter experts and were sought to participate on each of our work groups. We have described "co-design and partnership" to be one of the guiding principles by which our OHT has chosen be the foundation of our collective efforts. This principle, which will be reflected in our Collaboration Agreement,

identifies the development of a patient and family advisory committee for the OHT. Our OHT recognizes the value individuals with lived experience bring to a high performing health care system and high quality care, as well as quality improvement, system redesign, change management, and governance. We are committed to embracing patients, family, caregivers and individuals with lived experience as full partners in the OHT. Our Interim Steering Committee and future governance structure will include representation and meaningful participation of these critical stakeholders.

Patient, family and caregiver engagement extends beyond the primary patient population. The OHTs represent a comprehensive shift within the healthcare system and ought to seek the involvement of the entire community. One of our key partners is the City of Greater Sudbury who has a mandate to provide services to all residents of Greater Sudbury. Consideration will be given to a community-wide engagement process that speaks to the long-term vision of the OHT. For example, a community conference inviting all citizens to participate would generate greater involvement and ownership across the community. This type of inclusion would invite all citizens to become architects of a large-scale transformation and fundamentally shift the health culture of our community.

V PHYSICIAN AND CLINICIAN LEADERS

OHT recognizes the value that physician and clinician leaders bring to a high performing health care system and high quality care, as well as quality improvement, system redesign, change management, and governance. We are committed to collaborating with physicians and clinicians throughout the stages of development, governance, and future operations by providing meaningful opportunities for physician leadership. Primary care is the patient's medical home and needs to have a leadership role in the formation and operationalization of our OHT. We understand that purposeful engagement with primary care and meaningful physician leadership are critical factors for success at all stages of development and operation. Therefore, we have sought engagement with, and leadership from physicians throughout the development of our OHT. Our Steering Committee will include representation from our primary care members, and it will operationalize a Primary Care Advisory Committee to provide a forum for family physicians, nurse practitioners and other primary care disciplines to engage and support the OHT.

One of the ways we will further engage community-based physicians is through opportunities to expand team-based, interdisciplinary care opportunities and collaboration. Existing physician groups in affiliation with FHT's, FHO's, CHC's and NPLC's represent the best opportunity for early expansion of the OHT. This expansion represents a significant opportunity to deliver integrated care and better support primary care practitioners, and our OHT will explore how resources could be better aligned to support these initiatives.

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

At maturity, we will have the ability to efficiently and effectively communicate as well as digitally and securely share information across the network, including shared patient records among all care providers within our OHT network. Sharing patient information with members of the health care team (including the patient) is a foundational component of our work and one that will require substantial investments of time and resources. We will leverage and expand upon many of the existing technologies by which information is currently being shared.

Many providers and primary care teams in this region have advanced electronic medical record (EMR) systems for serving patients. These systems are best of breed systems for their individual stakeholder group such as Meditech at Health Sciences North. 83% of primary care clinicians within NE LHIN leverage two OMD certified vendors: Accuro and Telus PS Suite. Each offers cloud based products and a patient portal. Personal health Information is typically stored in a server-based or cloud-based database. In this region, several stand-alone databases do not share a data network that would facilitate data sharing, integration or care coordination. Although some local partners have created mechanisms for sharing data, most EMRs are not part of an integrated system that exists on a single, digital platform. There is limited capacity to share data in an encrypted, secure manner and providing access to personal health information for patients is extremely limited to a few healthcare providers. We will leverage available solutions to maximize the digital integration of our local healthcare system, including Hospital Report Manager (HRM), Client Health and Related Information System (CHRIS), Connecting Ontario Clinical Viewer (COCV) and Ontario Laboratories Information System (OLIS).

HRM is an eHealth solution that enables clinicians to receive patient reports securely and electronically from participating hospitals and specialty clinics. HRM electronically delivers text-based Medical Record reports, (e.g. Discharge Summary), and transcribed Diagnostic Imaging (excluding image) reports from sending facilities directly into patients' chart, within the clinician's EMR.

We will explore the possibility of utilizing CHRIS to support the delivery of care at home and in the community. CHRIS has a secure online portal called Health Partner Gateway (HPG). Approved providers can access patient records, including clinical assessments and documents, and share up-to-the-minute patient information on

HPG. Providers can also send, receive, and accept patient referrals and service orders in real-time. We have heard our primary care providers' concerns with using CHRIS because it is not compatible with their EMR systems. And the lack of integrated authentication platform, forces physicians to remember and use multiple username and passwords, impeding physicians to adopt and access systems across the continuum.

The COCV is a secure, web-based portal that provides real-time access to digital health records including dispensed medications, laboratory results, hospital visits, Home and Community Care Services, mental health care information, and diagnostic imaging reports and images. We will leverage COCV as a data-sharing solution to the best extent possible; however, COCV has data contribution gaps and challenges that need to be addressed. COCV currently contains acute care data, LHIN data, and access to other provincial assets. While COCV is a digital enabler for information sharing, there are limited data contributors to the COCV Clinical Data Repository (CDR). It should be expanded beyond acute care settings to include clinical care data from across the continuum of care including primary care, specialist care, community support services, and homecare providers.

Ontario Laboratories Information System (OLIS) is a province-wide, integrated repository of tests and results that provides providers with timely access to patients' lab test orders and results to aid clinical decision-making. Many of our members currently use OLIS and we will endeavor to expand access to OLIS across our OHT.

Our team recognizes how Digital Health will support the need for real-time collection, utilization and sharing of patient information. There is a need to design and develop Digital Health architecture that will include EMR system integration to support communication, collaboration, and data sharing. Investments in a digital health strategy will be required for a technology solution that integrates existing EMRs to facilitate data sharing and care coordination. We believe that a provincial solution is needed to create a digital platform that provides the infrastructure for comprehensive and integrated data network that connects all healthcare providers across Ontario. There is a need to work with vendors for an information management solution that integrates core solutions and manages care transactions beyond view access to information. Ideally, Ontario Health will develop a province-wide, secure Digital Health Information platform for information sharing and enabling interoperability amongst all EMRs, data depositories and portals.

Our OHT will pursue the development of a patient portal that will give patients access to the information they require to manage their health needs. A single provincial patient portal, like Sunnybrook MyChart needs to be considered, as an interim, until time the OHT transitions to a single IT organization who can integrate and server the collective partners. Primary care should remain the central owner of all reports leading to a comprehensive single clinical patient record and single point of access to patient data. To enhance this comprehensive record, clinicians must receive discharge information and clinical documentation via POI, HRM or other electronic

solutions.

There are three critical aspects to the sharing of patient information within the team-privacy, security and integration. The OHT will need to develop a robust privacy policy and protocol system that respects the rigorous requirements of the Personal Health Information Protection Act. This will need to be supported by privacy training as well as identifying Health Information Custodians and Privacy Officer(s) who will shepherd a privacy program. We will create an OHT privacy team to oversee this transformation. OHT members with well-defined policy and controls can provide mentorship, best practice and support to organizations with fewer resources where possible to establish secure data sharing. Providers have the legal authority to collect, use, and disclose personal health information (PHI) for the purposes of providing health care. When data is to be used for administrative or secondary use purposes, we will ensure that patients and/or their substitute decision makers are aware of the sharing of data with consent, where applicable. The following privacy safeguards and requirements will be put in place as the OHT develops: a privacy and security assessment for each site; a review of appropriate data sharing agreements, patient consenting requirements and confidentiality pledges; and, leveraging the expertise of members with privacy expertise to support partner organizations.

There will be a need for a coordinated cyber-security service that will be mandatory for all health providers in the region to protect our patients and ensure continuity of health services. This will include a cyber-security assessment of the current service providers. In order to protect patient information, we are committed to implementing appropriate safeguards, including:

• harmonizing our privacy and security policies, procedures and practices amongst our participating partner sites;

• complying with all privacy and security policies associated with provincial and other digital health;

• developing or leveraging privacy and security training and resources to support our understanding and compliance with privacy and security requirements;

• identifying and mitigating privacy or security risks; and,

• Tracking privacy and security performance and accountability measures.

Data sharing agreements are in place to protect patient privacy and confidentiality for members who are currently sharing patient information. Some of our smaller members may not have the capacity or expertise to participate in rigorous data sharing agreements and there is a need to develop a data sharing agreement for the entire Ontario Health team. In the future, integration between partner sites will require appropriate data sharing agreements. To enable the secure sharing of health information we will ensure that all partner organizations that access PHI will have

appropriate data-sharing and legal agreements in place between digital health delivery partners, relevant Health Information Custodians (HIC), patients/clients, and any other party involved in the access and disclosure of PHI.

Our digital health strategy will be linked to our quality improvement program and require the provision of a decision support specialist. The patient database of personal health information could be mined to assist in the understanding, planning and development of programs and services that meet the priority health needs of our patients and providers. Providing patients with access to their personal health records and facilitating communication between patient and provider will be enhanced by a more integrated digital health system. We will use collective data to inform our understanding of our OT attributed population and their needs. The data will be used to inform care-planning, priorities and tracking costs for patients across their episode of care; thereby improving the integrated care pathway design to enhance patient experience and outcomes. We also recognize that as our team grows, we will need to analyze the data, track trends, design programs for more evolving population health needs.

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

Members of Équipe santé Sudbury and Districts Ontario Health Team (our OHT) are committed to ongoing learning and continuous quality improvement. Each have confirmed that there are no identified concerns with respect to governance, financial management, compliance with contractual performance obligations or compliance with applicable legislation and regulations.

In Year 1, the collaborating organizations will explore the possibility of formal accountability structures to ensure that any individual performance or compliance issues that arise are addressed and will work to develop data governance model and evaluation framework that will determine how partners collect, analyze and share data, as well as communicate mutual performance outcomes. A strategy to define the accountability structures will be integrated into the development of the governance framework and supporting terms and agreements. Further, members will identify how to best share resources and expertise to take advantage of the strengths, such as data analytics, decision-support and reporting, of the larger organizations.

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

I OVERVIEW OF MEMBER EXPERIENCE

Many of our members have experience leading or participating in quality improvement, performance management, and continuous learning initiatives. Leadership and governance teams are focused on ongoing mentoring, coaching and development to build capabilities across the system. Our OHT will incorporate continuous quality improvement and information sharing throughout the OHT development process. Engagement of our target population as well as that of our francophone and indigenous population will be embedded into all aspects of quality improvement and performance monitoring.

I.a PHYSICIAN OFFICE INTEGRATION AND HOSPITAL REPORTS MANAGER

Physician office integration was created for the North East and North West regions as a way for primary care providers to receive hospital discharge reports, diagnostic imaging and lab results directly into their EMR. This allowed providers to follow-up with their clients after an inpatient admission or an emergency department visit and have the information necessary to provide appropriate care. More than 220,000 reports from 28 hospital/independent health facilities are sent monthly to 705 active providers across the North East region.
In 2018, the North East region decided to transition to Hospital Reports Manager so that providers would now be able to received reports from across the province. In addition, providers would receive e-notification as soon as their clients are admitted to hospital or are in the emergency department.

I.b INTEGRATED CARE COMMITTEES

Through the North East LHIN, many member organizations participate in specific steering committees to better integrate and improve care. The Alternate Level of Care Steering Committee examines the utilization of ALC beds and how Health Sciences North can collaborate with long-term care, rehabilitation facilities, community mental health and other services and supports to reduce the ALC rate.
The Regional Mental Health Advisory Council is made up of more than 20 health professionals and persons with lived experience from across the region. They work together to improve access, enhance coordination, and strengthen system sustainability when it comes to mental health and addiction services. This led to the development of the Regional

Opioid Strategy and the 'hub and spoke' model for Rapid Access Medicine Clinics in four centres (Sudbury, Sault Ste. Marie, Timmins and North Bay).

I.c NORTHEASTERN ONTARIO FAMILY HEALTH TEAM'S STANDARDIZED PERFORMANCE MEASURES

In Northeastern Ontario, 27 family health teams have joined together as members of the Northeastern Ontario Family Health Team Network (NEOFHTN) to implement a regional quality improvement program tailored to the specific needs of their population. They decided to track performance on a common set of indicators for the nine most common programs. These indicators are meaningful, measurable and actionable. Through the standardization of indicators, teams are able to focus on improving patient care. In addition, these common set of indicators allow teams to compare results and identify areas of quality improvement, and even more importantly success stories that they can share with their peers. These common set of measures will lead to collaboration, shared learnings and scalability across the region. Through the use of Ocean tablets, patients are able to access tools such as falls prevention screening, mental health screening, smoking cessation, preventative care, and patient experience surveys. This tool will increase patient's access to programs, while ensuring that the team is focusing on what matters most to the patient. The Ocean Platform will allow the North East to connect with patients in the clinic or within their homes. This quality improvement initiative was recognized by AFHTO's Bright Lights Award in 2018.
In Year 1, the ESSDHT will explore creating a collaborative quality improvement plan and shared indicators for a performance dashboard.

II OVERVIEW OF COLLABORATING ORGANIZATIONS

II.a NORTHERN ONTARIO SCHOOL OF MEDICINE (NOSM)

One of NOSM's strategic goals and priorities is to "graduate health care professionals who have the knowledge, skills, competencies, and humility to provide care adapted to the needs of Northern, rural, and remote – including Aboriginal and Francophone – communities." In addition, the Continuing Education and Professional Development (CEPD) Office is dedicated to providing high quality, learner-centered, continuing medical education, faculty development and professional development opportunities. CEPD educational programming promotes scholarly activity, longitudinal learning, enhances clinical and teaching competencies, and enriches the overall performance of health-care professionals and faculty to better meet the health needs of Northern Ontario. For example, NOSM and Health Quality Ontario delivered Improving & Driving Excellence Across Sectors (IDEAS) quality improvement training to healthcare professionals across the North East and North West.

II.b HEALTH QUALITY ONTARIO

Health Quality Ontario regional Clinical Quality Leads and Quality Improvement Specialists have been key partners in driving quality across organizations in Sudbury. For the 2019-2020 Quality Improvement Plans, the focus regionally was to improve transitions from hospital to home by collaborating with local partners to develop change ideas and select indicators to measure improvement.

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.

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.

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

Many members of the our OHT have embedded meaningful engagement and input from persons with lived experience into their organization's planning, decision-making, and quality improvement initiatives. During Year 1 and beyond, these partnerships will remain a priority as we work to ensure that the healthcare needs of PLwD and their caregivers are reflected. The members of the our OHT identified a number of approaches used to gather feedback and solicit input from PLwD and caregivers. These approaches include:

- Advisory councils and/or committees;
- Co-designing new initiatives;
- Surveys;
- Focus Groups;
- Embedding PLwD, caregivers and families on organizational councils/committees;
- Involving PLwD in designing policies;
- PLwD and caregivers involvement in developing handouts and educational materials;
- Verbal, on-the-spot feedback; and
- Suggestion boxes.

The voices of PLwD and caregivers are embedded into many of the organizations' strategic, policy, and operational planning processes. For example, Health Sciences North (HSN) is committed to patient and family-focused care. Patient and Family Advisors are embedded and engaged throughout the organization, and at all levels. HSN has a well-developed patient and family advisory committee where patients are active participants on key improvement initiatives and work closely as partners to develop strategic plans and priorities for action. Patient advisors sit on multiple organizational committees and are involved in the hiring panel for Managers to VP level positions, they co-facilitate the delivery of general orientation, living healthy community workshops, and review policies, patient hand-outs and much more.

Persons with lived experience have been involved throughout the planning process for our OHT, and they have been invited to join each of the working groups and join larger planning meetings. In co-designing the future of our OHT with persons with lived experience, we are striving to ensure that the pathways is being designed meaningfully reflect what is most important to them. During Year 1, we will continue to prioritize the input of persons with lived experience in decisions around governance, planning, and care design. The team will explore options for PLwD and caregiver feedback, including the imminent release of the Older Adult Experience Survey' and Caregiver Satisfaction Survey developed by the Regional Geriatric Programs of Ontario.

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 committed to engaging with our community and the individuals that comprise our attributed population, as well as our neighbouring communities and potential OHT neighbours. We recognize and embrace the imperative to involve the people we serve. In Year 1, co-designing a system that works for PLwD and their caregivers is one of our primary goals, and we will improve and expand this process as our OHT continues to develop.

Many of our members and collaborating organizations are continually seeking input from the community through strategic planning, patient advisory committees, governance positions, community focus groups, open houses, surveys, social media, and planning tables.

I THE CITY OF GREATER SUDBURY

The City of Greater Sudbury actively involved the community and other OHT

participating organizations in supporting and developing its Population Health Call to Action Strategic Plan 2018. Engagement activities included in the plan's development included:

• strategic planning processes that included community members and patient advisors;
• patient advocates;
• patient counsels;
• patient/family/caregiver governance roles;
• social media engagement;
• and patient satisfaction surveys.

II NORTHERNONTARIO SCHOOL OF MEDICINE (NOSM)

The Northern Ontario School of Medicine (NOSM) strategic planning process was consultative and inclusive, wherein NOSM leadership visited more than 50 rural, remote, Francophone, and Indigenous communities across the North to discuss Northern Ontarians' ongoing health-related needs. This input provided important guidance to setting the five strategic goals at the heart of NOSM's 2015-2020 Strategic Plan.

III HEALTH SCIENCES NORTH (HSN)

Health Sciences North's recent strategic planning process included broad community engagement which encompassed a cross-sectoral, multi-agency process. The hospital wanted to hear from as many diverse groups as possible and were able to reach out by holding 50 external focus groups. They engaged with more than 3,100 patients, employees, medical staff, learners, volunteers, foundations, community partners, and engaged with numerous communities across Northeastern Ontario including First Nations, the 2S-LGBTQ community, Noëlville, Espanola, Elliot Lake, Parry Sound, Timmins, Sault-Ste. Marie, to name a few.

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

Many of our members have experience with cross-provider funding and understanding health care costs across the system. We will leverage this experience track and reduce costs across the system.

I HEALTH SCIENCES NORTH (HSN)

HSN has led the north east in the implementation of bundled care models of service delivery that span the decision to treat to the end of the post-acute rehabilitation phase. Managing these models includes promoting greater integrated care delivery, and driving high-quality, efficient care, and improving experiences of care and clinical outcomes. As a provincial leader in bundled care, HSN is regularly invited to speak about its experience with bundled care, including on aspects of establishing community partnerships, agreements, and reporting.

Furthermore, HSN has developed strong partnerships with community partners and the NE LHIN HCC utilizing gain/risk pricing to ensure quality care is delivered to patients undergoing total joint replacement. As a result of this experience, HSN is in a strong leadership position to implement the bundled care models for stroke and coronary artery bypass graft surgery, as well as future models. HSN has a well-established and proficient decision support and finance teams that provide the necessary data to monitor and ensure best practice is met. For example, length of stay (LOS), re-admissions, and emergency department visits are carefully monitored and addressed to ensure best-possible service is delivered in a timely and efficient manner.

HSN is committed to delivering high quality care in a best practice environment while being fiscally responsible. To support this commitment, HSN works closely with Health Quality Ontario and the NE LHIN, and continues to support and mentor newcomers to bundled care in the north. By providing guidance and ensuring equity of services throughout our region, HSN supports the elimination of barriers caused by rurality by engaging with community partners close to an individual's home upon discharge.

II COMPASS

At Compass, cross-provider funding occurs at many levels. The Ministry of Children, Community and Social Services (MCCSS) have a case resolution process linked to a community table where complex families who have exhausted all possible social service options have access to a complex needs funding application process that is

vetted through a leadership table and forwarded to the MCCSS regional office. Once the funding is approved, an agency is identified as the broker and is responsible to cover cost for the specialized services (e.g., autism, intensive residential treatment, and others). The community table consist of Children's Aid Society of the Districts of Sudbury and Manitoulin, Children's Community network, Child and Community Resources, Compass, and Children's Treatment Centre.

III SUDBURY FAMILY HEALTH ORGANIZATION (FHO) CLINIC

The Sudbury FHO created a walk-in clinic for their patients to increase same-day access to primary care. The 40 physicians share the human resources for reception and operating costs of the clinics. Physicians also rotate through to provide services Monday to Friday 9:00 am to 8:00 pm.

IV QUALITY IMPROVEMENT SPECIALIST ROLES

In Family Health Teams (FHTs) and Nurse Practitioner-Led Clinics (NPLCs) in Ontario, quality improvement specialists are a shared resource. The Quality Improvement and Decision Support Specialist for FHTs is hosted by the City of Lakes Family Health Team and supports eight other FHTs in the north east. The Quality Improvement and Information Management Specialist for NPLCs is hosted by the Sudbury District Nurse Practitioner Clinics and supports eight other NPLCs in the north. Collectively, their roles focus on the use of data and analytics to help clinicians achieve better health outcomes and improve care for their patients. Shared priorities are developed by the multiple sites and the quality improvement specialists' time is divided among the teams.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

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

Max word count: 1500

I OVERVIEW

Due to the complexity of the existing systems and inter-dependencies of key stakeholders, operationalizing the care re-design priorities requires a highly coordinated and planned approach, supported by both project management and process improvement expertise. Using an evidence-based project management framework complemented by a suite of available quality improvement tools, a targeted team of engaged leaders, clinical champions, subject matter experts will be selected from within the existing talent pool of the members and collaborating partners. This project team will be responsible for prioritizing, sequencing, and leading the care re-design and delivery of Year 1 expectations. Integral to this team will be PLwD and caregivers to co-design and inform the creation of a highly integrated care journey.

II WITHIN 30 DAYS

Within the first 30 days of receiving proposal approval, the project team will be accountable for developing the project charter, establishing a high-level communications plan, initiating project artifacts/documents and building the critical stages, sequencing, and timelines for an execution plan.

The project charter will reflect the purpose of the project, the goals as well as the project metrics. Clear identification of the scope of the project will keep all team members and stakeholders focused while minimizing the potential for the project to become unmanageable (i.e., scope creep). A high-level summary of project milestones will be developed, and an initial register of high level risks will be documented. A stakeholder and resource inventory will be created to identify additional resources and stakeholder engagements/expertise that may be required to support project execution. Recommendations will also need to be made around the storage and shared access to project documents and artifacts.

A detailed communication plan will be designed as a means of keeping OHT members sufficiently informed to avoid any disappointment regarding schedule or quality goals. A key focus of the communication plan will be to engage and inform front line staff and partners around progress and to celebrate achievements. PLwD and caregiver stories demonstrating the improvement in their experience will be key highlighted to maintain motivation and momentum. The communication plan will identify target audiences, information needs, clear accountabilities, target timelines and method of delivery, throughout Year 1 of the project cycle.

III WITHIN 60 DAYS

After approval of the project charter, a more detailed work plan will be designed. Particular consideration will be required to design the sequencing and coordination of concurrent activities, as well as impacts to front line staff to ensure that those directly involved in care delivery are not overwhelmed with change fatigue. Additionally, process improvement milestones will be established, work will be distributed to key leads along with clear roles and accountabilities, and clinical team members will be identified and engaged. Assessment of any human resource implications may be required as part of the project planning, and early engagement of human resource expertise may be required if there are to be implications for roles, job expectations and/or conditions of employment.

Specific process and performance metrics will be developed with clear identification of how measurement will occur, and who will be accountable for the data collection and analysis, as well as reporting format and frequency. Baseline data will need to be collected against which we can measure improvement. Counter measures will be carefully selected for measurement and monitoring to ensure that there are no unintended or negative consequences to other process or system performance.

Evaluating experiences of care for PLwD and caregiver will be a key performance indicator. A number of methodologies will be considered including experience of care surveys and experiential evaluation through interviews, journaling, and experiencing the journey with PLwD/caregivers.

Gaining a clear understanding of the impact to the front-line workers' daily work and satisfaction is critical. The individuals who participate most closely in the patient's journey are those who can more readily identify improvement opportunities, gaps, and redundancies. Implementation of an ongoing feedback loop will assist in evaluating the impacts of the improvement strategies being implemented.

A risks/issues log will be maintained through project management to ensure pro-active identification of risks and establishment of any mitigation strategies and to use as a means of escalating any challenges or barriers which might require Executive/ Governance intervention. Reviewing lessons learned from previous initiatives and capturing them throughout year 1 will guide and inform the project spread and sustainability into the coming years.

IV WITHIN 90 DAYS

Prior to the ninety-day mark, we expect to have a "project kick off" to generate enthusiasm, awareness and engagement with all key stakeholders and partners. Champions will have also been selected to lead targeted improvement teams. The application of evidence-informed change management practices will help to support individuals at all levels within the partnering organizations to understand the need for

change and actively contribute to making valuable changes to care.

By ninety days, we expect to have small workgroups in place, led by champions, executing the work. Supported by the application of lean methodology, the work will include conducting process mapping, identifying desired state, developing the strategies to achieve desired state, and performing concurrent tests of change using PDSA (Plan, Do, Study, Act) cycles. PLwD and caregiver representatives will be key partners in the re-design and evaluation of improvement activities. The Project Steering Committee will be responsible for the oversight and will meet frequently to continuously evaluate and where necessary, re-align improvement activities and strategies based on ongoing feedback collected by our Year 1 population, staff, and practitioners, as well as monitoring of the key process and performance metrics. Reporting and communication with the Executive/Governance Collaborative will occur as pre-determined in the approved communication plan.

V WITHIN 6 MONTHS

The six-month milestone presents an opportunity to complete a comprehensive but targeted stock take on the progress of this initiative. The Project Steering Committee will use both quantitative and qualitative data to evaluate the effectiveness of the improvement strategies towards attainment of the stated goals. This will be inclusive of PLwD, caregivers and front-line staff evaluations/feedback as well as cost effectiveness to the system. A plan for sustainability of the successful strategies will include targeted monitoring and auditing as required.

The stock take will support validation and/or revision to the planned improvement strategies for the next six months to assure that the planned activities continue to align with the target outcomes. Timelines may be re-affirmed or revised based on progress to date. Additionally, the six-month evaluation also provides an opportunity to decide whether there are additional partners to be engaged, and the capacity to which engagement should occur in order to continue progress towards the goals.

Identification of unmitigated risks/barriers would occur at this key milestone. This may include legislative barriers, financial or human resource challenges, or other risks that may have to be escalated beyond the Project Steering Committee for consideration/resolution. The comprehensive Project stock take report would be presented to the Executive/Governance Collaborative for review and where required, consensus as to decisions that may be required to further advance this initiative.

Finally, celebrations of the successes achieved will be communicated with the front-line staff, PLwD and caregivers representatives, and partners involved in the planning and execution of the strategies to improve the patient journey, as per the Communications plan. Virtual celebrations, acknowledgements of effort, and the telling of lived experience stories are key to maintaining stakeholder engagement,

demonstrating the outcomes of collaborative efforts, sustaining the momentum of change, and generating community confidence.

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

Scaling successful health care innovation is critical to the success of transforming our health care system. Leading in a complex and changing environment requires that all leaders within the OHT understand the impact and pitfalls of change (see Kotter's model for change in appendix A). It also requires that, along with innovative thinking, leaders be aware of their own beliefs, values, and biases surrounding this change initiative and be able to unfreeze the paradigms that may prevent us from achieving our goals. Furthermore, we would posit that leaders must also know how to engage others through the transition phase of change. Like all change initiatives, it will evoke emotions for everyone involved which will require exceptional leadership. Leading from this paradigm will increase our chances of achieving a successful transformational change.

All of our members have committed to the ministry's vision for change as outlined in the guidance document and have developed terms of reference that outlines our commitment to shared purpose, values and guiding principles.

Together, we are proposing a change approach that will assist us in achieving the quadruple aim of providing:

- Better Patient and Caregiver Experience
- Better Patient and Population Health Outcomes
- Better Value and Efficiency
- Better Provider Experience

Our goals for Year 1, as outlined in Appendix X, reflect our readiness for change and will ensure that every step of the change process we integrate:

[i] Communication: transparency and engagement of all of our internal and external stakeholders will require continuous and purposeful communication to ensure we are accountable and transparent. This will also allow us to identify any weak signals that may

require our attention in our change journey.

[ii] Quality Improvement:

• Evidence-informed improvement science strategies that will assist us in doing quick PDCA cycles so that we can adjust quickly and develop nimbleness in our service delivery model.

• Engaging and empowering frontline staff, physicians, PLwD and caregivers to use their expertise and experience to assist in improvements.

[iii] Equity: Through our change process we will integrate Co-designing service delivery model with the various populations we work with (indigenous, francophone) to ensure role model our shared values:

• Respect and Dignity

• Empathy and Compassion

• Equity and Engagement

• Accountability

• Transparency

We will continue to work closely with primary care physicians to help us embed a sustainable service level change and to continue to build the relationships required across our community to ensure we are impacting positively our quadruple aim.

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

One of the ideas may be to create new or unique positions using an inter-agency shared staffing model. We may also identify that new resource allocation to an agency or member is explored by the governance team.

The proposed model of care maintains the existing services for patients not enrolled in the OHT patient cohort. We believe that the improved processes for our Year 1 target population will free up primary and acute care provider time, allowing more focus on meeting the needs of non-Year 1 patients. In addition, improvements among OHT member relationships as well as digital health will presumably benefit patients outside of the Year 1 population. We will establish system indicators that measures unintended consequences (like harm or reduced service levels) for non-Year 1 target population.

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.*

ax word count: 1000
om James: Two Content sources: pasted from WG6 folder section 6.4 and Debbie's email Oct 23rd

Legislative issues
· Union role changes
· Public Hospitals Act
· Privacy
· Funding – for what we do well
· Global budget
· Too restrictive e.g. SAAs
· Virtual care is not compensated
· Physician remuneration
· FHG vs. FHO models
· Regulatory colleges
· Public/Private relationships
· Governance – Many Boards
· EDs protecting jobs
· Conforming to everyone's privacy policies
· Capacity in the system
· # of physicians
· # of PSW's i.e. Health HR
· Relationships among organizations personalities
· Equity- Acknowledge Social determinants of health
· Clarify: funding as one OHT envelope includes NPs but not Physicians
· MOH – needs to be more organized- Less understanding- Less responsiveness
· New government in power at election - Political risk
· Competition & protectionism with OHT process
· No federal vision to support provincial - Relationship with First Nations
· Timeframe too short
· Patients lack of understanding how health care - Free health care is not free
· NPs cannot roster patients

Item	*Description*	*Possible Approach-Mitigation*
Variance in practice /professional regulation	Members offer varied services requiring different scopes of practice. Without adequate oversight there could be staff working	Ensure that each service maintains and tracks records of their staff credentials and that a process is in place to ensure that staff are working

	outside of their scope creating risks to the patient.	within their scope. Provincial professional organizations will need to be involved as we integrated roles and process. This could be a big risk if we don't work with the professional groups right at the start.
Quality and Patient Safety	As organizations shift their focus to priority populations, there is the risk that those from other populations become lost in the system. This could create gaps in diagnosis and treatment for these groups. *Research shows that initially change often takes additional resources and then as the processes progress then cost savings can be obtained.*	Performance monitoring both for the OHT population and the remaining populations with the goal of identifying impact of change on other services and readjusting as gaps are identified. The project first year intervention might need to be adjusted (check and adjusted) to eliminate negative patient impacts during the project.
Available, affordable, and supported housing	Accessing affordable housing is a challenge. There are challenges in having the ability to support those in need of housing.	Engage district social services, local landlord associations, and Ministry of Housing to identify possible solutions that may include rent supplements, and additional housing units with supports, continued private/public partnerships to incentivise affordable and accessible housing in both urban and rural settings.
Reliable Transportation	Accessing health care services in the North is often a challenge due to limited	This is a risk especially for older adults as they may not

	transportation infrastructure. Citizens are required to rely on private modes of transportation which may not be available, accessible or affordable for some of our residents.	be may able to get to appointments. Mitigation: We need to be aware of this risk and use strategies such as: more virtual care, make funding available to assist in developing transportation solutions for patients who need to get to appointments.
Patients and providers might get confused on what services are part of the new OHT and not part of the services	As the system transforms there will be some services within an OHT and others not. This may increase patient and family confusion making it more challenging for them to obtain the services that they need.	Work hard to get family physicians engaged with the OHT team and invest in working hard to keep providers updated on changes etc. This will help increase the chance of patients/families have the required information they need to do their jobs.

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

Équipe santé Sudbury and Districts Health Team have recognized a number of non-financial contributors that would boost the overall success of our Year 1 implementation, including:

[i] Internally (with Sudbury OHT Membership)
• Project Management software, training and framework
• Communication Portal for members to share data to all members in real time, and at the same time
• Data Standardization including relevant associated data on Francophone and Indigenous populations

[ii] Community
• Direct participation and collaboration from Patient Advisory Councils, Patient Advocates

[iii] Other Associations
• OMA suite of support

• Shared portal with other OHTs to relay successes & failures, obstacles & opportunities

[iv] Governmental
• A definition from MOHLTC re what a successful OHT would consist of, pass/fail criteria
• Province wide IT infrastructure which would support Digital Health Platform (i.e. HSSO)
• Insight into the Ministry's vision of the future of digital health and how it incorporates patient portal
• Clarity on future Home & Community Care and possible legislation changes.

[v] Digital Health
• It would be very helpful if the ministry could work with the OHT digital teams to help support them in the development and implementation of tools that will especially help with the sharing of patient care plans etc.
• Home and Community HPG- Presently there is working occurring to help provide access to health care providers so that key stakeholders can see detail patient care plans using this platform. There might be support that the ministry can provide to speed this process up.

[vi] Human Resource Management
• Appendix A focusses on Home and Community changes specifically. There are questions about how we will transition home and community staff. To proceed with this approach direction and support from the ministry will likely be required as Home and Community is provincially directed.
• Union management support may also be required as the OHT works on implementing the year one intervention. For example, as NE LHIN HCC case coordinators are assisted to the OHT, the team may need them to report to the OHT project team. Support on transitioning or contracting the staff will likely be required as there may be union challenges or issues that need to be addressed.

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:

atient Care Risks • Scope of practice/professional regulation • Quality/patient safety • Other	**esource Risks** • Human resources • Financial • Information & technology • Other
ompliance Risks • Legislative (including privacy)	**artnership Risks** • Governance

• Regulatory • Other	• Community support • Patient engagement • Other

isk Category	isk Sub-Category	escription of Risk	isk Mitigation Plan
ee 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 *N/A*

Ontario Health Teams
Full Application Form

7. Membership Approval

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

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

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

Ontario Health Teams
Full Application Form

APPENDIX A: Home & Community Care

Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.
In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.
Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team's proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.
Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

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

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care.
Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

Max word count: 1500

I OVERVIEW

Our long-term vision for a 21st century system of home and community care is one that is person-centred, integrated, and in which a patient's goals drive their service and care plans. In our future state, system-level care coordination is driven by primary care, and home care delivery and community support services that are integrated as one seamless, comprehensive continuum of care wrapped around individuals and their families to support them in their place of choice.

Our long-term vision for the design and delivery of home and community care is centred on the quadruple aim. The four objectives of the Quadruple Aim are:
Improving the patient and caregiver experience;
Improving the health of populations;
Reducing the per capita cost of health care; and,

Improving the work life of providers.

II BETTER EXPERIENCES OF CARE

Within a modernized system of home and community care, patients will experience better care as a result of streamlined services provided by a multi-disciplinary team approach. With care coordination being linked to primary care, this will ensure patients have one point of contact in their health care journey. Another positive outcome will be ease in navigating health care system regardless of where one is on their health spectrum. As a result of improved communication and coordination, one will benefit from less need to manage multiple providers within the home and avoid unnecessary and duplicate assessments. From a patient and caregiver perspective, they will actively engaged in service planning and development of care plan that is flexible to one's changing needs. As an active member of one's care team, client and caregiver feedback will be in the forefront.

Through the use of standardized assessments, a holistic approach to wellness will be achieved factoring in both health and social service needs. Personalized service delivery will be provided by a team of consistent and dependable providers most knowledgeable of the individual's diagnosis and changing needs. Patients will receive care in a manner that is simplified reducing confusion and frustration with the system which in turn allows for better integration of in-home providers,

III BETTER HEALTH OUTCOMES

We will increase opportunity for better health outcomes for our patients by providing 24/7 access to health care supports and ensuring that our patients receive timely access to the right service at the right time and in the right location achieved by a strong and informed care team. Service implementation will be guided through evidence-based outcomes with individualized approaches to care planning being clinically informed to enhance outcomes. With the plan to follow a patient through their health care journey better health outcomes could be realized through timely responses and involvement of other applicable services.

IV BETTER VALUE

One of our goals for our long-term vision for Home and Community Care is to provide a more integrated care model that delivers higher quality and efficient care to improve patient and family experience and improved outcomes. With a person-centred focus, members of our OHT will work together to provide seamless care services which leverage current existing strengths, resources and services and where we start

thinking like a system and less like individual providers. OHT Care Coordinators will be well trained with a full comprehensive understanding of services to ensure that the patient receives the right service at the right time to reduce duplication of service and gaps in service delivery.

In terms of leveraging existing services, we will use the One Client One Plan (OCOP) model currently being pursued as this addresses improvements in collaboration, minimizes duplication of efforts, introduces efficiency in referral processes, and provides a patient/caregiver focus. In addition, we will leverage existing regional infrastructure within LHIN HCC, and established partnerships amongst CSS organizations and LHIN HCC that have been actively improved upon over the past few years. Tremendous time and effort involving HCC and CSS partners has been spent reviewing and evaluating existing processes and these implemented changes are demonstrating to bring value to the health care system by standardizing approaches to services across our large geography of the North East and various populations.

V BETTER EXPERIENCES OF DELIVERING CARE

In the Sudbury area, our vision is to reduce the number of agencies that are delivering in home services to a single patient supporting community health services in a coordinated manner which makes best use of our staffing resources. Patients will have one provider for all of their in-home services, one number to call, and significantly reduced assessments respecting one another's ability to assess. This supports the concept presented early of the power of one. All providers will document electronically, as well as have access to and be able to contribute to the patients' digital care plan working on one compatible system. In an ideal state, care providers would work together, providing support and overflow to each other to deliver the full scope of specialized and secondary in-home services thus reducing some of the existing waitlist and service initiation delays. This approach has been practiced within the high-risk seniors group of providers. Reimbursements would be outcome based, instead of strictly fee-for-service. The contract with the patients with the selected service provider would include incentive payments for patient and population outcomes. Accountability for performance would be strengthened by working together and achieving and sustaining positive patient outcomes and experiences.

Traditionally, the sectors of NE LHIN HCC and community support services (CSS) have been complementary yet fragmented and disconnected. In northeastern Ontario these two sectors have been working together to integrate and coordinate themselves as one united, comprehensive home and community care with positive results and

improved relationships amongst providers. In large part, much of this work has been driven by the *One Client One Plan* (OCOP) project, which envisions a continuum of services that are connected via a "no wrong door" philosophy and an integrated electronic record system that eliminates duplicate assessments, coordinates referrals and scheduling, and provides shared access to an individual's care plan delivering on an innovative approach to home and community care that can be expanded to other sector partners.

VI COMPREHENSIVE CONTINUUM

From the time one enters health and social services and as their needs increase they will be well supported by a network of providers responsive to maintaining one's wellness.

VII CARE COORDINATION

Our long-term vision is to have care coordination embedded within primary care. Primary care will recognize the need for home and community care services and then engage the OHT Care Coordinator to initiate care planning. Through this direct linkage, a stepped approach to care that is clinically informed and augments services based on a patient's goals will be implemented. Embedded OHT Care Coordinators will be proactively involved in managing and coordinating the patients care needs and system navigation requirements. In order for our long-term vision to succeed, untying care coordination from service allocation restrictions will improve the patient and caregiver experience and increase the flexibility to truly operate with a patient focused approach.

VIII NEIGHBOURHOOD MODELS

In 2019, home and community care began launching "neighbourhood models," in which care coordination, system navigation, and services are co-located in buildings with high densities of older adults who receive assisted living services. This demonstrates another innovative effort being made to address system fragmentation and improved coordination and advanced planning of services minimizing the volume of involved providers. In our long term vision, expansion of this model will be explored further for other high density geographies as it does address similar positive expectations of embedding care coordination with primary care, being easily

identifiable for a population of residents.

IX HEALTH HUMAN RESOURCES

The growing void of health human resources to support the care needs of our attributed population is clear and present risk to quality care placing greater emphasize on the need for services to be efficient and well planned. Across northeastern Ontario, health service providers and service provider organizations struggle to recruit and retain health care professionals—from personal support workers to nursing and allied professionals—leaving individuals at risk both in the community and in acute and long-term care settings. This problem is further exacerbated by the lack of bilingual professionals and those with cultural safety training and practiced skills available.

X INFRASTRUCTURE

The coordination and delivery of home and community care services is a complex system that requires significant resources, including personnel, digital health, and back office services. We support a home and community care system that leverages a shared regional infrastructure to support standardized assessment and delivery mechanisms, while enabling economies of scale that are sustainable.

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

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

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

Role/Function	**Organization**	**Delivery Model** (What type

	of provider (dedicated home care care coordinator, FHT allied health professional, contracted service provider nurse, etc.) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.)

Managing intake
Developing clinical treatment/care plans
Delivering services to patients
Add functions where relevant
See supplementary Excel spreadsheet NOTE from James: Table is populated

Max word count: 1000
The Year 1 population will have a range of health and social service needs to assist with optimum functioning. It is anticipated that XX% will require home care of the estimated XX identified population that will be supported Year 1. These individuals will have progressed with their dementia diagnosis beyond early stage and will be presenting with moderate to complex cognitive difficulties with increasing need for caregiver support due to cognitive decline, increased behavioural tendencies and increased health care support related to diagnosed co-morbidities.
With an innovative approach described in the above section achieved, dedicated efforts to implement improvements to transitions and streamline collaboration amongst health care providers will be the focus. It is expected to result in an increase of success for our target population that can later serve as a model for future OHT patients. Having one dedicated OHT care coordinator (CC) will differ from our current system approach experienced by patient and family. Having one OHT CC will facilitate care conferencing and improve warm handoffs within the person's care team. Increasing access to a digital platform will keep partners better informed and improve transitions home from acute care settings. This will be beneficial to supporting timely access to care and improve discharge planning with all identified partners involved. An improved time to first visit by the individual's essential service provider will occur with better coordinated resources planned.

Innovations within the primary care team will result in a "just in time" approach to patient scheduling trialed in one setting which could be duplicated in other primary care environments. With the continued expansion of embedding care coordination in primary care and a shift in having dedicated OHT care coordinators for this particular Year 1 population, the potential of pilots and implementing best practices will continue to expand within the dedicated OHT team. In reviewing the existing inventory of professionals within our system, the functions of care coordination can be supported

with the use of other resources such as hospital social workers, CSS coordinators and First Link Navigators who are already in place but often not recognized for their role in care coordination.

The emphasis on patient/family involvement will deliver a consistent approach to care planning and service implementation. Empowering patient and family roles within the care team as a respected voice of change to the system, is expected to increase satisfaction and truly establish a patient centered approach. Services will be well planned with the capabilities of also responding to crisis situations that may result. Small steps towards innovation with reduced barriers of process that currently exist within the first year, will support the building blocks of a mature OHT. System improvements and initiatives already occurring will continue to be a high priority by the Ministry and our OHT. These include 24/7 access to support, focus on reducing ALC, premature admission to LTC, unnecessary ED and hospital admissions.

Within the modernized home and community care service identified OHT care coordinators will complete intakes, assess needs regardless of setting and pull together essential providers based on need and patient feedback. Reassessment will be the function of the lead agency involved at the time. Strong collaborations will be responsive to changing care needs supporting timely access to specialized supports as well and enhanced supports within the home building on quality improvements currently underway.

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

Our plan for transitioning home and community care resources to our OHT in year one and in following years will be staged and strategic. There are currently several initiatives and collaboration currently in progress between the NE LHIN and community partners, such as One Client One Plan (OCOP), Neighbourhood model, care coordination embedment in primary care, cluster care in retirement homes, and partnerships with community paramedicine. These initiatives will continue to be supported and expanded through Year 1 population and beyond.

For our Year 1 population we have the commitment of the NE LHIN to dedicate CC resources as well as consider realignment of caseloads and development of efficiencies to adequately meet the needs of our Year 1 population. Our intent is to embed HCC care coordination into primary care offices to provide support and integrated care to our year one population. This CC will follow patient through their journey in the health care system, including care, primary care, long term care and community-based services. This collaborative CC will reach out to all community partners and multidisciplinary team members to ensure all services are wrapped around the patient. Individuals and families will be engaged throughout health care planning, delivery and throughout their care journey as an equal member of the care team.

For our Year 1 population, collaboration between our LHIN HCC, as well as North East Specialized Geriatric Care (NESGC), Alzheimer Society, Health Science North (HSN), LTC homes and our HSP/SPO partners will be essential to achieve success. It is also important to note that with the current PSW capacity issues facing our region, providing and meeting our support goals for our Year 1 population and beyond, will be challenging. It will be critical to ensure there is open communication and collaboration on all levels as well as an interest to step “outside the box”, and have SPOs work as one organization to meet the needs of the patient/family.

We also have a commitment from related community partners to continue with open and collaborative dialogue to ensure support and care transitions are completed with ease. As a result, our goal is the individual will receive timely care and has only one CC who follows them through their entire care journey. This CC will follow best practice guidelines, but also be open and flexible to patient wishes and expectations for care. The individual and their caregiver will be at the centre of all care related decisions.

In Year 1 and beyond, we will actively continue working towards embedding and enhancing Care Coordination in primary care offices such as FHT, CHCs as well as other settings such as apartment buildings with high home care and EMS use, as well

as placing attention on our marginalized and immigrant populations. Going forward, primary care providers (Family MD, NP) will have ability to link their patients to care coordinators/system navigators to help them access the support and services they need, whether it's a day program or Meals on Wheels or nursing care in the home.

It will be imperative that all community partners, primary care and care coordinators be able to access and use the same digital tool. CHRIS systems and HPG access will be expanded to ensure all partners have access. With time, the goal will be for all providers to not only have access, but also be able to document patient interactions, assessments, and provide their contributions to a shared care plan.

It will be essential for future years, to clearly identify the current NE LHIN home and community care resources available to expand our OHT. Community/Access Care Coordinators, as well as administration and non-clinical staff will need to be considered when growing our OHT.
Our goal will be to have one assessment completed by the most appropriate person in the patients care journey. Assessments will be shared and all partners will have access and be able to contribute their information. Individuals will have access to their health records and be at the center of all planning. They will only have to tell their story one time, as assessments and sharing of information will be standardized.

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

The following barriers have been identified by our OHT members. These will impede our OHT vision of a modern home and community care model in the Greater City of Sudbury.

I CURRENT LHIN HCC CONTRACTS WITH SERVICE PROVIDER ORGANIZATIONS (SPOs)

Current contracts bind the LHIN HCC care coordinators to fulfill the terms of these contracts, which limits flexibility, innovation and patient choice. Often an SPO is assigned a patient because of a contractual obligation, instead of selecting the most appropriate provider, or taking into consideration patient choice. In the future, home and community care should be freed from these contractual obligations which include guaranteed service volumes. The layers of red tape involved in onerous reporting,

administrative burden and associated costs could be eliminated if current contracts were eliminated or managed elsewhere.
Sudbury has a large proportion of Francophones requiring French language services and not all providers are able to meet this requirement.

II OTHER BARRIERS RELATED TO LHIN HCC

The Home and Community Care Act places restrictions on who can do long-term care assessments and determine eligibility. LHIN HCC care coordinators are also solely responsible to assess patient decision-making capacity for personal and long term care. It also places restrictions on who can coordinate care and complete referrals. This is also reflected in HCC policies and processes, which state that a care coordinator must be a registered professional. This is also a requirement under the "Regulated Health Discipline Act." Due to high patient caseload volumes and workload, decision making can be delayed.

There are many others involved in the health care continuum who do care coordination. That function is common in community support service (CSS) organizations and in hospital. CSS organizations are experienced in coordinating care in a more holistic way.

The LHIN HCC and CSS agencies have both adopted the use of the InterRAI suite of tools. The HCC utilized the Rai-HC, while CSS agencies use the RAI-CHA. Although very similar in nature, there are differences. The Rai scoring is used to determine patient needs but more clinical judgement is needed to truly identify all needs. More trust needs to be established that assessments are completed by competent and skilled staff to avoid duplicate assessments.

Quality and Accreditation Standards specific to LHIN HCC are followed. However, many other providers are also accredited utilizing different sets of standards.
THE LHIN HCC is a regional structure and Sudbury care coordinators support other communities in the area. In addition, Sudbury care coordinators support First Nation Evacuees. This adds to the workload.
III DIGITAL PLATFORMS
There are a variety of digital platforms being used by OHT partners. Although there has been a shift towards the use of HPG and the CHRIS patient software by CSS agencies, HSSO controls the digital platform and there have been delays to implement changes and improvements. OHT members will require training and full access to these platforms. Part of the barrier is the Personal Health Information

Protect Act, related to privacy, confidentiality and the definition of “Circle of Care.”.

IV FUNDING

Funding is an ongoing challenge. The HCC and CSS agencies fully agree that they are the solution to ending hallway health care, but there have not been significant changes to base funding allocations. For example, while there have been new investments to expand services, CSS agencies in Sudbury have only received a 2% increase to base funding in 10 years. Funding needs to complement solutions to enable individuals to remain in home.

There is a need for increased numbers of LHIN HCC care coordinators to manage the large volumes of patients, while completing all functions of their job descriptions. Our OHT Plan calls for expansion of their existing roles which will be a barrier going forward.

Silos in funding, including different physician models, SPO contracts and other contracts such as LSAAs and MSAAs will make it challenging going forward.

V HUMAN RESOURCES

Ongoing PSW shortages are creating extensive waitlists and problems in all sectors including LHIN HCC and CSS providers. Recruitment and retention of qualified workers is becoming increasingly difficult. Collective Agreements and compliance to the Employment Standards will create challenges in the creation of OHTs. For example, wage parity will be a problem when employees from different agencies work side by side. There is an ongoing need for the regulation and accountability of trained PSWs. The wellness of front-line workers is a concern as many are experiencing work burn-out due to prolonged work force shortages.

Sudbury LHIN HCC has a total of 35.5 Care Coordinators who provide care coordination support to on average 3,430 active community patients. The Sudbury LHIN HCC Access team has a total of 33 Care Coordinators who complete a total of 14, 560 referrals per year (280-300 per week).
The OHT for our defined year population, will impact other patients who rely on CC support, but who do not fall within our OHT population. There may be a reduced number of CCs who are able to provide care, navigation and support to these patients.

VI REGIONAL INITIATIVES

LHIN HCC and CSS providers have developed several North East regional \programs including Post Stroke Virtual Assisted Living for High Risk Seniors, Personal Support Services for Low Acuity Clients, Respite Services, Rapid Response Nursing, Telehomecare, North East Healthline, Information and Referral, Health Care Connect, Family Managed Home Care, etc. This regional approach includes standard operating guidelines and compliance reviews. There is one central banker who not only manages funding but also statistics. These regional initiatives have been highly successful, but could be at risk going forward with separate OHTs in our region.

VII LOCAL INITIATIVES

One of the cornerstones of our application is giving individuals more choice in service providers. The Greater City of Sudbury has been divided off into four geographies which have been assigned to four CSS agencies for assisted living high risk seniors, PSS low acuity and respite services. While providing our patients with choice is ideal, this could affect the provider's ability to meet service targets. This group of providers has formed a collaborative partnership which has ensured that these population groups receive quality services. This cohesive partnership could be affected by additional providers providing these services. SPO organizations are also divided geographically for personal support services.

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APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

I OVERVIEW

Équipe santé Sudbury and Districts Ontario Health Team (the Team) will continue to leverage and expand its digital assets through these 3 virtual care models: Video based, telephone audio support and Tele homecare. Video: Ontario Telemedicine Network (OTN) eConsult, PC based Videoconferencing (PCVC) and on premise Videoconferencing equipment is currently available across the Team's region. Patients and family will be offered access to the Team's OTN assets and services to avoid transportation and increase access/use. Clinical use today includes specialty services such as dermatology, oncology, and psychiatry, as well as access to primary care within and across our region.

Audio: An 800 telephone service to the care coordinators will grant patients and clinicians access to live-person support, ensuring quality and oversight. This service ensures access for those patients without high speed internet.

TeleHomecare: The greater city of Sudbury paramedic will deploy home monitoring tools and services. These services are well established and provide additional capacity to support the Year 1 patient population .

II VIRTUAL CARE

While over 10% of the citizens of Sudbury do not possess high speed internet, the Team is working with the City of Sudbury's Smart City project and funding opportunities to increase connectivity and bandwidth in underserviced areas. This is an exciting opportunity with representation from Health, College, University, NOSM and all school boards, which are in the process of partnering with private organizations to implement a low-cost service within the 3 Indigenous hubs in the city of Sudbury.

Given the strength in virtual care, increasing Year 1 patients who received care from our team with a virtual encounter by 2-5% will be met . By offering a care coordination service, these resources will be equipped to promote all of the above

services, which will lead to increased patient literacy, and an increase in clinical adoption. The care coordinators and clinicians will leverage client surveys and audit usage reports to measure efficacy and efficiency for all virtual care. The OTN extensive benefit evaluation framework, templates, and experience will be extended across Year 1. HSN who has also adopted the Canada Health Infoway (CHI) Benefit Evaluation framework during its 2014 CHI Ambulatory project, will be extended across the virtual care services.

III IMPLEMENTATION

The plan is to leverage the existing 4 virtual care models: Video based, telephone audio support, patient portal and Tele homecare. OTN eConsult, PCVC and on premise VC equipment across the OHTs , will enable clinician to clinician and clinician to patient virtual care. Patients and family will be offered access to members OTN assets and services to avoid transportation and increase access/use. An 800 telephone service will grant patients and clinicians access to the care coordinators to ensure quality and oversight. Patients and providers will be able to leave voice messages. The OHT will extend the use of all existing patient portal solutions, whether they are medical record systems such as Accuro, Telus, Myhealth, Alayacare,... or eReferral solutions such as Ocean, or Caredove until a provincial or OHT comprehensive patient portal is developed. And lastly, the paramedic 24 hour services will deploy home monitoring tools and services, increasing Telehomecare.

Increasing the use by 2-5% will be met quickly, in light of existing investments. By offering a care coordination service, these resources will be equipped with the tools to promote each service, increase patient literacy, and support clinicians promoting these services. The care coordinators and clinicians will leverage client surveys and audit usage reports to measure efficacy and efficiency for each virtual care encounter. OTN also possesses extensive benefit evaluation surveys, templates, which will be extended. HSN has also adopted the Canada Health Infoway Benefit Evaluation framework, for all other virtual care services.

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.

I OVERVIEW

Patients accessing their health information is a key enabler for integrated care and will be transformed within eReferral, patient portal and a mobile internet site.

eReferral: The team have access to many eReferral solutions, residing within Caredove, myHealth, Lifelabs and Ocean each solution allows patients to access their appointments and reports online. The Year 1 scope is to expand patients' access to their appointments and patient record (reports) within these existing services. While longer term, a unified and integrated eReferral solution centralizing all appointments and reports would be preferable, leveraging the current assets will allow us to quickly learn, increase patient literacy, and increase family engagement.

Patient Portal: The Team will extend the use of all existing patient portal solutions, which are medical record systems-based such as Accuro, Telus, Myhealth, Alayacare, etc. Over 50% of the team members are in the process of deploying or increasing access to patient portals within their Electronic Medical record vendors. Each vendor provides diverse features: two-way communication, patient record access, self-referral and access to education material.

Internet site: A single landing page centralizing all educational and reading material for patients, families and clinicians to share, will increase collaboration, coordination and standardization. This landing page will possess a public facing material and a secure provider and clinician mobile feature. The secure and non-public site will embed clinical tools, best practice material, links to eReferral forms and services, and focus on building a multi-year collaboration environment.

Longer term a provincial or OHT comprehensive patient portal strategy, centralizing the OHT content including appointments will be required above and beyond the existing local assets. HSN is planning to join the ONE Meditech Expanse NE LHIN service, which will come with a Meditech patient portal but it will remain a hospital-based patient portal. Therefore, the Digital Health Team will work with NE LHIN partners and Ontario Health to conclude an approach and strategy leading to a single provincial or NE LHIN Patient Portal (such as MyChart).

II PATIENT ACCESS TO HEALTH INFORMATION

Patients' access to their health information will reside within eReferral, a patient portal, a mobile internet site and education material (print online).

eReferral is deemed a short term solution to grant patients access to their appointments via the numerous online eReferral solutions in place today, which are: Caredove, My Health, Oceans. Longer term, a unified and integrated eReferral solution would allow clinicians to see all appointments across the OHT, which in return would allow primary care to track, access, and amend, while the patient accesses a single patient portal with all appointments.

Until such time as there is a provincial Patient Portal solution or a NE LHIN based unified patient portal model, primary care should remain the central repository of reports, eReferrals, and clinical data leading to a comprehensive single point of access for patients. The OHT will develop strategies to enhance the use of POI, HRM and Telus/Accuro interoperability features to enhance patient data and access.

II.a. Internet site & Educational material

A single landing page, where lives all educational and reading material for patients, families and clinicians to share, will increase collaboration, coordination and standardization. This central point will offer a secure clinician mobile feature, where common non-public facing material can be shared, such as tools, links to eReferral, contact information and other information.

III OTHER CONSIDERATIONS:

Ontario Health is being asked to negotiate a provincial Microsoft Cloud pricing model and discount. Today, most of the

Team possesses a variety of Microsoft cloud licenses to serve office operations, provide security and to enable collaboration among teams. These tools have been procured to serve corporate business needs. The intent is not to enable clinical and patient collaboration or clinical applications. Microsoft services are being expanded to offer patient to clinician secure text messaging, secure on demand video conferencing, integrated patient portal, and clinical EMR interoperability, Microsoft Cloud services will become the IT infrastructure to enable OHTs. If Ontario Health is not in a position to negotiate an OHT price point, HSN has already negotiated a LHIN wide hospital model and is prepared to work directly with Microsoft Canada.

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).

I LONG TERM

Longer term, clinicians need to possess a device they can carry into all OHT facilities, where all patient record systems are pre-established and available as icons. The password entered upon logging into the device in any OHT organization or at home, will become federated across all modules, systems, icons, etc. There will be “unified identity” across all patient record systems, Office tools, collaboration tools, mobile phone/apps, etc. single IT organization accountable to care for all systems in the OHT, will therefore eliminate the silos, address security and privacy needs, and manage interoperability. This single IT organization will therefore become accountable and contracted to build a single integrated patient record, reducing the fragmentation via interoperability, servicing acute, primary care, LTC, and community.

II HEALTH INFORMATION CUSTODIANS

While HICs will continue to be supported, the goal is to transition to a single Agent to avoid complex security, privacy and data sharing models. This Agent will not only become a single IT organization holding all vendor contracts, but a centre of

excellence in Informatics which includes change management, project management, analytics, AI, research and overall accountability for adoption and standardization. Funding, governance and releasing controls will be challenging within the OHT, but the efficiencies gained in clinical workflow and patient centered care will make the effort worthwhile.

III SHORT TERM

In the short term, information sharing and planning among clinicians and entities will be supplied via interoperability services, a dedicated IT team and consolidated platforms.
Interoperability services will leverage existing services, such as POI, HRM, CCIM/IAr and HPG. HSN today hosts and services NEODIN, NEON, POI, CCIM/IAR and supplies NE LHIN Hospital data to Connecting Ontario, HRM. Each organization will optimize their processes to ensure expedited documentation is shared within these services, avoiding the use of interim options: faxing, phone, and texting, HSN who currently does not contribute to CCIM/IAR due to privacy barriers, will enable this functionality giving providers access to Mental Health assessments.

A dedicated team: Leveraging HSN experience and resources will lead to expedited solutions and services. HSN has begun exploring the possibility of leveraging the Telus interoperability features, which should lead to enhanced importing and exporting of primary care and hospital data. HSN has also submitted a funding proposal to Ontario Health, as part of its NEODIN accountability, to integrate NE LIN images between hospitals and independent health facilities. HSN has already enabled this service within the Champlain LHIN. HSN will work with the Digital Health team members, to further expand leveraging provincial assets and its Ontario Health contacts.

Consolidating platforms: Leveraging and reducing the number of primary care instances will increase standardization and ease integration within the hospital sector, who are well advanced in their consolidation plans within the NE LHIN. Transitioning to cloud based primary care solutions should further be considered to allow vendors partnered with OHT entities to deal with interoperability, security and privacy matters.

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

Excel, manual audits, online surveys and OHT decision support resources will continue to be used to monitor quality and performance. The central care coordinator and the OHT team members, will be provided with aggregated data. Data we plan on measuring are:

# of Secure text messaging transactions: clinician to clinician and clinician to patients
% positive feedback from patients/family
% clinician feedback and surveys
% ED avoidance and lower admissions
% meaningful virtual visits (use of platforms)
10-15% increase: Patients who have access virtual care
10-15%: patients have accessed patient portals
# of Travel Avoidance
# of virtual home consults
85% satisfaction with care transition
100% of target population will receive a phone call upon hospital discharge
15 from baseline – primary care reassessments will be conducted within 7 days of discharge.
# of incremental HRM, POI and HPG reports/data exchanged across the OHTs.

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

Cloud-based applications that can serve OHTs are constantly being introduced and made available, especially as we learn from other OHTs, provinces, the United States, Meaningful User and accountable care. For example, Microsoft is sunsetting the cloud based skype, collaboration services, and transitioning to TEAMS: a secure text messaging, communication, on-demand video and patient record collaboration solution. Within this traditional Microsoft Office 365 and email system, offering vendors to build OHT mobile apps, including patient portals, integrating hospital information systems, care coordination, analytics, etc.

Remaining fluent and continuously learning, the Digital Health working team will meet on a monthly basis, allowing for vendor presentations, strengthening our knowledge on the art of the possible and constantly adjusting with the market. Furthermore, the use of fax machines is an example of the lack of digital services within the OHT, a symptom of diverse systems, complex processes, and siloed IT organizations. It has become obvious throughout our OHT Digital Health working group that we have been given the opportunity to solve these problems collaboratively which is a great opportunity to build new relationships with patients, clinicians, and vendors.

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

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

Name:	
Title & Organization:	,
Email:	
Phone:	

Appendix – Glossary of Terms and Acronyms

Appendix – References and Endnotes

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Appendix – Section 3

Year one	Year two	Year three
Transitions – streamlined, collaborations	Health Literacy	Long Term Care
Timely Access to Care	Acute Care	Mental Health and Addictions
Care Coordination, Dedicated Resource, Best Practice & Learnings	Electronic Record/Patient Portal	Primary Care – Orphaned patients
Patient Engagement	Indigenous	LGBTQ
Francophones		New immigrants

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North East LHIN Delivered Home and Community Care Services

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Information & Referral	The Information & Referral (I&R) Program is a regional program that serves people across the entire North East LHIN geographical area by providing information to connect the public to various community agencies. It also provides information on long-term care homes and North East LHIN programs and services**.** The Program is an integrated model with a *regional* toll free telephone line, 310-2222, available to all residents.
Health Line	A publically accessible online database of health services (public and private) maintained through regular updates by a team home and community care team assistants (Current content is estimated to be 98% up to date) Health Services for North East - northeasthealthline.ca https://connect.northeasthealthline.ca/ -- Offers a way for the public to access LHIN-funded community support services and mental health and addiction services through use of a common referral form. 211 Telephone Information line, Citizen Service Centres and Libraries
Health Care Connect	Health Care Connect is a program funded through the Ministry of Health-Long Term Care that refers Ontarians who do not have a physician to a primary care provider (family physician or nurse practitioner) who may be accepting new patients in their community. This program is managed through a team of registered nursing staff.
Care Coordination	NE LHIN Home & Community Care is responsible for coordinating services as set out in the Home & Community Care Services Act 1994. Care Coordinators are regulated health professionals with expertise in nursing, social work, occupational therapy, physiotherapy or speech therapy, who work directly with patients in hospitals, doctor's offices, communities, schools and in patients' homes. NE LHIN Care Coordinators work with patients and families across Northeastern Ontario.
Nursing Services	• In home nursing services (visits or shift) • Ambulatory clinic nursing • Rapid Response nursing • Nurses Skilled in Wound, Ostomy & Continence
Nurse Practitioner	• Palliative Care

- Primary Care

Telehomecare	Remote monitoring of patients with Chronic Obstructive Pulmonary Disease (COPD) or Heart Failure (HF) using tablets by a team of registered nursing staff.
Therapy Services	In home therapy services are provided on a short-term basis to determine needs, to provide recommendations, to teach self-managed care, or for the direct provision of therapy. Therapy services include: • Dietetics • Occupational Therapy • Physiotherapy • Social Work • Speech-Language Pathology
Personal Support	Provides people support with activities of daily living/personal hygiene according to maximums established through legislation.
Placement Services	Care Coordinators complete assessments and determination of eligibility for short-term, long-term and interim placement to long-term care homes.
Medical Supplies	Medical supplies may be provided on a short-term basis to support professional interventions such as nursing and some therapy services.
Medical Equipment	Medical equipment rental may be provided to support short term needs.
Ontario Drug Benefits	The NE LHIN is authorized to issue Ontario Drug Benefits Cards to patients for coverage of medications related to the reasons for which they are receiving treatment, for example: IV therapy.
In Home Laboratory Services	Care Coordinators are able to authorize in-home lab services for home- bound patients where there are no alternatives such in mobile lab services available in the community in which they require the services.
Transportation	Care Coordinators are able to authorize ground and air transportation for patients on care, for medically necessary reasons.
Medically Complex Children	Support for medically complex children and families includes: • Care Coordination • In home nursing, personal support and therapy services • In school nursing and personal support services • Mental Health and Addictions Nurses in schools • Eligibility determination for Enhanced Funding

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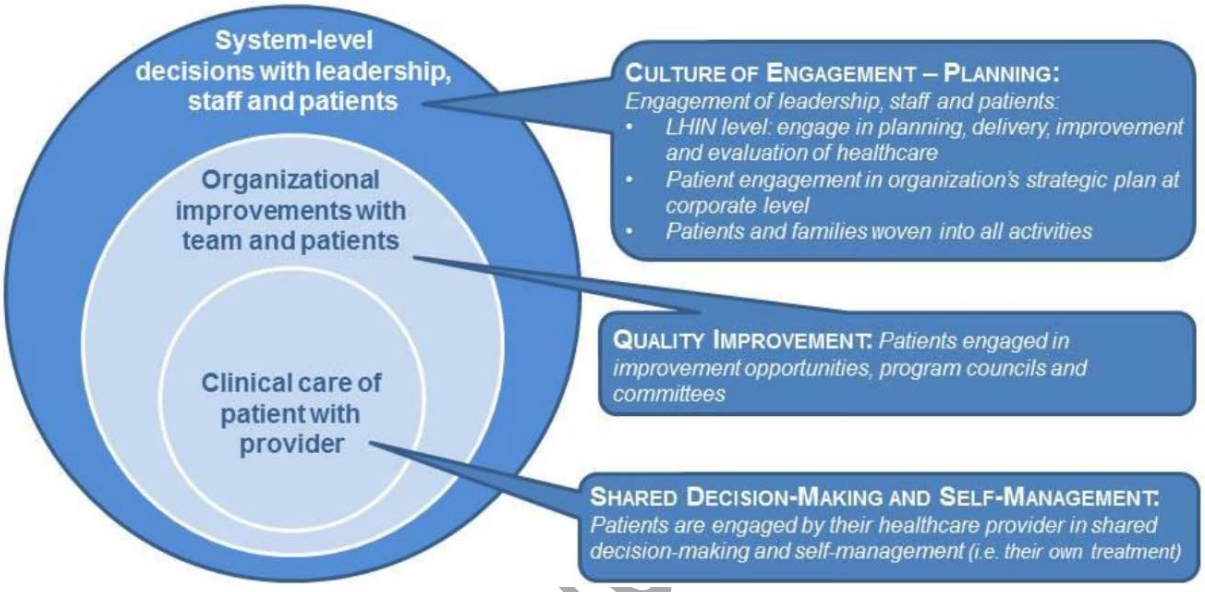
HSN Partners – Three Levels of Patient Engagement

Patient engagement means including the voice of patients and families in our work; from point of care to the planning table, to ensure we deliver patient-centred care.



Priority (need to identify the intervention/service/etc. that happens with the priorities)	**Outcomes**	**Data/Measure**	**Targets (what target are we trying to achieve from baseline? What is baseline?)**	**Source (where is this data coming from, is there a proxy? Is there baseline data available?)**
Improved transitions	All OHT patients will experience more successful and streamlined transitions across all care services and service providers, leading to patients receiving care at the right time, and in the more appropriate setting	- Patient experience with care transitions - % of OHT year 1 patients connected with in-home services within 24 hours following discharge from hospital - % of patients who are reassessed by their primary care provider and care coordinator within 7 days of discharge from hospital	- 85% patient satisfaction with care transitions - 100% - 15% increase from baseline (baseline from HCC)	- Patient experience tool (needs to be adopted) - HCC - Baseline and future data from HCC but access through HSN
Timely Access to Care	Patients will receive timely access to the right care in the	- % of patients who have access to same day/next day primary care appointments to address acute or escalating	- 100% of patients will have access to same day/next day appointments	- Tracked on a pilot bass with one primary care provider/clinic (ex:

	right place, promoting optimal outcomes	issues.		NEOMO). Currently, the goal is within 5 days. 98.1% and 88.6% of patients receive their nursing and personal support services, respectively.
Care Coordination, Dedicated Resources, Leverage Best Practice and Learning	There will be dedicated care coordination resources that use best practice guidelines and learnings to provide care coordination that benefits the providers as well as the patients and caregivers	- % of patients who meet the year one population criteria who are receiving services from the OHT model (this can be from a care coordinator, system navigator, primary care practitioner, etc. depending on complexity). - Care coordinators will be embedded/connected to OHT-member primary care practitioners, as needed.	- 100% of patients meeting year 1 criteria will be receiving services in the OHT model - Unable to attach a target at this time without knowing patient volumes as some primary care providers will already have care coordinators embedded, and some will come from HCC - 80% satisfaction *we	- Primary care - HCC & Primary Care - Care provider satisfaction tool

		- Care provider satisfaction	need a proxy or new metric for this.	(needs to be adopted)
Patient and Family Engagement	Patients and families will be engaged throughout health care planning, delivery and throughout their care journey as an equal member of the care team (involved in all levels of OHT as partner)	- Patient and caregiver satisfaction (patient and caregivers are included in discharge planning) - Utilization of respite services to relieve caregivers - Caregiver burden: caregivers are feeling better supported and less overwhelmed caring for their loved ones	- 85% patient satisfaction with care transitions - 15% increase from baseline in referrals for respite care and referrals used; 15% decrease in cancelled/missed referrals - A decrease in Zarit Burden Score between pre-post survey	- Patient experience tool (needs to be adopted) - HCC - Zarit Burden survey results to be administered at outset of patient journey and at 6 months

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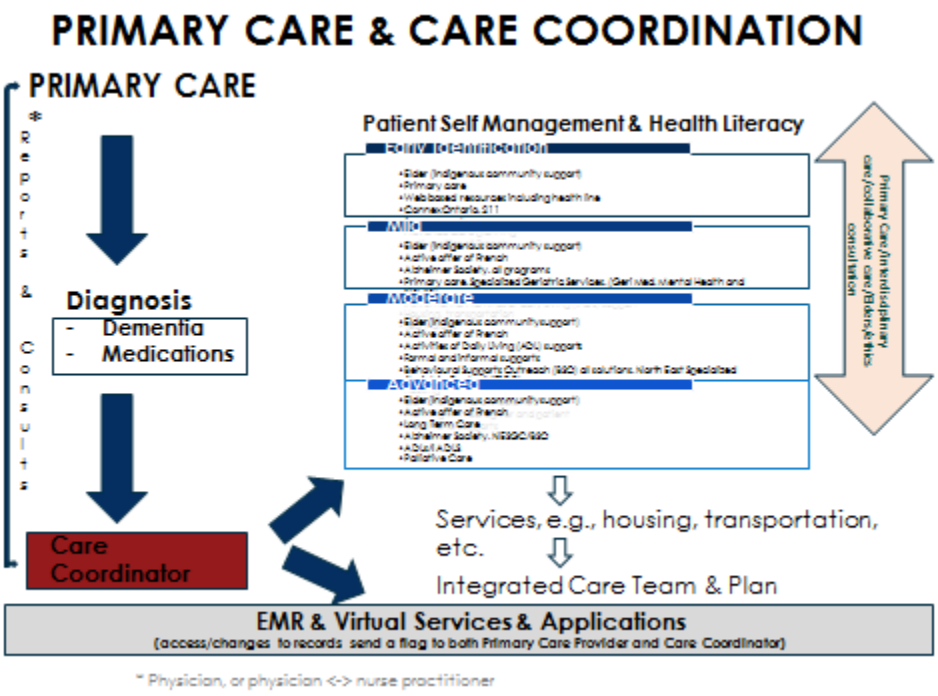

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NE LHIN Dementia Service Model – Patient Centered Care

North East Dementia Strategy 2018

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Memorandum of Understanding

This Memorandum of Understanding is made as of the 19th day of December 2019 amongst all Members who are part of "Équipe Santé Sudbury & Districts Health Team".

1. **PURPOSE OF THE MEMORANDUM OF UNDERSTANDING.** The purpose of this Memorandum of Understanding is to formalize how the Members will work together in the planning and design phase towards the creation of an "Équipe Santé Sudbury & Districts Health Team" (OHT) between December 19, 2019 and the completion of the first year of operation of the OHT after its approval by the Ontario Ministry of Health.

   This Memorandum of Understanding builds on the Readiness Self-Assessment submitted by 39 organizations and individuals to the Ministry of Health on May 15, 2019 who declared their intent to work together, and subsequent consensus reached between the Members with regards to guiding principles for the OHT.

   The Members acknowledge the utility to reaffirm how they will engage with one another.

   Through this Memorandum of Understanding, the Members want to articulate how they will drive the design of the OHT to best suit the needs and interests of the local OHT. The planning and design phase of the OHT sets the tone and expectations for our conduct and relationships as Members that will then continue through the journey of the creation of the OHT.

   In short, the purpose of the Memorandum of Understanding is to provide a framework for the Members to work together and support their collaboration.

   This Memorandum of Understanding does not change the independent governance and authority of the Boards of Directors of the Members, or of other governing bodies.

2. **PROCESS.** Using the RISE (Rapid Improvement Support and Exchange) brief #3: Collaborative Governance as guideline, Members will work on establishing a written agreement that addresses the requirements articulated in the Ministry's OHT guidance document including;
   a. decision making
   b. conflict resolution
   c. performance management
   d. information sharing
   e. resource allocation

   with the aim of arriving at a collaborative governance model at the end of Year 1 that will include;
   a. a central brand
   b. a strategic plan
   c. coverage of the full continuum of care
   d. a single and fiscal accountability framework
   e. an anticipated service delivery model and a framework for achieving all of the prescribed OHT components required for a fully functioning OHT at maturity;

f. A governance structure and joint management model;
g. An approach to funding allocation and administration of funds;
h. Termination and wind-up rights and obligations;
i. Insurance and indemnity requirements for all participating Parties;
j. A collaborative process and principles to be established to identify the timing and transition of provider services.

3. MUTUALITY

The Parties agree that in their interactions with each other they will: (i) demonstrate and maintain transparency and trust; (ii) demonstrate and maintain responsiveness to timelines and communications; and (iii) maintain acceptable levels of privacy and confidentiality protection.
The Members agree to follow the follow the Values, Guiding Principles as already agreed to. In addition, the Members agree to meet the Year 1 and Long Term Expectations of OHTs (as defined by the MoH).

4. RELATIONSHIP BETWEEN THE PARTIES

4.1 For the purposes of this MOU, no Party shall have authority to make any statements, representations, or commitments of any kind, or to take any action which shall be binding on any other Party except as may be explicitly provided for in this MOU or authorized in writing by another Party

4.2 Except as explicitly provided in this MOU, no Party shall, in any public statement refer to the relationship of the other Parties to the collaboration pursuant to this MOU, or otherwise use the other Parties' name(s), without the prior written consent of the other Parties.

4.3 Nothing in this MOU shall be deemed to create any other relationship between the Parties, including, without limitation, a partnership or joint venture.

5. NON-BINDING MEMORANDUM OF UNDERSTANDING

The Parties agree that the terms of this MOU are non-binding except to the extent specified herein.

5.1 This MOU constitutes the mutual intention of the Parties with respect to its contents. This MOU is a formal undertaking and implies that the signatories will strive to reach, to the best of their ability, the objectives stated in this MOU.

5.2 The Parties understand and agree that no Party shall have any obligation or commitment to enter into a definitive agreement or to otherwise engage in business activities with the other Parties, unless and until the terms of such business relationship are accepted by the Parties and any required definitive agreement(s) is executed by authorized representatives of all Parties.

6. TERM AND TERMINATION

6.1 The term of this MOU is for a period of time necessary to enter into a definitive collaboration agreement.

6.2 Each Party to this MOU shall have the unilateral right to terminate this MOU without penalties or liabilities upon providing the other Parties with thirty (30) days written notice prior to the effective date of the termination.

7. ATTACHMENT

The Members support continuing to work on the draft Interim Collaboration Agreement as outlined in the attached recognizing that this is a living document that will change as Members continue to work through this meaningful and thoughtful engagement process. Year 1 Members will endeavor to finalize the Interim Collaboration Agreement by February 14, 2020.

<Attachment circulated independently>