Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

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

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

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

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

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

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

Participation in Central Program Evaluation

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

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

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Additional Notes

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

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

Ontario Health Teams
Full Application Form

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Linda Boich
	Title: Executive Vice President
	Organization: Niagara Health
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Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Kelly Cimek
	Title: Director, Planning
	Organization: HNHB LHIN
	Email: kelly.cimek@lhins.on.ca
	Phone: 905-945-4930 ext. 4249

1. About Your Population

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

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

1.1. Who will you be accountable for at maturity?

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

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

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

[2] 'Year 1' is unique to each Ontario Health Team and refers to the first twelve months of a team's operations, starting from when a team is selected to be an Ontario Health Team Candidate.

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

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

Maximum word count: 1000

In the Niagara Ontario Health Team - Équipe santé Ontario Niagara (NOHT-ESON) Self-Assessment, we proposed to be accountable at maturity for urban and rural Niagara region, which consists of 12 municipalities (Grimsby, Fort Erie, Lincoln, Niagara Falls, Niagara-on-the-Lake, Pelham, Port Colborne, St. Catharines, Thorold, Wainfleet, Welland, and West Lincoln) with a total population of 447,888 residents . The NOHT-ESON additionally recognized that our participating provider partners and collaborators may serve different catchment areas which may include Ontarians outside this region.

The population attributed to the NOHT-ESON, however, was defined through service utilization analysis of PEMS (primary care patient enrollment models) instead of geographic boundaries. This analysis was used to identify existing patterns of patient flow through virtual multispecialty physician networks comprised of primary care physicians and specialists, and the hospital where most of their patients are admitted. The NOHT-ESON recognizes the value of this patient attribution model as it places the patient/client at the centre, aligns with existing patient/client pathways and referral networks, and continues to respect the ability of patients/clients to retain full choice in who they see for their care.

This proposed population, and in particular respecting the unique catchment areas of our partners, aligns with the methodology through which patients/clients were subsequently attributed to the NOHT-ESON. Both our Self-Assessment, and the approach to attributing a patient population to OHTs by the Ministry of Health, recognize and place emphasis on existing patterns of patient flow.

The NOHT-ESON main accountability of the attributed patient population includes 364,720 residents of the Niagara region (excluding Grimsby and West Lincoln), as well as an additional 23,046 residents from other communities, for a total of 387,766 Ontarians. All service providers will continue delivering services within their current

contracts and catchment areas which may include Grimsby and West Lincoln. As a result, the MOH patient attribution model has attributed approximately 90% of Niagara region residents (excluding Grimsby and West Lincoln) to the NOHT-ESON, 8% of Niagara region residents to the Hamilton Health Team (typically Niagara region residents who access networks of primary care and specialist physicians that admit to hospitals located in Hamilton and Grimsby), and 2% of Niagara region residents to other Ontario Health Teams.

In our review of our attributed patient population, we see a high degree of alignment between the attributed patient population and the population and service area that our team proposed in our Self-Assessment, with 94% of our attributed population coming from 10 of the 12 municipalities in the Niagara Region. The outcomes of the patient attribution model for our OHT demonstrate a high degree of local service utilization by those who live in the Niagara region. This utilization is likely due to some of the unique characteristics of our geography, being a peninsula (with only one or perhaps two bordering OHTs) which makes care access patterns a bit insulated from other networks. This is evident in that our OHT has only one large acute hospital corporation, one specialty chronic/rehab hospital and only one PEM identified with patients that are also aligned to the Hamilton OHT. The most significant area of difference between our attributed patient population and our initially proposed population focus is a smaller than anticipated attributed patient population in the western areas of our region (i.e. Grimsby, West Lincoln and some parts of Lincoln).

Additionally, we note that the attribution model does not fully capture the following patient/client groups:
• Those served by non-patient enrollment model primary care practices (4 Community Health Centres and 58 fee-for-service physicians);
• Indigenous peoples
• People who are not currently attached to a primary care provider; and,
• People who are uninsured and who are accessing care within the system.

Therefore, we may anticipate the NOHT-ESON attributed patient population to increase once the service utilization of these population groups is analyzed and linked to appropriate networks. For example, the NOHT-ESON anticipates that a large number of patients/clients who access CHCs and fee-for-service physicians in Niagara are served for those who typically admit their patients to the single hospital member of our OHT.

Our broad network of partners and collaborators within the NOHT-ESON includes organizations who represent services across the full continuum of care, and organizations with a strong population-health and equity focus which positions us well to improve spread of health system improvements across Niagara.

The NOHT-ESON also identifies opportunities to work to build culturally safe and competent practices to better serve Indigenous peoples, and be more responsive to individual Francophone needs for those who access care in our network. To

accomplish this, the NOHT-ESON Planning Table includes multiple Francophone organizations, and provides an open invitation to providers who form the Indigenous Health Network to join and participate in the NOHT-ESON. Members of the Planning Table have also participated in two reconciliation and cultural competency workshops with the Indigenous Health Network (IHN), and are engaged in the regular sharing of information with this Network and its member providers.

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

In Year 1, the Niagara Ontario Health Team - Équipe santé Ontario Niagara (NOHT-ESON) will target the top 5% of people who use services provided by partners, which includes high-users across health care, community support sector, and social services (hereafter referred to 'health and social care'), and recognizes the unique barriers to health for Indigenous, Francophone or otherwise marginalized people. Individuals will benefit from an integrated care approach as they are often served by multiple organizations across health and social care and are atIn Year 1, the Niagara Ontario Health Team - Équipe santé Ontario Niagara (NOHT-ESON) will target the top 5% of people who use the services provided by signatories and collaborators, which includes high-users across health care, community support sector, and social services (hereafter referred to 'health and social care'), and recognizes the unique barriers to health for Indigenous, Francophone or otherwise marginalized people. Individuals will benefit from an integrated care approach as they are often served by multiple organizations across health and social care and are at risk to experience fragmented, uncoordinated care. In addition, the NOHT-ESON recognizes the need for an equitable approach to population health. That is, the Team will invest more time

and resources into this highest acuity, highest risk population, and over time ensure that we help keep the entire population healthier.

People within this 5% typically are experiencing one or more of the following:
• Complex medical needs and/or 4 or more chronic conditions
• Mental health and/or addictions issues;
• Complex social care needs including low-income/poverty, homelessness, no family/caregiver support, social isolation and those with psychological distress
• Developmental traumas (adult or children/youth) and/or;
• Multiple cross-sector needs (e.g. children and youth with Autism, developmental, medical, mental health/addictions and other needs).

This definition expands our proposed Target Year 1 population definition from our Self-Assessment in that it better defines people with health and social complexity from all of our individual partner and collaborator perspectives. Our proposed interventions will be designed to target 1,400 individuals within our Year 1 population, and will provide the framework for improved care for our entire attributed population at maturity.

The health care needs of the target population are broad and complex. Our Year 1 target population accesses hospital emergency departments and inpatient care, complex continuing care and rehab, home and community care, mental health and addictions services, and community support services at a higher rate than the rest of the attributed population. Not all individuals within NOHT-ESON Year 1 target are attached to a primary care physician (which is understood to be a protective effect to mitigate against increased levels of health care utilization). Given the complexity of health and social needs, primary care physicians may be challenged to coordinate their care. Local data indicates that Standardized ACG Morbidity Index (SAMI) scores (a measure of complexity of patients served in primary care) for Niagara region are in fact 5-10% above the average for Ontarians. Integrated care planning therefore presents a distinct opportunity for our OHT to both support primary care providers in serving their patients and improve health outcomes for patients/clients within the Year 1 population.

Other population cohorts are defined as: chronic (risk rising), stable (at risk) and well (unknown risk). These population segments typically use less health and social care resources, however will benefit through system redesign planned in subsequent years (please see Appendix C: Population Pyramid and Approach to Care). Our Year 1 focus will be leveraged to improve care for all system users at maturity by improving integrated care, improved service navigation, increased transitions to in-home and community based supports, and, improved access to communication. Through our focus in Year 1, the NOHT-ESON will benefit all system users through:
1. Increased ability to transition and link all patients/clients to the right service, at the right time, in the right place;
2. Improved provider-to-provider information flow, communication and relationship;
3. Increased patient/client, family and caregiver access to information; and,

4. Better experience and culturally safe and competent care for priority patients including Francophone, Indigenous and marginalized populations.

The overall costs for this target population are challenging to specify based on the data provided and collected to date for two reasons. The first is that the target population often has many co-morbid conditions, and as such, are not reflected in only one Health Provider Grouping category, but across multiple categories. In total, the top 5% population attributed to NOHT-ESON with significant co-morbidities represent an approximate total annual spend in excess of $700M across the continuum of care. This presents an opportunity to better identify and track health-spending across the care journey for the target population and identify opportunities for efficiency and improvement. Secondly, current data systems do not fully capture and do not consolidate all health and social system costs for patients/clients (e.g. community support services, EMS, and both services and transfer payments funded by other provincial ministries such as the Ministry of Children, Community and Social Services).

In identifying a Year 1 target population, the NOHT-ESON examined 2018/19 data related to the top 200 most frequent Emergency Department (ED) users, and found that these individuals visited the ED 5,037 times for an average of 25 times/year. Their top ED diagnosis categories were:
1. Abdominal and pelvic pain (454 ED visits)
2. Pain in chest and throat & other cardiac (272 visits)
3. Mental health and behavioural disorders (776 ED visits)
4. Mental health and behavioural disorders due to addiction or substance abuse (241 ED visits)
5. Dorsalgia visits related to back pain, backache or spine pain (121 ED visits)

In particular, it is important to note that the NOHT-ESON Year 1 target population, such as individuals with mental health and addictions, are increasingly accessing the ED for their health care. For example, in 2018 St. Catharines ranked first among municipalities in Ontario with populations of more than 100,000, for the number of residents who visited emergency departments experiencing opioid overdose. This is a marked difference for Niagara when compared to even 2016 and 2017 levels.

The top inpatient admissions through the ED make up 15% or 3,421 of all ED admits (19,196). On average, these individuals:
- Are older adults (average age 73);
- Have 4 or more comorbidities (26%);
- Represent 1.2 admissions on average;
- Have an average length of hospital stay of 7.6 days;
- Have a high ALC rate (16.7%);
- Have a higher risk of being readmitted within 30 days (14.6%); and,
- Have a higher risk of revisiting the ED within 7 days (10.4%).

Importantly, through our combined focus on individuals who are highly reliant on the

system for their care but continue to have unmet needs, we will embed strategies that will benefit all system users and maximize the impact of our health and social care investments.

The high prevalence and associated costs make this target population a logical starting point for a Year 1 focus for the NOHT-ESON. Through focusing on these populations together, we will be able to advance the Quadruple Aim objectives of:
- Improved patient/client (and family and caregiver) experience;
- Improved population health;
- Reduced health system costs; and,
- Improved care team well-being.

A high-level overview of the Full Application submission is provided in Appendix D: Executive Summary of NOHT-ESON Full Application.

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

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

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

  To support an understanding of Niagara region's population and demographic composition at a high level, Niagara Region Public Health has envisioned "Niagara's Village of 100" . Within this village:
  • 21 would be under the age of 20 years old;
  • 23 would be between 20 and 39 years old;
  • 35 would be between 40 and 64 years old;
  • 21 would be older than 64 years old;
  • 48 would be male; 52 would be female;
  • After taxes, median family income would be $72,105 and $46,684 for single

[3] Sub-region data was provided by the MOH to the LHINs in Fall 2018 as part of the Environmental Scan to support Integrated Health Service Plans. This data is available by request from your LHIN or from the MOH.

parents; and
• 82 people were born in Canada, 17 immigrated to Niagara, and 1 are a non-permanent resident.

Compared to Ontario, Niagara has an older population (second highest number of people aged 65+ and 75+ years across all Ontario sub-regions), lower income rates and people living in poverty, higher prevalence of health conditions (such as arthritis, cardiac), higher rates of negative health behaviours (such as smoking), high rates of premature death and a shorter life expectancy at birth.

In considering a population-health management approach and health equity lens, the NOHT-ESON notes a number of additional socio-economic and demographic factors which impact health outcomes and present unique barriers to health. These considerations must and will be reflected within all interventions used to improve health outcomes and patient/client care experiences.

1. There a number of systemic barriers that result in poorer health outcomes for Indigenous populations, including inequitable access and funding for Indigenous-led and Indigenous-delivered health care services. The NOHT-ESON recognizes that income, employment, housing, and health outcomes of Indigenous peoples fall well below broader community standards. At present, no single data source provides a complete picture of Indigenous populations' health outcomes in Ontario. In considering non-Indigenous organizations providing care to Indigenous populations, NOHT-ESON identifies that services offered should be both culturally-safe, and delivered by culturally competent health care providers. A key component of ensuring this delivery is continuing to build relationships and understanding between non-Indigenous providers and Indigenous health authorities, networks, providers and communities.

2. Language barriers, such as those experienced by Niagara's Francophone population, tend to contribute to poorer patient/client assessment, misdiagnosis, and decreased confidence in services received. To address these concerns, the NOHT-ESON identifies a need to focus on increasing the number of bilingual health professionals in the region, increasing the capacity to deliver Francophone services across the continuum of care, and improving access to Francophone services. The Niagara sub-region is comprised of 382,759 Ontarians, and includes the highest percentage of people who report French as their mother tongue in the geography of the HNHB LHIN (5.4%).

3. Underlying stigma and discrimination often negatively impacts the LGBTQ+ community, including their physical and mental health. For example, due to a lack of access to appropriate, non-judgmental care, individuals who are sexually and gender-diverse experience health inequities when compared

to heterosexual or cis-gendered individuals, such as: increased risk of cancer (breast and anal), STIs, and depression and suicidality. The NOHT-ESON will seek to leverage the capacity to serve the LGBTQ+ community through knowledgeable partners such as Quest CHC – who currently operates the third largest trans health clinic in Canada and provides trans care to patients/clients attached to external primary care providers.

4. Niagara region is home to 3,000 Migrant Agricultural Workers employed by local businesses through the federal Temporary Foreign Worker program. Migrant workers experience a variety of challenges accessing primary care and other health services due to language/cultural barriers, scheduling issues, lack of transportation, a fear of loss of employment, social isolation, literacy issues and lack of information regarding available health services. Common health challenges for this population are often compounded by their work conditions/job exposure, and include: hypertension, diabetes, musculoskeletal injuries/pain, dermatological, respiratory diseases and abdominal pain.

5. Affordable housing and access to housing with support services (Housing First or Home for Good best practice models), similar to other areas within the province, remains a challenge in Niagara region. Niagara has seen a dramatic increase in emergency shelter occupancy rates beginning in 2015 (2015: 85%; 2016: 98%; 2017: 108%; and, 2018: 105%) as a result of declining rental vacancy rates of low-market housing, and overall increases in rental and housing prices.

6. The Ontario Marginalization Index shows significant variation across Niagara with areas experiencing the highest levels of material deprivation. St. Catharines, Niagara Falls, Welland, Port Colborne, and Fort Erie demonstrate poor population measures of health and social well-being. The index is composite measure of 6 indicators: high school education, lone parent families, government transfer payments, unemployment, low-income families, and housing in need of repair.

Members of the NOHT-ESON recognize that considerations related to health equity and population health will be instrumental to the people-centred/driven focus of our OHT model, and will include:
• Supporting Indigenous-led and delivered services;
• Providing culturally safe services and/or using culturally-informed practices;
• Ensuring language-specific services are available for Francophone and newcomer communities;
• Embedding principles of trauma informed care and harm reduction; and,
• Delivering holistic models of care across the lifespan continuum.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

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

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

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

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

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

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

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

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

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

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

Max word count: 500

Through the Self-Assessment process, we engaged with organizations across the Niagara region to initiate planning. Through those efforts, 36 partners were identified during the Self-Assessment planning process. We have continued to expand our

[5] Indicate whether the organization is a Health Service Provider as defined under the *Local Health System Integration Act, 2006* (and if so what kind – hospital, long-term care home, etc.), Community Support Service Agency, Service Provider Organization, Public Health Unit, Independent Health Facility, Municipality, Provider of Private Health Care Services, Other: Please specify

memberships and partnerships, and the NOHT-ESON Planning Table now includes: 42 ‘Partners’; 2 ‘Collaborators’; 6 patient/client, family and caregiver advisors. Overall, 60 primary care physicians are included as partners through their physician groups.

The number and breadth of partners involved in this Ontario Health Team is a strategic advantage as we move forward. The NOHT-ESON includes health and social care providers and organizations across the entire geography of the Niagara region, to ensure the Planning Table is well positioned to drive meaningful progress on key Ontario Health Team metrics, building on trusting relationships and partnerships.

Our strategic advantages:

Organizations collaborating at the Planning Table have numerous and long-standing formal and informal partnerships that support successful delivery of integrated and coordinated patient/client care services across the lifespan and continuum of care, and have a successful track record of working together to improve population health outcomes for the residents of Niagara. (See section 2.4 for further information.) The diverse range of health and social care providers and organizations at the Planning Table represents a key strategic advantage of the NOHT-ESON to support spread and scale at maturity.

As we proceed, other service provider partners will be identified and invited to join the NOHT-ESON Planning Table, underpinned by our philosophy of inclusion and partnerships.

We have agreed on a set of guiding principles (see Appendix E: Guiding Principles) to inform our work moving forward, and are committing to continue the development of the NOHT-ESON through a Collaboration Agreement. The NOHT-ESON has developed tools to ensure ongoing communication and transparency among all participants, and will provide onboarding support for new partners as they join the OHT.

Collaborating to advance the Quadruple Aim:

Key members who have been invited and engaged at various points along the process, but have not been regular participants at the NOHT-ESON Planning Table in the completion of this application, include:
• Indigenous service providers
The NOHT-ESON currently has an open invitation to Indigenous service providers who sit on the Indigenous Health Network to join and participate if and when they deem appropriate.
• Primary care physicians who are not included in team-based care models
A Primary Care Retreat occurred on September 7, 2019 that included solo and team-based primary care providers to share information and elicit input regarding key

priorities for the NOHT-ESON.

As a team, we are committed to ongoing outreach and collaboration in recognition of the collective benefits of a continued partnership to form one NOHT-ESON. More importantly, we acknowledge that this is the beginning of a journey, that there are knowns and unknowns, and our discussions will continue to evolve as we engage in comprehensive planning to deliver on the vision of a full continuum of care that is integrated, innovative, and improves health outcomes and experiences for people and providers, and ensures value for our broader Niagara community.

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

Participants around the table include long-standing health and social care delivery partners and new partners to expand ability to focus on population health and across the full continuum of care. Among the 44 partners and collaborators involved in some capacity in the NOHT-ESON, no member identified as having never worked with another member. This is illustrative of the strong relationships and history of collaboration in the region. On average, members indicated partnerships or collaborative activities with at least 15 other members of the NOHT-ESON. Please see Appendix F: Collaboration Matrix, for a summary of our existing partnerships and working relationships.

A sampling of collaboration initiatives involving NOHT-ESON members include:

Population-Level Initiatives

• Members: Centre de santé communautaire Hamilton/Niagara, Quest Community Health Centre, Bridges Community Health Centre, Niagara Falls Community Health Centre. An advisory committee guides this work and includes additional partners not listed above.

o Initiative: One of the most recent and successful partnerships has been the collaboration of Niagara's four Community Health Centres in the creation of the Interprofessional Primary Care (IPC) Mental Health and Addictions Team. With a team of 6 Mental Health Counsellors and 3 Mental Health Outreach Workers, the team provides individual psychotherapy and psychosocial support to clients of primary care providers working in solo practice through a central referral process

- ☐Since 2018, received over 1,350 referrals from 115 physicians/nurse practitioners
- ☐97% of patients/clients reported a positive impact on their overall mental health

• Members: (Four-site model) Centre de santé communautaire, Fort Erie Native Friendship Centre, Contact Niagara for Children's and Developmental Services, John Howard Society of Niagara, and service partners: Pathstone Mental Health, Community Addictions Services of Niagara, the RAFT and a bilingual nurse practitioner.

o Initiative: Integrated youth services sites (YWHO) serves youth, with a priority focus on people who identify as Indigenous or Francophone, and provides low-barrier, quick access to mental health and addictions services, housing, education/employment, primary care, and other drop-in/recreational and cultural activities

- ☐Over 35 agencies and service providers participated in the proposal development
- ☐Niagara was the first new YWHO site across the province to officially open its doors for soft launch in June 2019

• Members: Youth Resources Niagara, Pathstone Mental Health, Port Cares, Boys and Girls Club of Niagara, John Howard Society of Niagara, Family and Children's Services Niagara, Niagara Chapter of Native Women, Positive Living Niagara, Contact Niagara, Youth Probation, Community Addiction Services of Niagara.

o Initiative: Niagara Youth Court Screening Initiative began in 2015 with the goal to develop an intervention that addressed the gaps in the mental health and criminal justice system. The collaborative community model involves a multi-agency team of mental health, addiction, and justice service providers who offer screening to all First Appearance youth at court in St. Catharines and Welland for mental health, addictions, and other basic needs such as housing, employment, and education
  ☐Over 200 youth have been screened, almost 60% identified as having a mental health concern, and over 40% demonstrating substance use concerns. These youth were supported through early intervention services

• Members: March of Dimes, Community Support Services Niagara, Niagara Region Seniors Seniors.
o Initiative: Wellness Supportive Living Program supports population health and integrated care through a 10-year initiative mobilizing three community support agencies into four senior designated social housing apartment buildings with high volumes of LHIN personal care support services, 911 calls, and eviction rates.
  ☐In 2008, the program resulted in redirecting 815 hours of LHIN personal care support services (that previously served 72 residents) back into the community
  ☐Reduction in 911 calls
  ☐39% reduction in eviction notices
  ☐Reduction in social isolation and loneliness

• Members: Niagara Region Seniors Services, Niagara Region Public Health, Alzheimer Society of Niagara.
o Initiative: Supporting Independent Living is a 10-year tri-agency collaborative partnership, delivered through shared accountability and advanced integrated care, to mobilize rapid response services to at-risk seniors across Niagara region, and to begin the development of a service plan to stabilize health and/or environment
  ☐Reduction in 911 calls for those individuals consenting to service
  ☐3 day average wait time for service
  ☐75% of clients with sustainable service plan in place
  ☐Serves 175 seniors annually

• Members: Hospice Niagara, Centre de santé communautaire Hamilton/Niagara, Alzheimer Society of Niagara, Niagara Chapter of Native Women, Fort Erie Native Friendship Centre, caregiver advisors.
o Initiative: Niagara Caregiver Network is a new initiative that offers free, culturally sensitive and inclusive programs to adult caregivers in English and in French, provides information on community resources to help the caregiver navigate the health system. Three different training programs are offered in 2019.
  ☐All of them serve to strengthen caregivers' competence, improve knowledge and skills, help manage stress, prevent burnout and improve caregivers' experience in caring for others
  ☐In the first 6 months, 70 caregivers have attended programs

• Members: Brock University, McMaster University's Michael G. DeGroote School of

Medicine, Niagara Region, Hotel Dieu Shaver Rehabilitation Centre, Niagara Health, and additional community organizations.
o Initiative: Interprofessional Education for Quality Improvement Program (I-EQUIP) is an applied experiential learning program in quality improvement, providing an opportunity for students and front-line staff to work together on a variety of quality initiatives that improve patient care
☐Since 2012, there have been 66 projects that have helped to enhance quality improvement in Niagara hospitals and community organizations
☐Resulted in 9 publications, 9 national/international conference presentations, 66 local presentations and all students moving on in their studies in quality

Ending Hallway Medicine
• Members: Niagara Region EMS, Niagara Health, Welland McMaster Family Health Team, Quest Community Health Centre.
o Initiative: EMS MHART (Mental Health and Addictions Response Team) began in 2018 and is a seven day a week response to low acuity 911 calls for mental health and addictions by a paramedic and mental health nurse in an SUV
☐Decrease in number of patients transported to the emergency department
☐More than 100 Naloxone Kits distributed to at risk individuals
☐More than 250 referrals to community services

• Members: Niagara Health, Hotel Dieu Shaver, Niagara Region EMS, Niagara Region Public Health, Long-Term Care Homes, LHIN, Community Partners, Hospice Niagara.
o Initiative: Winter/Surge Planning, over the last three years, during the winter/flu season with the goal of mobilizing supports for pressures and outbreaks.
☐Partner participation in response to system pressures

• Members: Quest CHC, CASON, CMHA Niagara, Niagara Health.
o Initiative: USAT – Urgent Service Access Team provides primary health care for those with frequent emergency hospital visits for mental health and addictions, and/or those with opioid dependencies. Beginning in 2013, USAT is a regional resource that works with clients on a short term basis to ensure clients are provided with immediate services while linking and connecting clients to ongoing primary health care, mental health and addictions services, and other social services
☐An Integrated Care Plan is provided for all clients

• Members: Niagara Region EMS, Hotel Dieu Shaver Rehabilitation Centre.
o Initiative: EMS FIT – Falls Intervention Team began in 2018 and is a seven day a week response to low acuity 911 calls for people who have a ground level fall, and proactively visits those who frequently fall in between 911 call responses. A paramedic and Occupational Therapist respond to calls in an SUV.
☐Decrease in number of patients/clients transported to the emergency department

• Members: Hospice Niagara, Niagara Health, LHIN.
o Initiative: Transition Coordination Program (1-yr pilot) with goals to improve

transitions in end-of-life care, from home and hospital to hospice
- ☐Over 400 individual transitions plans completed
- ☐145% increase in admissions to hospice from hospital
- ☐100% of patients/clients and families identified that the program had a positive impact

• Members: LHIN and contracted service providers, retirement homes, Behavioural Supports Ontario.
o Initiative: Transitional Care Bed Program is a short term program for people who are ready to be discharged from hospital but are not ready to go home. People may also need temporary care supports to regain their strength and well-being, and time to make decisions about their future living arrangements while they recuperate. The program began in 2015 and provides personal support in either a retirement home or assisted living setting. Transitional care is only intended as a short term measure with a maximum stay of 30 to 60 days.
- ☐890 patients have been discharged from transitional care
- ☐27,575 saved ALC Days

• Members: CMHA-Niagara, Niagara Health.
o Initiative: Co-located mental health and addictions programs to improve alignment and integration between services. Partners share the commitment to work collaboratively to create a system of supports and services for individuals residing in Niagara who experience mental health and addictions.
☐The co-located services opened in April 2019

Bundled Care
• Members: Niagara Health, Hotel Dieu Shaver Rehabilitation Centre, LHIN, Community Health Centres
o Initiative: Since 2015, NOHT-ESON members have participated and implemented bundled care beginning with Integrated Comprehensive Care (ICC 2.0) for 1,258 patients/clients with COPD and heart failure. Building on the outcomes identified below bundled care has been expanded to include hip and knee replacement in 2018/19 and additional bundles in 2019/20
- ☐41% reduction in emergency department visits
- ☐38% reduction in 30-day readmissions to hospital
- ☐30% in average length of hospital stay
- ☐3,745 hospital days saved, or $2.8 million in cost avoidance

Health Links
• Members: 18 members-Alzheimer Society of Niagara Region, Bridges Community Health Centre, CMHA-Niagara, Community Addiction Services of Niagara, Community Support Services of Niagara, Hospice Niagara, March of Dimes Canada, Niagara Falls Community Health Centre, Niagara Health, Pathstone Mental Health, Quest Community Health Centre, Regional Municipality of Niagara, Home and Community Care, Niagara North Family Health Team, Portage Medical Family Health Team, Welland McMaster Family Health Team, Niagara Medical Group Family Health

Team, Centre de santé Communautaire Hamilton/Niagara, Meals on Wheels Niagara.
o Initiative: Since 2014 Integrated Care Planning has been implemented with a focus on spread and scale
☐33% reduction in 30-day inpatient readmission rate for patients/clients with integrated care plans
☐32% reduction in rate of hospitalization for ambulatory care sensitive conditions
☐Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
☐33% reduction in emergency department visits

Back Office and IT Integrations
• Members: Niagara Health, Hotel Dieu Shaver Health and Rehabilitation Centre
o Initiative: Hotel Dieu Shaver leverages the IT infrastructure and services from Niagara Health. This shared IT model also enables very close collaboration and partnerships with both organizations.
☐Niagara Health & Hotel Dieu Shaver Health invested in an innovative tool in 2016 that improved the flow of patients by helping them to more quickly access the proper level of care they need. With this tool, patients at Niagara Health needing rehabilitation or complex care will be identified sooner, allowing for a more seamless transition to the next level of care and resulting in reduced wait times

• Members: Consumer/Survivor Initiative of Niagara, Hospice Niagara, CMHA-Niagara
o Initiative: Back office integration initiative that involved full service support including, financial & payroll data quality, reporting compliance, data analysis support, financial and service data contact for funders, audit lead (5 year collaboration)

• Members: CMHA-Niagara and Gateway Residential and Community Support Services of Niagara
o Initiative: Developed a client records management system including joint procurement and hosting. This involved IT hardware and software support for the CRM system (6 year collaboration).

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

The NOHT-ESON rates the degree of alignment between our current membership and the provider networks revealed through analysis of patient/client flow and care patterns as high. The NOHT-ESON identifies that 90% of residents within Niagara region are captured within our attributed population. The information provided about our patient/client provider referral networks and physician relationships validated our existing NOHT-ESON membership and proposed interventions.

NOHT-ESON is comprised of multiple health and social care sectors who are committed to partner with stakeholders who provide in-patient and ambulatory care, primary care, home and community care, rehabilitation and complex care, hospice and palliative care, supportive housing, long-term care and assisted living, emergency health services, and community-based services (e.g., mental health and addictions) to meet patient/client needs.

Our proposed partnership and collaborator network includes representatives across the full continuum of care. NOHT-ESON has the collective capacity among its partners to address the needs of the Year 1 target population and at maturity. The planned goals and implementation strategies for Year 1 can be carried out through service providers and organizations at the Planning Table, and leverage the expertise of other collaborators within specific population health and social areas.

Throughout our Year 1 implementation and beyond, the NOHT-ESON will build on our existing successful partnerships, and expand and create new partnerships to support patients/clients across the lifespan and continuum of care. We will also work to build culturally safe and competent practices for the Indigenous population and be more responsive to individual Francophone needs across the region. The Planning Table will also continue to strengthen primary care engagement.

As part of our Year 1 implementation plan, the NOHT-ESON will monitor progress and will use an open-door approach to encourage and welcome additional members to effectively meet needs of our attributed population.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

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

2.6.2. Other Collaborating Organizations

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

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

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

Max word count: 500
Integrated/Coordinated Care Delivery Capacity for Full Attributed Population:

The NOHT-ESON will continue to build on current collaboration efforts to support integrated care delivery for individuals who access care within Niagara. As per section 2.4, there are numerous integrated care initiatives and models in place in Niagara that will be sustained and/or expanded. Initiatives identified below will support delivery of a full and coordinated continuum of care for our Year 1 target population, and will be the foundation for spread and scale at maturity.

Integrated Care Delivery Capacity for Year 1 Target Population:

During Year 1, the NOHT-ESON will continue to support existing patients/clients participating in Integrated Care Planning, while expanding to net new patients/clients through three key initiatives.

1. Integrated Care Plans
We have set a target of a 25% increase in Integrated Care Planning activities in Year 1. This means we are targeting to support 1,400 patients/clients (1,100 sustained + 300 new) through this process.

2. Transitional care navigation
We have identified small tests of change to improve transitions in care, and will analyze Integrated Care Plans to identify trends and opportunities to address systems barriers concerning transitions across the lifespan and sectors of care.

3. Care coordination in primary care and other settings
NOHT-ESON will develop a strategy to embed LHIN Care Coordinators into primary care, including Family Health Teams and Community Health Centres, Emergency Medical Services, and other settings where patients/clients would benefit from Integrated Care Plans and other coordinated services due to their complex health and social care needs which results in high service utilization.

4. Digital Health
The NOHT-ESON will expand and scale existing services and solutions to enable secure and private sharing of health information, including Integrated Care Plans with providers, and also enable patients/clients to receive easier access to their health data and care providers.

Additional NOHT-ESON activities will target a broader number of patients/clients in Year 1.

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?

Ontario Health Teams
Full Application Form

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

PARTNER EXPANSION

Membership across the continuum of health and social care will continue to be inclusive, and add new members and collaborators who can strengthen our ability to make a meaningful difference in the way we care for people within the attributed population, and improve the health and social outcomes for the entire population. Our Year 1 priorities on Partner Expansion include: validating and updating the partner and stakeholder inventory, completing an analysis of partners to prioritize for additional engagement, and building more formal partnerships. Through a fulsome communications and stakeholder engagement plan, various outreach and engagement strategies will be used (e.g. a Stakeholder Forum to be held in Fall/Winter 2019-20) to ensure two-way feedback loops of various audiences and participants.

A wide range of partners are welcome, including both traditional and non-traditional partners. For example, as we leverage existing complex case resolution tables in Year 1 additional partners will be identified and engaged.

SERVICE EXPANSION

The NOHT-ESON will use a thoughtful, planned approach for Year 2, building on the opportunities and lessons learned, as follows:

- Outcomes determined by trend analysis of integrated care plans, and care pathways identified through Year 1 outcomes
- Identify opportunities to enhance value for money and efficiencies in Year 1
- Learnings from the system transformation of mental health and addictions currently underway by the Niagara Addictions and Mental Health Network
- Enhanced primary care engagement feedback
- Tests of change to support further integration of all home and community care services
- Further patient/client, family and caregiver engagement and input

These strategies will identify opportunities to be tested, spread and scaled from Year 1 to maturity. Transition improvements and models of care, such as Integrated Care Plans, will be the focus, including bringing additional and diverse partners all focused on the same goals. An evaluation framework will be developed and implemented to

track progress and the inform planning throughout the process.

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

Max word count: 500

The NOHT-ESON has a local primary care physician champion with two years' experience as the Niagara sub-region Primary Care Clinical Lead at the Planning Table who is committed to support ongoing primary care engagement.

Our Year 1 commitment is to strengthen the NOHT-ESON relationship with primary care physicians building on the September 7, 2019 regional Primary Care Retreat. The NOHT-ESON will leverage existing relationships to strengthen additional relationships with primary care physicians who are part of those practice models. In addition, the NOHT-ESON is committed to continuing to embed care coordinators in primary care as a mechanism to demonstrate the value of integrated care for patients/clients, for physicians themselves, increasing their capacity to provide holistic and comprehensive care.

The primary care physicians who participated at the Primary Care Retreat have agreed to continue to meet to build on the work initiated during that session, including engaging larger numbers of practitioners and defining opportunities to create clear two-way communication channels. See Appendix G: Primary Care Retreat Summary Discussion for input identified at the engagement retreat.

Further plans to expand primary care partnerships will take into account the challenges presented by the diversity of models within primary care in Niagara (26 PEMs, 4 FHTs and 4 CHCs), including a high number of fee-for-service physicians (58).

Input provided by the Primary Care Retreat additionally identified a need to support succession planning for the 60,000 patients currently enrolled to primary care physicians who are over 65 years of age and are anticipated to exit the system. See Appendix H: Overview of Primary Care Physician Population and Practice Models in Niagara for further information.

2.10. How did you develop your Full Application submission?

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

Also consider in your response:

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

Max word count: 1000

The planning process for the Full Application started with a review of the readiness Self- Assessment process and opportunities for improvement. A Planning Table representing signatories and collaborators from the Self-Assessment guided the development of this application using a consensus-based approach to decision-making.

It was identified through the Self-Assessment readiness process that further meaningful engagement and co-development with both the Indigenous and Francophone communities were required to ensure their needs and barriers to health care were understood and their perspectives were embedded in the redesign process. Members of the NOHT-ESON Planning Table were invited to participate in two days of learning and relationship-building with the Indigenous Health Network (who hosted) to improve understanding of the history and barriers Indigenous peoples face in accessing health care which is culturally safe and competent. The sessions were well attended and were meaningful in moving forward the process of reconciliation and understanding.

As a result, the Planning Table committed to leveraging diverse forms of knowledge by striving to integrate a Two-Eyed Seeing approach, and making meaningful space for Indigenous providers at the NOHT-ESON. As such, the Planning Table continues to regularly share information with the Indigenous Health Network and commits to

embedding Indigenous cultural safe and competent practices in the continuum of care. The Planning Table has identified an interest in and need for continued education to fully understand how to build an OHT that meets the needs of Indigenous communities in Niagara.

The Francophone community was also identified as needing to be fully represented in the Full Application process. In the Full Application phase the Centre de santé communautaire Hamilton/Niagara has actively participated in the Planning Table as well as in both the Digital Health and Home and Community Care working groups. The HNHB-WW FLHPE (Entite2) participated in the Planning Table throughout the full application process to ensure that the Francophone lens is consistently applied to the re-design, planning and delivery of services that meet the needs of the Niagara Francophone population. Foyer Richelieu, a designated French LTC also participated at the Planning Table. Overall, fourteen of the current NOHT-ESON members are identified to provide French language services but not all have the capacity to consistently deliver these services.

The group also identified the need to include patient/clients, families and caregivers in the process. Patient/client, family and caregiver representatives joined our Planning Table as well as the working groups. Furthermore, they were fully involved in the full review of the final Full Application submission.

To support communication, a SharePoint site was established to share meeting minutes, resources and draft application materials. Members of the group also participated in webinars to strengthen the NOHT-ESON understanding of OHT building blocks and related considerations.

A roster of half-day and full day meetings was scheduled as the group determined how to work together - collaborate, how to make decisions - through consensus, and how to move to completion of the Full Application. The NOHT-ESON also established working groups to guide some of the more detailed components of the application (i.e. home and community care working group, patient/client, family and caregiver working group, communications working group, digital working group, and coordinating group).

The NOHT-ESON Planning Table reviewed the attributed population and confirmed the Year 1 focus population. The NOHT-ESON also discussed the high level priorities to support Year 1 outcomes and the necessary components to support spread and scale in moving to maturity. A consulting firm was retained by the NOHT-ESON Planning Table to facilitate sessions to inform the required elements of the Full Application.

Communication materials (i.e. Executive Summary, Board of Directors Briefing Note, Board PowerPoint presentation, etc.) were developed to ensure consistent communication to the respective governing bodies.

3. How will you transform care?

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

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

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

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

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

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

Max word count: 1000

The NOHT-ESON is committed to delivering a full and coordinated continuum of care for patients/clients. As a team, we will work to achieve common goals related to: improving health outcomes, patient/client experience, provider experience and value. In line with the Quadruple Aim the NOHT-ESON has identified performance improvement opportunities based on:

- Our collective understanding of our high-use populations;
- A primary care engagement retreat with regional primary care providers;
- A review of other local data and information sources;
- A review of our attributed patient population; and,
- Knowledge sharing and discussion with at our broad Planning Table.

Six key health system performance indicators have been identified as the focus for Year 1, along with the measured outcomes achieved from our Integrated Care Planning initiative as of Q4 2018/19 (forming our Year 1 service targets):

1. 30-day inpatient readmission rate for patients/clients with integrated care plans
   - Measureable outcome to-date: 33% reduction

2. Rate of hospitalization for ambulatory care sensitive conditions
   - Measurable outcome to-date: 32% reduction

3. Avoidable emergency department visits and hospital admissions

4. Frequent ED visits (4+ per year) for mental health and addictions
   - Measureable outcome to-date: 33% reduction

5. 7-day physician follow up post-discharge

6. Patient/client reported experience, provider reported experience and patient/client reported outcomes

Aligned with a population health approach we will undertake three activities:

1. Segmenting the population into groups with shared needs (e.g., complex patients defined as the top 5% of the attributed population including those with mental health and substance use, frail seniors, people with multiple chronic health conditions, and people who require a palliative approach to care);
2. Designing in-reach and out-reach services appropriate to each population group with defined care pathways; and,
3. Identifying system level gaps and barriers to support the delivery of services that addresses the broader social determinants of health.

Year 1 Priorities include:

- Improving Care Coordination and System Navigation

Rationale: Patients/clients, families and their caregivers find the health care system difficult to navigate, and are often frustrated trying to find and access available services and coordinating care across multiple providers.

• Improving Care for Marginalized and At-risk Populations
Rationale: Ensuring equity in health service delivery means working intentionally to reduce barriers to care for marginalized and at-risk populations including Francophone and Indigenous, individuals with mental health and substance abuse challenges, homeless and low-income

• Improving Relationships, Integration and Communication with Both Primary Care and Community Service Providers
Rationale: Primary care providers are the foundation of integrated care. The NOHT-ESON is committed to supporting primary care physicians' integration into the NOHT-ESON structure and enhance the already high level of service provided to patients. Due to a shortage of primary care providers in the region, with a significant portion of providers who are over the age of 60 years old, recruitment of primary care providers will need to be a priority. Through a retreat with primary care providers, community service providers, and patients/clients, the NOHT-ESON has identified tangible opportunities to support and improve integration with primary care.

• Enhancing Patient/Client, Family and Caregiver (P/C/F/C) Experience
Rationale: Ensuring patients/clients are at the centre of their care is vital to improving outcomes and continuity of care. Mechanisms to incorporate the P/C/F/C experience into planning, coordination and care redesign activities will be important.

Our Team's Assets:
• Strong history of collaboration across providers
• A large number of partners currently use Health Partner Gateway that allows partners involved in patient/client care to initiate, share, and/or update an Integrated Care Plan through a secure digital solution
• Existing complex case resolution tables and other planning tables
• Adherence to existing provincial service standards of evidence-based practice across providers
• Crisis support and various other digital support, including Big White Wall, and drop-in/walk-in services available with no appointment required
• Digital supports including eVisit and other OTN solutions
• Niagara Health Navigator, Ontario's first digital health ecosystem desgined to protect patient privacy and security while connecting patients to their health data and care providers for secure, convenient, single sign-on serevices in Niagara
• Existing patient/client relations processes, clinical practice & program/process reviews, issue resolution and consultations to inform quality improvement and service reviews
• NOHT-ESON website that will provide information for patients/clients/families/caregivers
• Existing Niagara Caregiver Network

• Enhancing access to primary care and other supports in homeless shelters (REACH)

Services We Intend to Provide and Our Approach:
• Integrated care planning (including the ability to leverage past experience with the Health Links model) and caregiver and patient/client self-management support in Integrated Care Plans
• Transitional Discharge Support
• Service Navigation
• Care Coordination
  - Access to care coordination 12 hours/day, 365 days/year
  - Embedded in various settings including CHCs
  - Embedded Care Coordination in Primary Care
• An EMS model of "in-home checks". EMS real-time communication linkage with Care Coordinator during in-house calls to support Integrated Care Plan updates
• Co-development of programs and services with patients, clients, families and caregivers at the table
• Patient/clients engagement strategies
• Representation on patients/clients/families/caregivers advisory committees, planning councils, system transformation committees, governing Board positions/committees, working groups and strategic planning consultations
• Patients/clients/families/caregivers satisfaction and engagement surveys, focus groups
• Training for service providers on FLS active offer
• Culturally safe and competent care
• Improved communications with the Indigenous Health Network

Priorities at Maturity include:
• Creating a single/centralized patient/client information systems for providers and patients/clients;
• Standardizing care and reducing duplication;
• Reducing wait times and increasing access to services, and streamlining access to care;
• Improving relationships, integration and communication with primary care; and,
• Allocating resources to best meet the needs of our community.

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

NOHT-ESON participating members have actively worked together and co-designed this Full Application through our Planning Table. The work of the Planning Table was informed by individual Working Groups that were created to have focused discussions related to:

- Home and community care redesign;
- Digital health;
- Communications; and,
- Patient, client and family/caregiver engagement.

Refer to Appendix I: NOHT-ESON Structure for an overview the Planning Table and Working Groups configuration and Collaboration Agreement.

Following the development of this Full Application, the Planning Table will continue to meet to begin implementation planning related to our Year 1 initiatives. This commitment is further articulated in the Collaboration Agreement. Importantly, we see the work of NOHT-ESON as a natural extension of the extensive collaboration and partnership activities already underway between NOHT-ESON participating members, and regardless of the results of the Full Application the NOHT-ESON and collaborators are committed to continuing these planning and implementation discussions so that we can provide better, more coordinated care for our most complex clients.

Our Integrated Care Planning approach (outlined further in Section 3.3.1) was selected as one of our core initiatives because we have demonstrated postive outcomes related to the reduction of hospital use and hallway medicine. Specific outcomes include:

- 33% reduction in 30-day inpatient readmission rates;
- 32% reduction related to hospitalization for ambulatory care sensitive conditions;
- 34% reduction in ED visits; and
- 30% reduction inpatient visits.

Through our proposed approach to redesigning care, we aim to replicate these outcomes across a larger number of patients/clients so we can make an even more meaningful impact in reducing hallway medicine. We will extend our Integrated Care Planning approach to sustaining Integrated Care Plans for 1,100 patients/clients and providing 300 net new Integrated Care Plans for patients/clients in Year 1, to prevent at minimum:

- 4,030 ED visits
- 780 inpatient admissions
- 130 ED visits for ambulatory care sensitive conditions

Moving forward as we further segment our target population, individual Working Groups or Teams will focus their work on change initiatives. Additionally, given the level of detailed work required in redesigning home and community care, implementing our digital health initiatives, and broadening our NOHT-ESON communications, we expect those Working Groups to continue. In addition, we will leverage existing planning tables to support this care redesign process.

We have developed the following NOHT-ESON Guiding Principles to guide our work going forward (see Appendix E: Guiding Principles for further information):
• Commitment to our Patients/Clients, Families and Caregivers, and to the Quadruple Aim
• Authentic Partnership and Co-design
• Collaborative Culture
• Population Health, Equity and Access
• Commitment to providing French language services
• Coordination and Integration
• Spread and Sustainability
• Innovation and Excellence
• Commitment to Quality Improvement
• Creativity/Continuous Learning
• Commitment to a Journey

Working collaboratively, we plan to identify duplication as well as process improvements to ensure best value, system improvements and reallocate resources to priority areas to better serve people.

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

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

3.3.1. How do you propose to coordinate care?

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

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

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.

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

Max word count: 1000

Given that our target population is focused on the top 5% of users across the health and social care continuum, care coordination is essential as these patients/clients are typically connected with more than one service provider. Our Year 1 approach involves three distinct groups of care coordination initiatives:

1. Integrated Care Planning
2. Transitional care navigation (see 3.3.3. for further information)
3. Care coordination in primary care and other settings

Integrated Care Planning:

Our Integrated Care Planning approach is a wraparound model of patient/client care that provides a coordinated interdisciplinary team of health service providers based on patient/client needs, and assigns a patient lead coordinator to ensure seamless, care coordination and system navigation. Currently 18 NOHT-ESON member organizations are delivering or involved in ICPs across multiple providers and care settings. The Child and Youth sector also employs an Integrated Care Planning model through single point of access and case management processes, and the implementation of coordinated service planning through the Ministry of Children, Community and Social Services.

Our Year 1 goal is to expand this participation to members of NOHT-ESON. Through

this expansion, we are targeting 1,400 patients/clients to receive ICPs in Year 1. This includes both new patients/clients to receive this service as well as supporting existing patients/clients who are already actively receiving this service. Integrated Care Planning requires approximately 40 hours of effort per patient/client per year. As such, it is estimated that this effort will require approximately 25 FTEs. This effort will be managed within existing FTEs and does not require additional outside investment.

Year 1 Target Population: Once a patient/client has been identified, that patients/clients identifies the lead coordinator from the organization(s) involved in their care and participates in developing an ICP, determining the right care, at the right time, by the right provider. No door is the wrong door, as every service provider uses a collaborative approach for Integrated Care Planning and works with the patient/client to communicate their plan to all involved providers.

Through ICPs we are able to improve the patient/client, family and caregiver experience with the health care system, promote meaningful patient/client input into their care plan and ensure ongoing care coordination among partners providing health and social care. The NOHT-ESON has the collective capacity among its partners to address the needs of the Year 1 target population, with agreement to develop a plan for the expansion of this service. The NOHT-ESON will leverage current technology platforms to share critical patient/client information in real-time for decision-making and coordination, and as part of this work will look to expand access to that system among participating members. The NOHT-ESON's approach will ensure partners work from a single integrated framework which has been co-developed to ensure an integrated, coordinated approach that best serves patient/client needs and supports future planning. At maturity, the team will additionally scale its bilingual integrated care planning approach.

Care coordination in primary care and other settings:

The NOHT-ESON will develop a strategy to embed LHIN Care Coordinators into primary care, including Family Health Teams and Community Health Centres, Emergency Medical Services, and other settings where patients/clients would benefit from ICPs and other coordinated services due to their complex health and social care needs which often result in high service utilization. Our approach to Home and Community Care coordination is outlined in further detail in Appendix A: Home & Community Care.

In Year 1, we plan to start initiatives related to existing LHIN home and community care services, including working to:

• Prioritize and specialize care coordination for different levels of risk, crisis and/or specialties:
☐An inventory of care coordinators across all providers in the NOHT-ESON will be completed to validate resource availability.
☐Understanding that care coordination resources are limited, care coordination will

be prioritized for those with greater needs, particularly the Year 1 target population.
☐Care coordinators will be more focused and specialized to coordinate different cases that require specialized knowledge and have different levels of risk and crisis.

• Embed care coordination in primary care:
☐A primary care engagement model will be developed to enhance engagement and integration with primary care.
☐LHIN care coordinators will be shared and embedded in primary care (including Family Health Teams, and Community Health Centres) with a clear mandate to provide care coordination for all physicians in a specific geographic area.
☐Where patients/clients do not have a primary care physician, they will be assigned to a care coordinator based on their geographic area of residence.
☐Care coordinators will be responsible for intake, completing the RAI-HC assessment, developing an Integrated Care Plan, referral to services, arranging home care services and meeting with the primary care team.
☐In the long term, this model will be spread, scaled and expanded to other organizations with high care coordination needs.

• Embed care coordination in emergency medical services:
☐Health resources will be shared and embedded in mobile integrated health teams to build capacity and update care plans and coordinators for unscheduled 911 calls.
☐A paramedic will be paired together with an appropriate health care resource (RN, NP, or other care coordinator as available). They will be responsible for intake and creation of Integrated Care Plans, development/refinement of existing Integrated Care Plans, coordinating service needs, delivery of service at point-of-care where appropriate/possible (e.g. IV/catheter restart, wound care, etc), and ED/Hospital avoidance measures. These functions may be delivered in the patient/client's home, in response to EMS calls received via 911 (unscheduled non-emergency medical needs), including calls from patient/client residences, Long Term Care (LTC) and assisted living facilities.
☐A small PDSA cycle will be completed in Year 1 to test the concept. Data and outcomes will be measured, as well as a cost and benefit analysis.

• Improve triage and referrals
☐Intake with accountability to triage and refer to all CSS organizations, home and community care
☐A triage tool and gold standards framework will be implemented to ensure patients/clients are triaged consistently and effectively across the NOHT-ESON.

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

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services the need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe

which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

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

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

Max word count: 1000

There are several actions we will take to improve service navigation for our target population. As noted above, our Integrated Care Planning initiative includes service navigation, and includes within its scope the coordination and navigation of all health and social care services the patient/client may require. However there are additional new service navigation initiatives we plan to start as part of our Year 1 efforts. These include:

1. Engaging Primary Care in Care Coordination and Navigation

☐There should be a clear access process when patients/clients, families and caregivers are seeking care. This access process should be well known to primary care, and will be strengthened through embedding care coordination and navigation in primary care organizations including Family Health Teams and Community Health Centres (as discussed in Section 3.3.2). If patients/clients do not have a primary care provider, then they will be connected to an organization or Care Coordinator within the closest proximity to the patient/client's residence. Current connections to key community support sector and social service providers should also be strengthened to ensure patient/client and family/caregiver needs can be holistically identified and addressed.

☐Connecting care coordination and primary care provides patients/clients with a more accessible and personalized way of navigating the system.

☐Care coordination and navigation services will also be enhanced to not only connect patients/clients, families and caregivers with the services they need, but to also provide assistance in answering questions and concerns, and/or to provide clear direction on where more information is available.

2. Communicating and Educating Providers, Patients/Clients, Families and Caregivers

☐Broad and targeted communication and education initiatives for all service providers, patients/clients, families and caregivers will be implemented to increase awareness and understanding of available services and supports within the community.

☐Communication and education will be delivered through multiple channels, including the web, directly through service providers, key locations in the community, including schools, community centres, child care centres, seniors centres, hospitals, libraries, malls, and grocery centres.

☐Content and vehicles for communication and education will be designed specifically for target populations in mind, and how it impacts patients/clients, families and caregivers.
☐A current inventory of all services and supports available in the Niagara Region (including community-based and private services) that exists in 211 help line service will be leveraged and published on a digital navigation website for all providers, patients/clients, families and caregivers to access.

3. Culturally Safe and Competent Practice
☐Using a population health approach, barriers to access will be reduced to achieve more equitable, inclusive, respectful, and culturally-competent and safe care, with a particular focus on marginalized populations such as Francophone or Indigenous communities.

4. Francophone Community
☐Collection of Francophone patient/client, family and caregiver data is not consistent across providers. Without this data it is difficult to identify or anticipate the navigation needs for FL patients/clients. While quantitative data is lacking, the FLPE (Entité) has published qualitative reports that clearly highlight the gaps and navigation needs for the Francophone population (see Home and Community Care for Francophone Seniors, and One on One Interviews for more information.)
☐The need for FLS system navigation is exacerbated by the scarcity of French language human resources throughout the system across professional designations required. To meet the needs of the Year 1 population, the NOHT-ESON will strengthen the use of designated FLPs and expand the use/capacity of others throughout the continuum of care.
☐The NOHT-ESON will use the FLSPs (Centre de santé and Foyer Richelieu) to support navigation needs in Year 1, referring clients that would be better served in French to these providers. Recognizing that there are two agencies with limited capacity to support navigation needs, develop a model of navigation that would embed bilingual navigators in these agencies and broadly across Niagara. The NOHT-ESON will explore and develop opportunities for improved system navigation for the Francophone population of the attributed population.

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

As part of our Year 1 work, we plan to support people transitioning from all settings to/from other care and social support settings through the creation of transition strategies based on care pathways.

We have identified small tests of change to improve transitions in care, and will analyze Integrated Care Plans to identify trends and opportunities to address systems barriers concerning transitions across the lifespan and sectors of care, recognizing the unique barriers to health for Indigenous, Francophone or otherwise marginalized people. It is important to note that the Integrated Care Plan approach is underpinned by a philosophy of providing warm-handoffs between providers to ensure seamless care.

The following additional activities will inform the NOHT-ESON planning around transitions in care:
• Care coordination and system navigation;
• Transition pathways, tools, protocols and an inventory for specific sub-populations will inform Year 1 strategies to drive improvement; and,
• Explore realigning or reorganizing Care Coordinator and Patient Navigator functions to support integrated care allowing for improved transitions.

This will ensure common and standardized transition tools are used in conjunction with improved system navigation. These tools will include standard protocols for discharge and transition planning, including what, how, when, where information is to be communicated between providers, patients/clients, families and caregivers. This is particularly important for marginalized populations who are served by our expanded definition of home and community care services.

By focusing on transitions, our approach will simultaneously address multiple issues around inefficiency and fragmentation and build more integrated care by:
• Bringing together partners from across the continuum of care;
• Ensuring that services are coordinated and complementary with a focus on continuity of care; and
• Sharing information between providers with a high standard of accuracy, promptness, and consistency.

Fundamental to our approach of improving care transitions is ensuring one common plan that is individualized to the patient/client needs with an identified lead who supports clear and consistent communication amongst service providers and patients/clients and their support networks. An individualized care plan is intended to guide care, regardless of where the person’s care is taking place. A care plan is designed to help individuals and their providers address all aspects of care including:
• Goals an individual wants to work towards;
• Support services and who is providing these services;
• Emergency contact numbers;
• Medications; and/or,
• An eating/exercise plan.

Transitional care navigation supports a person's transition across the continuum by surrounding them with an integrated health and social care team that best supports a person's care needs. Outcome measures will include:

1. Reduction of hospital LOS and complex care ALC rate
2. Reduction of hospital re-admission rate
3. Improved patient/client satisfaction with transitions
4. Increased volume of patients/clients with Integrated Care Plans
5. Delayed hospital discharges
6. Streamlined long-term care placement
7. Streamlined referrals to hospice and palliative care
8. Improved patient/client experience and outcomes

Additional care transition initiatives that we anticipate starting work on in Year 1 are discussed in further detail in Appendix A: Home & Community Care, including developing and sharing a common transition planning tool across all providers.

3.4. How will your team provide virtual care?

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

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

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

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

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

describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Max word count: 500

The NOHT-ESON notes that individuals who access services in a way that presents a high cost to the health care system or high service utilization, are more likely to report poorer self-perceived health (both general and mental health). Therefore, the NOHT-ESON has identified a number of strategies and priorities for improving patient/client self-management and health literacy. These include:

• Greater patient/client, family and caregiver involvement in care planning;
• Working with the patient/client to co-develop patient/client care goals;
• Centering our provision of care and services around helping patients/clients achieve those goals, including providing clear, consistent direction across our care team interactions with patients/clients aligned to their care goals;
• Empowering and supporting patients/clients to make healthy life choices through improved resources and support, and incorporating motivational interviewing as a technique to more effectively work with patients/clients, families and caregivers and be their coach towards achieving their health goals;
• Providing greater patient/client, family and caregiver access to patient/client information through the rollout of myChart in Niagara Region;
• Creating and redesigning patient/client resources from hospital and across the continuum to use more accessible language and formats for information to support patient/client, family and caregiver including at discharge from hospital;
• Ensuring patients/clients have appropriate tools to self-manage their care
• Patient/client self-management and education programs offered at the hospital, Family Health Teams, and Community Health Centres
• Collaboration with Public Health to display information in TV screens in waiting rooms
• Developing online platforms within children's mental health
• Developing French language education material and facilitating workshops for caregivers from the Francophone population (leveraging Quebec's model)
• Providing psychoeducation supports for parents

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

Caregivers are one of the health system's most important resources. For example, an engaged and supported caregiver can make the difference between a patient/client needing long-term care bed, or being able to successfully manage at home. NOHT-ESON's approach to supporting caregivers is centred on three key approaches:

1. Improving Access to Care Coordination and System Navigation

Challenge: Patients/client, families and caregivers find the available network of health and social care services confusing and difficult to navigate, and working to manage different providers and care schedules is stressful and time-consuming, leading to caregiver burnout.

As part of our long-term vision, we plan to:
o Expand opportunities for co-design of the Integrated Care Planning process, and co-development of individual Integrated Care Plans with patients/clients, families and caregivers
o Expand service navigation services
o Use the Integrated Community Lead (ICL) Model: an approach to providing services where a single community service provider supports the client and caregiver, including identification and connection to the services they want and need, coordinating those services, making the client or caregiver aware of who to call when they require help, and supporting the client/caregiver through various transitions.

2. Improving communication and access to patient/client information
Challenge: Repeating the same story regarding a patient/client's care journey and care needs to multiple providers is frustrating and inefficient. Families and caregivers find it challenging to ensure they are kept in the loop regarding changes to a patient/client's care plan or the services they are receiving; and documenting care details is often manual, time consuming and fragmented.

As part of our long-term vision, we plan to:
o Improve provider-to-provider communication regarding the patient/client's story, care goals, and attached services.
o Implement and expand provider-to-patient/client/family/caregiver communication through access to a care coordinator/system navigator, and leveraging the use of digital tools including Niagara Health Navigator (please refer to Appendix B: Digital Health)

3. Providing additional caregiver and patient/client supports to reduce caregiver burnout
Challenge: Caregiver burnout places strain on the health care system in two primary areas. First, when caregivers lose the ability to successfully support those for whom they care for, patients/clients often require higher levels of care in more expensive care settings (e.g. hospitals, long-term care homes, etc.). Secondly, when the patient/client's caregiver is not well supported, the stress and effort from caregiving negatively impacts the caregivers own health resulting in increased service use.

As part of our long-term vision, we plan to:
o Strengthen our local caregiver network and expand the availability and use of paid and unpaid individuals to support patients/clients and reduce caregiver burden.
o Increase the availability of in-home respite supports to provide caregivers a break and help reduce burnout.
o Improve education and competencies of respite workers to better support and

mitigate risks (e.g. dementia training).
o Develop and provide more patient/client-self management tools which caregivers can leverage to increase confidence and simplify the efforts needed to best support a patient/client's care at home.
o Provide emergency respite to support caregivers when they themselves are in need of emergency medical services.
o Provide digital information and services to reduce time and effort of visiting providers in person (e.g. providing x-rays, test results electronically).
o Improve existing community day programming for non-LTC patients/clients to ensure greater stimulation and activity for seniors.
o Review root cause and identify opportunities to address PSW staff shortage to improve access to care.

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

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

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

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

The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers, implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.

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

Max word count: 500
The NOHT-ESON will identify patients/clients through the use of four primary mechanisms/approaches:
1. Provider/patient/client relationships and service encounters
2. Standardized risk-assessment tools
3. Data-driven finding mechanisms
4. IDS Business Intelligence Tool

1. Provider/Patient/Client Relationships and Service Encounters
NOHT-ESON will use existing provider encounters as a primary patient/client identification mechanism. For example, if a patient/client seeks care from a primary care or community care provider to receive care, that provider may identify that the patient/client may benefit from an Integrated Care Planning approach and initiate that process for a patient.

2. Standardized Risk-assessment Tools
Standardized risk-assessment tools are commonly used in several care settings, including LHIN home and community care. Patient scoring on risk assessment measures (e.g., MAPLe scores of 4 or greater and Cognitive Performance Scale scores greater than 3 are indicators of home care need) will be used to consider whether specific NOHT-ESON care planning or service navigation approaches should be provided to the patient/client.

3. Data Driven Finding Mechanisms
As a longer-term strategy, NOHT-ESON will develop and employ data driven case finding mechanisms to support prospective identification of patients/clients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients/clients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential patients/client with multiple conditions and complex needs. This process will be supported through using the EMS Integrated Decision Support to analyze health system use and trends across care settings to improve and refine organization-specific analysis methods.

4. Integrated Decision Support (IDS) Business Intelligence Tool
IDS will be used to track the patient/client journey across the health system and support measurement and reporting of outcomes (see Appendix: J: IDS Business Intelligence Tool - Sample Patient Profile). Individual patient journey visuals are available for hospital and community based services where service encounters are linked and harmonized into one patient profile. Detailed information can be reviewed on a per patient/client and aggregate basis.

Once patient/clients have been identified for Integrated Care Planning, and have agreed to participate in this service offering, the Integrated Care Lead organization will track, follow and support the patient/client and coordinate the involvement of other service providers in that patient/clients care. Through reporting from all Integrated Care Lead organizations regarding the patients/clients receiving Integrated Care Planning, we will utilize our Integrated Decision Support system, to track and report on patient/client outcomes.

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 NOHT-ESON will work to build culturally safe and competent practices to better serve Indigenous peoples across the region. To do so, the Planning Table provides an open invitation to the Indigenous Health Network to join and participate when they deem appropriate to do so. Members of the Planning Table have also participated in two reconciliation and sensitivity workshops with the Indigenous Health Network, and are engaged in the regular sharing of information with this Network.

There are systemic barriers that result in poorer health outcomes for Indigenous populations, including inequitable access and funding for Indigenous-led and Indigenous-delivered health care services. The NOHT-ESON recognizes that income, employment, housing, and health outcomes of Indigenous peoples fall well below broader community standards . At present, no single data source provides a complete picture of Indigenous populations' health outcomes in Niagara.

In considering non-Indigenous organizations providing care to Indigenous populations, at this time, the NOHT-ESON recognizes there are weaknesses and gaps in providing culturally safe and competent care in our current system.

It is a critical aim of the NOHT-ESON to build relationships and understanding between non-Indigenous providers and Indigenous Health Network, providers and communities to address these weaknesses and gaps.

Two recent examples of Indigenous and mainstream service provider partnerships, include:

• Integrated youth services sites (YWHO) serves youth, with a priority focus on people who identify as Indigenous or Francophone, and provides low-barrier, quick access to

mental health and addictions services, housing, education/employment, primary care, and other drop-in/recreational and cultural activities
o Members: (Four-site model) Centre de santé communautaire, Fort Erie Native Friendship Centre, Contact Niagara for Children's and Developmental Services; John Howard Society of Niagara, and service partners: Pathstone Mental Health, Community Addictions Services of Niagara, the RAFT and a bilingual nurse practitioner.

• Niagara Caregiver Network is a new initiative that offers free, culturally sensitive and inclusive programs to adult caregivers in English and in French, provides information on community resources to help the caregiver navigate the health system. Three different training programs are offered in 2019.
o Members: Hospice Niagara, Centre de santé communautaire, Alzheimer Society of Niagara, Niagara Chapter of Native Women, Fort Erie Native Friendship Centre, caregiver advisors.

3.7.2. How will you work with Francophone populations?

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

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

Max word count: 500
The Centre de santé communautaire Hamilton Niagara (CSCHN) actively participates in the NOHT-ESON Planning Table, as well as in both the Digital Health and the Home and Community Care Working Groups. As well, the HNHB – WW FLHPE (Entité2) participates in the Planning Table and in the Communications Working Group to ensure that the Francophone lens is consistently applied the re-design, planning and delivery of services that meet the needs of the Niagara Francophone population. Foyer Richelieu (the only designated French LTC in all Southern Ontario) participates in the Planning Table and in the Home and Community Care Working Group.

Currently, the engagement of the Francophone population and the planning of French language services (FLS) is inconsistent across the region. In the Niagara area, 14 of the current NOHT-ESON members are identified to provide FLS. At the present time, per the 2019 OZi FLS reports, only a few participating organizations actively offer FLS, and approximately one third reported not having sufficient French language capacity within their organization. The identification of linguistic needs at intake

currently varies considerably.

As part of our plans, NOHT-ESON has identified a number of steps we can take to improve the care we provide for Francophone populations:

- Year 1 and Ongoing:

o NOHT-ESON member engagement: In collaboration with the FLHPE and French language service providers, the NOHT-ESON will develop an engagement plan that aims at informing, consulting and empowering the Francophone community to achieve meaningful and robust engagement that leads to concrete, measurable outcomes.
o Increase capacity to deliver FLS: The FLS Community of Practice and French language health service providers will offer engagement and education sessions on active offer, bilingual human resources recruitment and French language planning strategies to build capacity throughout the NOHT-ESON.
o Integrated FLS planning: Francophone perspectives (service providers, patients/clients and families and advisory organizations) will be embedded in all NOHT-ESON working groups to ensure French language services are not planned in isolation.
o FLS identification: The NOHT-ESON will work with French language providers to develop an accountability framework to hold organizations accountable for the collection and use of data to inform FLS provision.
o FLS evaluation: The NOHT-ESON will work with French language providers to develop an evaluation framework for FLS provision. The FLHPE will support and inform providers of their obligations around its FLS and support them to meet those obligations.

- Future State: The NOHT-ESON should seek designation as an FLSP in order to improve care pathway, and address the geographical disparities of FLS (many services only available in French in Niagara South).

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

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

Max word count: 500

The NOHT-ESON recognizes the unique barriers to health for marginalized populations as identified in section 1.3., including: those with low socio-economic status, experience homelessness or are precariously housed, rainbow communities or those who identify as LGBT2+, newcomer and migrant populations, etc. – and will continue to provide services as currently delivered and will be expanded through our

three priority strategies in Year 1.

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

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

Max word count: 1000

NOHT-ESON commits to meaningful patient/client, family and caregiver partnership and recognizes the expectation to adhere to the Patient Declaration of Values for Ontario, which includes recognizing these participants as valuable contributors to the OHT. The Guiding Principles created by the NOHT-ESON specifically include:

• Commitment to our Patients/Clients, Caregivers and Families and to the Quadruple Aim: In keeping with our respective organizational mission, vision, and value statements, delivering care that results in the best possible outcomes and experiences - to deliver better, faster, more coordinated, equitable and person-centred care is paramount to all that we do.

• Authentic Partnership and Co-design: We are committed to authentic partnership and co-design in our planning and implementation, embedding the perspective of patients/clients, caregivers and families in our work every step of the way.

NOHT-ESON partners collectively have evidence of examples of meaningful patient/client, family and caregiver (P/C/F/C) engagement through:
• Representation on P/C/F/C advisory committees, planning councils, system transformation committees, governing Board positions/committees, working groups, Niagara Health Engagement Network, and strategic planning consultations;
• Co-design of programs and initiatives;
• Experience and program evaluation input gathered from P/C/F/C satisfaction and engagement surveys, accreditation reviews, focus groups and other means; and
• Patient/client relations processes, clinical practice & program/process reviews, issue resolution and consultations to inform quality improvement and service reviews.

The NOHT-ESON has embedded patient/client, family and caregiver advisors at the Planning Table and seeks to further embed advisors within working groups to ensure their experiences and perspectives are considered and incorporated in the planning and care re-design processes. Moreover, a specific Patient/Client, Family and Caregiver Working Group is in the process of being established to represent a diverse perspective to inform the development of a patient/client, family and caregiver engagement framework. All patient/client, family and caregiver advisors were

provided orientation and support prior to and after participation at the Planning Table meetings. The NOHT-ESON commits to:
• Continuing to prepare patient/client, family and caregiver advisors for their roles at the Planning Table and within working groups,
• Supporting and valuing their roles, and;
• Empowering them to participate and lead re-design efforts.

Participants of the NOHT-ESON will engage, educate and build the confidence of advisors in these roles leveraging the rapid synthesis identified through RISE (Rapid-Improvement Support and Exchange) related to the types of knowledge, attitudes, skills, behaviours and physical assets that patients/clients, families, and caregivers need for their roles.

An intended output from the Patient/Client, Family and Caregiver Working group is to develop a comprehensive patient/client engagement strategy and framework that is co-developed to identify priorities and ways to build a culture of engagement. The framework will outline a range of engagement approaches from sharing, to consulting, deliberating, and collaborating that are customized based on the goals. Core principles for success include:
• Partnership – Authentic, timely and mutually beneficial relationships
• Learning – Expectation to learn about different perspectives and experiences, and about how to improve care
• Empowerment – Needs, concerns and perspectives can be openly expressed without fear of reprisal, and to make informed decisions
• Transparency – Partners are honest and open about limitations and gaps
• Responsiveness – Partners take action to demonstrate the positive impact of receiving input
• Respect - Actively showing appreciation for contributions.

Specific outcomes will be identified as part of the engagement framework with dedication to continuous quality improvement and evaluation embedded within the engagement framework to inform future program development, quality projects, transition effectiveness, and identification or resolution of gaps.

The engagement framework will specify a strategy for francophone communities and Indigenous peoples with a focus on reaching voices that are not typically heard and are difficult to reach. The framework will outline the goals/focus of engagement, plan for recruitment with specific criteria that captures different types of lived experience, ethno-cultural backgrounds, and socio-economic factors.

The NOHT-ESON will utilize several communication mechanisms to maintain high levels of involvement and collaboration of patient/client, family and caregivers. Some of which include hosting an interim landing webpage for easy access to information on the NOHT-ESON, a media release to bring awareness to the Full Application submission, etc.

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

The NOHT-ESON members are highly aligned to a strategic direction consistent with the vision and goals of the OHT model, including:

• Designing care to ensure patients/clients experience seamless transitions across different care providers and settings;
• Promoting the active involvement and participation of primary care providers throughout a person's care journey;
• Taking care of a person's complete physical and mental health needs, and not just one condition at a time;
• Encouraging and enabling healthy behaviours and activities, and self-care that promote physical and mental health and well-being;
• Providing interconnected care, so that patients/clients do not have to repeat their health history over and over again or take the same test multiple times for different providers;
• Enabling care that is easy to access and supports navigation;
• Providing the appropriate level of care in the appropriate setting, at the right time; and,
• Achieving better value by delivering better quality for the same or lower cost.

The NOHT-ESON health, community support sector and social service providers' measure, report on and strive to improve performance across their respective organizational frameworks that are linked to the Quadruple Aim. Through shared goals and strategic direction, providers will identify opportunities to collectively scale such frameworks to improve population-level heath outcomes; patient/client, family and caregiver experiences across the system of care; provider experiences across all sectors; and, ensure better value for total health spending. This will culminate in the creation of a NOHT-ESON Strategic Plan in Year 1 that explicitly outlines a collective path forward premised on the OHT model.

The NOHT-ESON participants demonstrate a high degree of alignment amongst shared organizational core values and with the Patient Declaration of Values for Ontario. This was validated through an environmental scan of providers values, and the creation of a set of Guiding Principles to support the planning of the NOHT-ESON.

The most commonly shared core values include:
1. Respect, Dignity
2. Innovation, Excellence, Continuous Quality Improvement
3. Collaboration
4. Accountability, Responsible Stewardship
5. Equitable Access, Inclusion, Engagement
6. Integrity, Transparency
7. Compassion
8. Client/Patient-Centred Care

As such, the NOHT-ESON commits to building a system of care based on mutual respect, a commitment to the Quadruple Aim, collaboration, partnership, trust, and engagement of patients/clients, families, caregivers, providers, and the community.

In order to encompass the strong alignment of shared values, guide decision-making and embed a culture which seeks to advance the work of the NOHT-ESON, participants developed a set of Guiding Principles (see Appendix E: Guiding Principles). These principles supported the completion of the Full Application and will continue to provide overarching direction to the NOHT-ESON as the network evolves over time.

Common practices shared amongst providers, which will be synthesized and scaled within the NOHT-ESON include:
• Sector-based practices to support clinical standardization, including common workflows and care pathways
• Data analytics and information management practices which are poised to extend to population health care and quality improvement
• Reporting and measurement practices

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

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

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

- ***How will your team be governed or make shared decisions?*** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but

not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?

- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.
- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***
- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?*** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

Max word count: 1500

The governance and leadership structure for NOHT-ESON is our Planning Table which is comprised of our:

- Partners
- Collaborators
- Patient/Client, Family and Caregiver Advisors

Decision-making at the Planning Table is consensus-based. As a governance structure evolves, the NOHT-ESON will take into consideration all performance management, conflict resolution, information sharing and resource allocation decisions. As a decision-making process, consensus decision-making aims to be:

• Agreement Seeking: A consensus decision-making process attempts to generate as much agreement as possible.
• Collaborative: Participants contribute to a shared proposal and shape it into a decision that meets the concerns of all group members as much as possible.
• Cooperative: Participants in an effective consensus process should strive to reach the best possible decision for the group and all of its members, rather than competing for personal preferences.
• Egalitarian: All members of a consensus decision-making body should be afforded, as much as possible, equal input into the process. All members have the opportunity to present, and amend proposals.
• Inclusive: As many stakeholders as possible should be involved in the consensus decision-making process.
• Participatory: The consensus process should actively solicit the input and participation of all decision-makers.

The relationship between the NOHT-ESON Planning Table participants has been

formalized through the completion of a Collaboration Agreement to guide our collective efforts going forward. As well, Planning Table participants have agreed to keep membership flexible to ensure the welcoming and inclusion of new partners.

Given the broad collective of partners who have come together to participate in this OHT, the Planning Table serves as both the governance and operational leadership and structure for the OHT at this time. The proposed system changes outlined in this Application are predicated on a coordinated implementation approach, with individual initiatives led by groups of partners based on the experience of those partners to participate in leading those initiatives.

Patients/clients, families and caregivers are already active participants in the Planning Table governance and leadership structure. The NOHT-ESON Planning Table is supported by the NOHT-ESON Coordinating Group, which provides administrative coordination for the Planning Table. This Coordinating Group is comprised of sector leads of the NOHT-ESON Partners and Collaborators, and meets on an ad-hoc basis as required to support the development of Planning Table meeting agendas and logistics, and other administrative items as required.

Currently the NOHT-ESON has established four working groups to further our work in targeted areas (refer to Appendix I: NOHT-ESON Structure):

- A Home and Community Care Working Group;
- A Patient/Client, Family and Caregiver Working Group;
- A Communications Working Group; and,
- A Digital Health Working Group.

As implementation proceeds, additional working groups may be created at the direction of the Planning Table to manage the implementation of specific NOHT-ESON initiatives, or groups of initiatives. This will also include leveraging existing planning and complex case resolution tables.

Currently our Planning Table includes several primary care organizations who, as work proceeds, will in-part represent primary care perspectives and interests at our Planning Table. Through our plan for conducting further engagement and coordination with primary care and other clinicians, any interested and available-to-participate clinicians will be welcome at our Planning Table to help guide our collective work.

To support with leveraging clinician leaders in helping their peers to embrace and embed change, the NOHT-ESON has a primary care physician champion at the Planning Table who is committed to support ongoing primary care engagement.

As this work moves forward and further direction from the Ministry of Health is received, we will evolve and refine our governance structure and look at different models (such as developing a terms of reference).

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

The NOHT-ESON approach is to organize care around the patient/client, based on the patient/client's care team which reflects their specific needs and the services they are receiving. Information will be shared across the team through several different channels including:

- Verbal/Phone: Through involving other providers, caring for a patient/client in the Integrated Care Planning process some information is shared in real-time. This includes both individual provider-to-provider information sharing as well as through existing structures that will be used to conduct Integrated Care Planning such as regional/clinical pathway specific care coordination tables.

- Fax: Fax remains our primary mechanism for sharing Integrated Care Plans with primary care providers. A structured communication is sent to primary care physicians to inform and involve them in the Integrated Care Planning process and the Integrated Care Plan itself. Over time this will be phased out as the NOHT-ESON takes on a more digital approach to sharing and communication across all partners.

- Digital: Information will be digitally shared with members of the patient/client's care team through leveraging the following technologies:
  - o Health Partner Gateway (HPG): to share Integrated Care Plans among care team partners
  - o ClinicalConnect: to share information regarding the clinical medical care patients/clients are receiving and their health system use
  - o EMS' Integrated Decision Support: to allow partners to understand patient/client journey and outcome data
  - o The Niagara Health Navigator: to act as a secure platform for information sharing

and enabling interoperability amongst our partners.
o eHealth Ontario: to enable access to existing provincial data assets such as the Provincial Client Registry and others over time as use cases and population needs arise.

We have identified some key critical success factors and an implementation plan to digitally enable sharing of patient/client information across providers:

- Scaling existing provincial digital health solutions: Currently, 19 of 33 NOHT-ESON partners have access to HPG. Niagara will expand the use of the HPG to other eligible providers across the sectors, including integration with ClinicalConnect viewer and Sunnybrook MyChart. The NOHT-ESON will leverage the Client Health and Related Information System (CHRIS) to enable care coordination and care planning and to streamline transition of patients/clients across care settings. HPG use will be expanded for planning the delivery of home and community care, managing referrals, and providing eNotifications to home and community care providers when their patients/clients show up at an ED or are seen by an EMS. Additionally, we plan to use CHRIS/HPG's multi-authoring capabilities for creating, viewing and notifying providers of changes to a patient/client's Integrated Care Plan.

To enable the secure sharing of health information we will ensure that all partner organizations that access PHI held in provincial digital health assets 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.

We have seasoned experts that can manage privacy and security programs required to support multi-provider service delivery as a Health Information Technology provider, governed by PHIPA. We will use their knowledge and experience with the underlying policy and standards within the province (including eHealth Ontario) to support partner organizations to deliver a robust IAA program by developing a minimum data set and data sharing agreements. We will leverage the guidance provided by the Ministry in the Digital Health Information Exchange Policy to develop a minimum data set, enabling the HSPs to access trusted PHI in a frictionless, reliable, and consistent manner.

- Ministry Engagement: We also plan to work with the Ministry to enable expanded access to the ClinicalConnect viewer, a provincial solution used to access historical patient/client record level data when patients/clients are in an organizations' circle of care, for non-traditional healthcare providers in the community. There are partner organizations in the NOHT-ESON that are classified as non-HICs (according to PHIPA), yet are critical partners to ensure the health and wellness of our population. We will require support from the Ministry to assist in clarifying data access, exchange, data use and disclosure for non-HICs as well as between HICs and non-HICs. Ideally, we feel that an implied consent approach would be suitable to manage privacy. If expressed consent is required for every patient/client in the circle

of care, this will put a significant burden on all providers to meet the operational process requirements.

Under PHIPA, two or more HICs can apply to the Minister for an order permitting all or some of the applicants to act as a single HIC. This could be an alternative solution, where we could try and explore a grouped consent for non-HICs by having a HIC be designated consent on the behalf of the group. This group could be viewed as a single HIC with respect to OHT operations and would provide a convenient way to respond collectively to access requests, etc. If we take the grouped HIC route, we will develop agreements between among those HIC and non-HIC participants to clarify operational roles and responsibilities.

- Enabling information sharing and interoperability: The NOHT-ESON also plans to explore leveraging the Niagara Health Navigator as a secure platform for information sharing and enabling interoperability amongst our partners. The solution is centered on an Authorization Server implementing the Federated Privacy Exchange (FPX) specification, an extension of the User Managed Access (UMA 2.0) open standard protocol. This particular authorization server enables granular data control by users, introduces an interoperable hub, and spoke architecture that supports a cooperative governance model for connected parties serving users on the network. We are actively engaged with eHealth Ontario to enable access to existing provincial data assets such as the Provincial Client Registry and others over time as use cases and population needs arise. Our existing Navigator program underpinned by our IAA service will enable a number of important digital services, including Patient Registration, Digital Immunization Record Management, Mental Health Virtual Support and Integrated Comprehensive Care.

- Enabling population health analysis and care: We plan to have the ability to query pooled data and anticipate implementing a robust business intelligence (BI) platform to capture, document, and report on patient/client data to further inform our understanding of our OHT attributed population and their needs. The data will be use to understand the population at an integrated care delivery or OHT level across partner organizations, and will help inform care planning, identify the cost drivers and tracking costs for a patient/client across their episode of care, and gather insights to improve the integrated care pathway design to enhance patient/client experience and outcomes. We also recognize that as our community grows, a dedicated team will be structured to analyze the resulting data and provide trends, design proposals and solutions, and more detailed population health needs.

Providing a platform for cross-provider communication and collaboration: In addition to the above plan for ensuring that patient/client information is shared securely and digitally across the providers for the purposes of integrated care delivery and planning, we are also exploring other options e.g. Microsoft Teams and eConsult platforms. These two-way communication platforms could enable increased cross-provider communication and collaboration, especially amongst physicians and specialists, allowing a faster communication, expedited advice and care delivery for

patients/clients, and a secure platform to share health information. In the long-term, we plan to integrate these platforms on the Navigator to enable providers and patients/clients to use the same platform for sharing health information. This will be enabled by developing and assigning appropriate user roles and access to providers and patients/clients.

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

The NOHT-ESON is committed to working towards the development of integrated care systems, reducing variation, and implementing clinical standards and best practices. We believe that an integrated care approach across the continuum will help ensure the efficient deployment of health and social resources where they can make the most positive impact on patients/clients, families and caregivers, and simultaneously address the challenges facing our health care system including reducing hallway health care.

No members of the team have had recent issues with governance, financial management, compliance with contractual performance obligations or compliance with applicable legislation or regulation.

During Year 1, existing accountability agreements with funders and their associated performance metrics remain in place. As the NOHT-ESON evolves beyond Year 1, we will focus on key patient/client experience, patient/client outcomes, and system and financial performance indicators that align to patient/client experience of care, population health and wellbeing, per capita cost of health care, and caregiver engagement/satisfaction.

Through a formalized reporting on and sharing of performance measures, the NOHT-ESON will identify any potential performance concerns or areas as they arise and address these at the Planning Table. Through the sharing of best practices and continuous learning opportunities, the NOHT-ESON members will be in a strong position to support any performance or compliance issue that arises with any individual member organization.

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

Quality and performance improvement and continuous learning are important priorities for the members of the NOHT-ESON. The NOHT-ESON will continue to build on our organizations' quality and continuous improvement processes and plans by identifying opportunities for alignment through the development, implementation, evaluation, adjustment of, and dissemination of a shared quality improvement plan. The NOHT-ESON will embed a culture of rapid learning and improvement through sharing of information, implementation of learning collaboratives and regular meetings to monitor progress and identify opportunities for improvement. Learning and improvement strategies will continue to be driven by patient/client experiences of care. Specifically, patients/clients will be meaningfully engaged in co-designing approaches to quality and performance improvement.

All NOHT-ESON members have identified some form of performance improvement or continuous learning initiative/activity in their organization. Together we are able to demonstrate a strong track record of successfully implementing quality and performance improvement and continuous learning initiative/practices. Across the members of the NOHT-ESON, common performance improvement and continuous learning initiatives include:

Performance Improvement:
• Sector big dot indicators
• Participation in the I-EQUIP program (Interprofessional Education for Quality Improvement Program)
• Regular (e.g., monthly) continuous improvement meetings
• Formal continuous improvement organizational policies at a governance and management level
• Patient/client input into quality improvement
• Accreditation and sector standards that guide practices and CQI initiatives
• Best practices shared amongst organizations
• Participation in sector and cross-sector quality committees
• Implement HQO recommendations and frameworks
• PDSA cycles
• Creating annual Quality Improvement Targets and implementing regular reporting
• ISO 9001:2015 certification

Continuous Learning:
• Formal submission of Continuous Improvement Plans to funders (i.e. LHIN) and Boards
• Program Evaluations
• Regular patient/client, staff, volunteer engagement surveys
• Staff education and training on new opportunities
• Review of EMR data to identify areas for improvement
• Online training programs for staff

It is also important to note that the members of the NOHT-ESON have experience working together on joint performance improvement and continuous learning initiatives, and many NOHT-ESON members are recognized as RNAO's Best Practice Spotlight Organizations. Specifically related to our Year 1 target population, 16 NOHT-ESON partners have collaborated and led a successful cross-sectoral initiative through Integrated Care Planning for over 1,100 patients/clients. Metrics are tracked monthly and reported quarterly to drive quality and performance improvement.

The NOHT-ESON has identified six key health system measures in form the performance measurement strategy in Year 1:
1. 30-day inpatient readmission rate for patients with integrated care plans
2. Rate of hospitalization for ambulatory care sensitive conditions
3. Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
4. Frequent ED visits (4+ per year) for mental health and addictions
5. 7-day physician follow up post-discharge
6. Patient/client reported experience measures, provider reported experience measures and patient/client reported outcome measures.

While these examples are not an exhaustive list of the Performance Improvement and Continuous Learning activities underway across the members of the NOHT-ESON, they provide examples of the already strong foundation and commitment to these priorities.

To inform these initiatives NOHT-ESON partners currently collect data to measure and analyze progress, successes and opportunities for improvement, including performance indicators supportive of ending hallway medicine. Common indicators exist for reporting of Integrated Care Plans which include the following (collected monthly):
• # patients/clients with an Integrated Care Plan or transition plans
• # of patients/clients with an Integrated Care Plan attached to a primary care provider
• Integrated Care Plan patient/client metrics & IDS data on broader patient populations
• # of health and social care providers and organizations involved in Integrated Care Planning
• # and type of system barriers of individuals with Integrated Care Plans
• Patients/clients self-reported timely access to primary care
• Patient/client total time from referral to initiation of an Integrated Care Plan
• Patient/client self-reported confidence scores
• Alternate Level of Care data
• Utilization rate of ED stretchers

Moving forward NOHT-ESON members will establish formal mechanisms for sharing performance improvement and continuous learning data, practices and outcomes and will look for opportunities to support the improvement initiatives of other organizations. The NOHT-ESON will seek to align governance, financial models and service delivery to quality and performance improvement to facilitate rapid learning and improvement. The NOHT-ESON will also look to leverage additional Ministry support to assist with rapid learning and 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.

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

pathways?

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

Max word count: 500

The members of NOHT-ESON have all demonstrated evidence of meaningful patient/client, family and caregiver engagement and inclusion in decision-making and governance. NOHT-ESON will continue with this commitment during Year 1 and beyond, working to ensure that patient partnerships, service and system co-design, and governance structures reflect the needs of patients/clients, families, and caregivers.

Each member of the NOHT-ESON that serves a client population identified at least one mechanism for gaining patient/client input. The majority also identified methods of engaging family members and caregivers as well. Common patient/client, family and caregiver engagement mechanisms include:

- Strategy and initiative co-design;
- Formal Advisory Groups where input is documented and action plans developed to address recommendations;
- Surveys;
- Program/service evaluations that leverage person-centred approaches to planning, focus groups, and direct feedback;
- Patient and Family care conferences;
- Comment boxes;
- Co-developed post-secondary research projects;
- Feedback through other formal and informal methods; and,
- Community engagement activities and inclusive governance models

All members, as part of our organizational philosophies and standards of practice, have mechanisms to ensure meaningful patient/client, family and caregiver relations and engagement. These inform organizations' program reviews, service gaps, job descriptions, recruitment, budget decisions, and strategic priorities.

NOHT-ESON has included patients/clients, families and caregivers in our Planning Table and plan will continue to include representation on Working Groups. This provides the opportunity to co-design all strategies and approaches alongside patients/clients, families and caregivers to ensure care is being designed, improved and managed in ways that reflect what is most important to them.

During Year 1 of operations, NOHT-ESON will ensure that patient/client, family and caregiver input and engagement mechanisms are reviewed, and where opportunities for improvement are identified, create plans to see enhancements are delivered. The NOHT-ESON will also establish a culture of implementing specific measures and

indicators to quantify the impact of patient/client, family and caregiver-led improvement initiatives on the patient/client experience and operations.

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

The NOHT-ESON is comprised of member organizations that provide foundational health and social care to the communities they operate in and serve. NOHT-ESON members recognize that the needs of the broader community must drive strategic policy and operational aspects of care. Currently members maintain formal engagement mechanisms with the community through:

- Townhall style meetings and community focus groups;
- Large scale online engagement, including surveys;
- Regular and ongoing meetings with MPs, MPPs, Niagara Region Mayors related to capital expansion projects or new services;
- Providers engage with local area municipalities and upper tier municipalities, with upper tier representation at the NOHT-ESON Planning Table; and,
- Participation in provincial associations/networks (e.g. Rehab Care Alliance).

Many NOHT-ESON members have strong community engagement and collaboration practices and can further collaborate through joint engagement and consultation initiatives.

Community engagement will continue to inform health equity goals of the NOHT-ESON, particularly those of Francophone and Indigenous priority populations. Recommendations identified through community engagement activities will be used to analyze and inform care strategies across the NOHT-ESON. As such, the Niagara OHT will continue to prioritize building relationships with the full diversity of community groups representative of our attributed population.

The NOHT-ESON will be hosting a Stakeholder Forum to engage healthcare organizations and other primary care physicians interested in joining the NOHT-ESON, and will roll out additional opportunities (e.g. public-facing NOHT-ESON website) to ensure meaningful opportunities for community participation are readily available and accessible.

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

Bundled care/integrated care:

Through Niagara Health, our team has experience with bundled care.

- Since 2015, Niagara Health has participated and implemented Integrated Comprehensive Care (ICC 2.0) with partner hospitals and NOHT-ESON participants, for 1,258 patients/clients with COPD and heart failure. Outcomes include:
  - 41% reduction in emergency department visits
  - 38% reduction in 30-day readmissions to hospital
  - 30% in average length of hospital stay
  - 3,745 hospital days saved, or $2.8 million in cost avoidance
- In 2018 Niagara Health expanded bundled funding programs for: hip and knee (working with LHIN Home and Community Care, Hotel Dieu Shaver Rehabilitation Hospital, for in-patient and out-patient rehab and community physiotherapy clinics), and dialysis care.
- Beginning in 2019/20, a new bundled care program for reverse shoulder and for ischemic and non-ischemic stroke will be implemented per MOH timelines.

Cross-Provider Funding:

- Four core service providers collaborate to distribute financial resources to support integrated care for children and youth with mental health.
- Multiple providers pool financial resources to provide access to emergency services, avoid hospital admission, and support the NOHT-ESON planning process.
- Various health and social care providers seek to maximize various funding envelopes to support community health and well-being. Examples include, but are not limited to:
  - Community paramedicine program
  - Concurrent disorders emergency shelter pilot
  - Low-income dental health programs
  - Behavioural supports within long-term care and community

NOHT-ESON organizations will identify and share costs and cost drivers at a program and service level. Organizations will leverage existing systems for tracking costs and value to quantify costs, generate cost analysis, in addition to quantifying value dimensions, such as resources/capacity, cost avoidance, time, patient/client wellness, quality and performance. Partner organizations have relied on fundraising, philanthropy, volunteer services and auxiliary services that have contributed to

revenues and capacity to provide quality patient/client care. This information will inform the broader system-wide and standardized cost models/structures related to the Year 1 target population.

Existing detailed process maps, completed for a number of clinical pathways, will inform costs associated with:

- System navigation & process improvement
- Performance measurement and outcomes
- Health care transition points (or potential gaps)
- Points of potential savings and areas for reinvestment

There is an opportunity for partners to develop a peer-support model to share financial resources, training and capacity, with early commitments to leverage the EMS Health Economist to assist with cost analysis/modelling for integrated unscheduled care.

NOHT-ESON will work on proposed, integrated funding envelopes and identify the most appropriate fund holder as the governance model evolves.

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

1.1 Develop detailed project plan
• 30 days: Confirm project team resources, and confirm Project Plan
• 60 days: Develop Project Charter and Project Plan reviewed and adjusted
• 90 days to 6 months: Project Plan reviewed and adjusted

1.2 Develop Terms of Reference for Planning Table
• 30 days: Develop draft Terms of Reference for Year 1 including decision making and conflict resolution
• 60 days: Revise draft Terms of Reference
• 90 days: Finalize Terms of Reference

1.3 Culturally safe and competent practices
• 60 days: Continue allyship while seeking guidance and advice from the Indigenous Health Network, support planning partners to engage in the Francophone Community of Practice (hosted by Entité de planification des services de santé en français)
• 90 days: Continue education and learning at the Planning Table and working groups, implement needs based planning to reflect needs of the Francophone community
• 6 months: Commitment to ongoing education and training and reporting on outcomes

1.4 Develop governance structure
• 30 days: Education on governance structure options
• 60 to 90 days: Ongoing governance structure discussion
• 6 months: Finalize recommendations on governance

1.5 Balanced dashboard aligned with Quadruple Aim
• 90 days: Develop draft
• 6 months: Finalize dashboard

1.6 Home and community care working group
• 30 days: Draft Terms of Reference and Workplan
• 60 days: Develop inventory of all home and community care services, along with navigation services
• 6 months: Develop and share a common transition planning tool across all providers, and implement and review test of change results

1.7 Digital health working group

• 30 days: Draft Terms of Reference and Workplan, identify program -resources, and hold program kick off
• 60 days: Development of Project Charter, and review and update partner inventory
• 90 days: Data flows, technical design, and communication & adoption strategy
• 6 months: Develop operations plan

1.8 Communications working group
• 30 days: Draft Terms of Reference and Workplan, and refresh communications and stakeholder engagement plan
• 60 days: Hold Stakeholder Forum, and review plan and adjust as needed
• 90 days to 6 months: Review plan and adjust as needed

1.9 Primary care engagement framework
• 30 days: Ongoing engagement with primary care
• 60 days to 6 months: Review plan and adjust as needed, ensure ongoing engagement with primary care

1.10 Patient/Client, family and caregiver working group
• 30 days: Draft Terms of Reference
• 60 days: Draft engagement Workplan specific to patients/clients, families and caregivers
• 6 months: Finalize and implement plan

1.11 Expand Integrated Care Planning
• 30 days: Align current integrated care planning to Project Plan, hold additional provider training/onboarding, develop strategy to leverage existing integrating care planning assets (Health Links Action Table and Niagara Mental Health and Addictions Collaboration Table) and develop reporting structure to planning table
• 60-90 days: Sustain existing Integrated Care Planning, support incremental expansion of Integrated Care Planning, and identify barriers to sustaining Integrating Care Planning
• 6 months: Sustain existing Integrated Care Planning, support incremental expansion of Integrated Care Planning, rectify barriers to sustaining Integrating Care Planning, and add additional organizations to HPG

1.12 Improve transitions in care
• 30 days: Draft transition strategies based on pathways
• 90 days: Conduct small tests of change
• 6 months: Analyze and identify trends and opportunities to address system barriers

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

NOHT-ESON Planning Table participants understand that change management is a critical component of implementing large-scale health and social care system initiatives. This requires a comprehensive understanding of the reason for change, a well-defined vision for the new state, and a clearly articulated set of directions and success factors to achieve the vision. Central to this approach is a consistent line of communication and collaboration between the agents and champions of change, and those affected by change, ensuring all parties understand the change and have a sense of ownership in the outcome. All participants of the NOHT-ESON align with the Ministry's vision for change, and have thus far committed to:

- Consistent and transparent governance and communication;
- Establish bi-weekly Planning Table meetings;
- Inclusion of patient/client, family and caregiver and other stakeholder input throughout process of change;
- Ongoing evaluation and rapid learning and improvement;
- Introduction of an intersectional, population-based lens;
- Inclusion of recommendations from other system-planning tables/initiatives; and,
- Leverage existing knowledge exchange platforms.

As we move forward there will be three critical success factors to our change management strategy:

- Accountability: We will establish clear roles and responsibilities for change initiatives to ensure individuals understand expectations. Clear, consistent communication of responsibilities and accountabilities will maintain support for change, and encourage collective ownership of outcomes.
- Communication: Consistent efforts to ensure transparency and communication, and review to evaluate whether adjustments are required within various communication methods across sectors.
- Commitment: NOHT-ESON members have demonstrated their commitment within the planning process by sitting on the Planning Table and in endorsing a Collaboration Agreement. As the NOHT-ESON evolves, clinician leads will be identified through each sector and organization to commit to spread.

Additionally, the NOHT-ESON recognizes that a major factor which influences the success of any change management implementation is the ability to effectively track and manage change during and after implementation. The NOHT-ESON will take an approach that focuses on establishing metrics and monitoring protocols that are based in outcomes so that information pulled from the process can be used to make decisions in real-time to support the change, and so that front-line staff and clinicians can see the impact and results of their efforts.

To support clinician leaders in helping their peers to embrace and embed change, the NOHT-ESON has a primary care physician champion at the Planning Table who is committed to support ongoing primary care engagement.

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

NOHT-ESON will develop implementation plans that identify strategies to mitigate risk to the broader population. All current service levels will be maintained for the broad population as we focus on tests of change for the Year 1 target population, and pursue opportunities for spread and scale.

The NOHT-ESON will leverage existing assets in order to manage change initiatives (e.g. complex case resolution tables and processes).

We have designed our approach to ensure care levels for patients/clients not included in our Year 1 population are not negatively impacted. In fact, we have chosen our Year 1 population because we strongly believe that through the increased integration and coordination of services across providers that Integrated Care Planning will achieve, coupled with our home and community care redesign and digital health efforts, that all users of the health and social system will experience a more integrated and patient/client-centred health and social system.

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

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

Max word count: 1000

The following systemic barriers have been identified related to regulatory, and policy barriers that may impede the ability to implement care redesign plans in the long-term. We offer the considerations listed below for review.

Legislative Barriers

With respect to care coordination, the Home and Community Care Act places restrictions on who can:

- Coordinate care (e.g., must be a LHIN employee);
- Complete referral processes (too restricted);
- Provide nursing care (must be designated); and
- Determine eligibility (too restrictive).

The Long Term Care Homes Act currently has a number of provisions and restrictions with respect to:

- LTC assessment, referrals, bed offers
- Patient choice and waiting in hospital
- Campuses of care (opportunities and restrictions)

• Who can determine LTC eligibility

Regulatory and Policy Barriers
The other regulatory and policy barriers identified to date include:
• Privacy and consent issues may limit the ability to involve all community support service organizations in home and community care
• Third party providers are not subject to the French Language Services Act and therefore there are no third party providers who deliver French language health services
• Current contract terms related to evergreening of provider service contracts/not going to broad based procurement for home and community care on a regular basis. This can also limit the ability to open up third party contracts to allow for changes on service models, address service provider accountability, and ensure quality improvement.
• Policy and practice of holding agencies accountable to meet the French Language Services Act
• Sustainable funding models for community sector and Indigenous-specific service providers
• Labour/collective bargaining/labour supply:
☐Collective agreements and transitions thereof
☐24/7 work schedules (constraining ability to work/provide services on weekends)
☐Introduction of standards and legislation to address labour shortages

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
We have identified a number of centralized non-financial resources or supports that would help NOHT-ESON deliver on our Year 1 priorities and meet Year 1 expectations set out by the Ministry of Health. We have organized our suggestions into 7 domains:

1) Communication
☐Central repository of resources that can be accessed easily by all
☐Messaging for communications (unions, boards, staff)

2) Resources
☐Dedicate a committed number of Ministry staff that will meet and work directly with this OHT

3) Legislation
☐Change privacy legislation to allow organizations to more freely share information

(with client consent)
☐Streamline regulations to ease patient transfer and enable better coordinated care

4) Training and Best Practices
☐Provide overview/training from OHTs that are moving forward successfully
☐A library of training opportunities across the Province
☐Share consistent standards and metrics for OHTs
☐Share leading ideas / emerging best practices
☐Share OHT models as an opportunity to adopt innovative ideas

5) Information Technology
☐Expand access and enrollment for Provincial and Regional technology solutions including OTN eVisit services and ClinicalConnect (among others)

6) Governance
☐Templates, approaches and policies to support governance for OHTs to leverage

7) Branding
☐Provide unified branding for OHTs

6.6. Risk analysis

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

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

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

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

6.7. Additional comments

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

Max word count: 500 N/A

7. Membership Approval

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

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

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

APPENDIX A: Home & Community Care

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

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

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

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

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

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

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

Max word count: 1500
Our Long-Term Vision for the Design and Delivery of Home and Community Care

Given the above, NOHT-ESON's long-term vision for the design and delivery of home and community care is centered on:

• Bringing home and community care closer to primary care, given the foundational role primary care plays in people's lives.
• Bringing home and community care closer to the patient/client, family and caregiver;
• Where appropriate or necessary, care planning conversations with patients/clients will include families and caregivers (subject to privacy legislation requirements); and
• Exploring possibilities in terms of services that go beyond conventionally defined LHIN home care to see whether patient/client, family and caregiver needs can also be served by different bundles of resources from the community support sector that would alleviate some of the system pressures and provide more timely access.

NOHT-ESON is fortunate in that LHIN Home & Community Care Coordinators are already organized in large measure around primary care – i.e. many of the 54 Community Care Coordinators in Niagara are assigned to patients/clients based on the patient/client's primary care physician, though many are also assigned to patients based on location (e.g., hospital) or other status (Palliative etc.). We recognize that by also attaching to other settings, Care Coordinator caseloads will need to be re-evaluated to ensure caseloads are balanced allowing Care Coordinators to effectively support their patients/clients.

At the same time we recognize that Care Coordinators must at times be specialized to serve certain populations, and located either in direct proximity to primary care or other service providers where care planning is taking place.

This vision focuses on the following 6 high level objectives:
1) Enhancing awareness
2) Improving Delivery
3) Building Capacity
4) Centralizing Access and Planning
5) Sharing, Embedding, Prioritizing, and Specializing Care Coordination
6) Ensuring Accountability

1) Enhancing Awareness

Challenge: Patients/clients, families, and caregivers struggle to obtain information about available services, access services in a coordinated way, and receive coordinated services that meet their needs.

As part of our long-term vision, we plan to:
a. Implement both broad and targeted communication and education initiatives for all service providers, patients/clients, families and caregivers to increase awareness and understanding of available services and supports within the community.
b. Design content and communication channels with target populations in mind, and how it impacts patients/clients, families and caregivers.
c. Deliver consistent communication and education through multiple channels, including the web, directly through service providers, key locations in the community,

including schools, community centres, child care centres, seniors centres, hospitals, libraries, malls, and grocery centres.

2) Improve Delivery

Challenge: While the challenges of personalizing and making home and community care more patient/client, family, and caregiver centered are well documented generally, the Niagara region struggles on these fronts particularly for our target and marginalized populations. Obtaining services from providers in French is a particular challenge, even from identified providers.

As part of our long-term vision, we plan to:
a. Connect care and include patient/client, family and caregiver in navigation decisions from a holistic perspective
b. Consistently document and share clear and simple patient/client care instructions (care plans, discharge/transition plans, etc.) with patients/clients and their families and caregivers (respecting patient/client privacy).
c. Provide 24/7 access and timely response to services
d. Improve care pathways and care planning to focus on early identification, transitions and warm handoffs across all providers.

3) Build Capacity

Challenge: The Niagara region includes a varied geography with a variety of population densities, for which it relies on 54 Care Coordinators who see patients/clients with diverse needs, and carry out their roles in a variety of settings – from offices in the community, to primary care, to high density apartment buildings and EMS services to name a few. We see the need to build their capacity and draw on our collective resources as providers to serve this complex geography better.

As part of our long-term vision, we plan to:
a. Leverage existing community supports, long term care homes, emergency medical services, and other resources in innovative ways to increase capacity and flow.
b. Understand and identify opportunities to improve capacity available to serve marginalized populations (e.g., Francophone, Indigenous) that are geographically dispersed but for which a critical mass of culturally and linguistically competent providers must be maintained and increased.
c. Ensure accountability for service delivery targets.
d. Support provision of home care services that specialize in the needs of Indigenous and French language populations.
e. Increase availability of services like Community Paramedic Mobile Integrated Health Teams to support “unscheduled” health care 24/7, improving response times and avoiding hospital admissions.

4) Share, Embed, Prioritize and Specialize Care Coordination

Challenge: Integrate home and community care with primary care, in accordance with our broader vision.

As part of our long-term vision, we plan to:
a. Share and embed Care Coordinators in locations that make sense given population needs, with an emphasis but not exclusive focus on primary care (including Family Health Teams and Community Health Centres), high density marginalized populations (e.g., those living in apartment buildings with high home and community care and emergency service use), emergency services, and others as appropriate. We expect that embedding Care Coordinators in such areas will improve communication, ensure continuity of care, strengthen relationships with primary care and identify natural connections between services to address needs of patient/clients.
b. Prioritize care coordination for those with greater needs, particularly the Year 1 target population.
c. Continue to maintain specialized Care Coordinators to support people that require specialized knowledge and skillsets.
d. Develop a bilingual digital platform, improve health literacy, and patient/client and family access to information, as well as simplify care pathways to increase people's ability to self-navigate and reduce the need for non-specialized care coordination so that care coordination resources have greater capacity to focus on those with more complex and specialized needs.

5) Centralize Access and Planning

Challenge: There are a range of access points and while Integrated Care Plans have been implemented and in use, they could function much more efficiently with digital integration.

As part of our long-term vision, we plan to:
a. Ensure patient/clients have a single point of contact for services
b. Expand contact/access/intake and referral process to include access to all community support service, home and community care organizations, to ensure "no door is the wrong door" in English or French
c. Provide digital/IT system access to all partners, including community support service agencies
d. Implement a single Integrated Care Plan for each patient/client based on a common platform and intake form for all care coordinators and service providers.

6) Ensure Accountability

Challenge: The diverse population of patients/clients and providers involved in home and community care makes it difficult to coordinate and maintain accountability among providers and for patients/clients, caregivers, and families, particularly for marginalized and vulnerable populations.

As part of our long-term vision, we plan to:

a. Develop common measures, data definitions, targets and quality improvement planning across providers
b. Embed NOHT-ESON reporting into common progress evaluation cycles
c. Ensure accountability for other service delivery targets.

The NOHT-ESON will act on the above vision through: system-level initiatives that impact system infrastructure and all providers; care-level initiatives that target priority populations; establishment of new pathways with a view to scaling and spreading them once success has been demonstrated which will identify capacity, growth needs, and constraints.

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

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

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

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

Max word count: 1000
Proportion of Year 1 Population Requiring Home Care

Current patient/client demographic and service data for whom an Integrated Care Plan has been developed in Niagara represents a proxy for anticipating the home care needs of our target population in Year 1.

In Niagara, a total of 1,038 Integrated Care Plans have been completed up to the end of March 31, 2019 for residents of Niagara. LHIN Home and Community Care was provided for 951 (or 92%) of the people with Integrated Care Plans. If this same proportion of care (92%) were applied to the Year 1 Target Population, the number of people for whom Home and Community Care would be provided would be approximately 1,300 patients/clients. The demographics, home care use and needs are anticipated to be comparable to the Integrated Care Plans completed thus far as outlined below.

Demographic Details:
- Average age: 73
- Gender: 58% female; 42% male
- Area of residence:
  - 39% St. Catharines
  - 19% Niagara Falls
  - 17% Welland
  - 25% all other areas
- 8% with language preference other than English (4% French)
- Indigenous cultural identify not well captured and underrepresented
- 75% live in private dwelling, 19% in retirement home/assisted living/supportive housing, 6% other/unknown
- 35% of people living in private dwellings live alone

Indicators of Home Care Use:
- Length of home care service ranged from two days to 366 days (average of 230 days)
- The most common types of home care services provided ranged from personal support (70%), nursing (66%), occupational therapy (62%), and physiotherapy (46%)
- A total of 259 people (or 25%) had a long term care home placement referral active at any point since the development of the care plan

Indicators of Home Care Need:
- 53% MAPLe 4 or 5 (high or very high)
- 19% with Cognitive Performance Scale score of 3+ (moderate to very severe impairment)
- 8% triggered the behavioural Clinical Assessment Protocol (CAP)

• 48% of people had Activities of Daily Living Self-Performance Hierarchy Scale score of 3+

Priorities for Innovating in the Delivery of Care

As discussed above, NOHT-ESON is distinguishing between system-level and care-level initiatives priorities for innovating in the delivery of care consistent with its home and community care vision.

SYSTEM LEVEL-INITIATIVES

1) Awareness-enhancing initiatives, including communications through multiple formats and channels and an inventory of all home and community care services.

The NOHT-ESON will support patients/clients, families, and caregivers to make informed choices by undertaking a variety of awareness-enhancing initiatives, including a digital service inventory, and any new navigation and coordination resources.

This inventory will draw upon:
• Existing LHIN resources/internal planning documents
• Other health system sources (e.g., Healthline)
• Consultation with patients/clients, families and caregivers, given their on-the-ground knowledge of services and how they can be accessed.

2) Consistent points of contact for patients/clients and families for home and community care.

This work will ensure a consistent point of contact from the time of initial service provision to connect people to all available services and supports in the community in a way that meets the patient/client's needs (including their socio-economic, cultural and language needs).

3) Develop and share a common transition tools across all providers.
This priority will focus on ensuring common transition tools are used in conjunction with improved system navigation. These tools will include standard protocols for discharge and transition planning, including what, how, when and where information is to be communicated between providers, patients, clients, families and caregivers. This is particularly important for marginalized populations who are served by our expanded definition of home and community care services.

CARE MODEL-LEVEL INITIATIVES

1) Embed care coordination in front-line services and locations

Based on existing successes NOHT-ESON will develop a strategy for redeploying care coordination resources. This will:
• Include existing Care Coordinator resources, as well as other resources that can potentially be leveraged from other providers in the region (see “Build Capacity” element of the long-term vision above)
• Consider a variety of possible locations/alignment for these resources, such as embedding them in:
  o Primary care offices (e.g., FHTs, CHCs)
  o Emergency response services
  o High-density apartment buildings with marginalized populations
  o Homeless shelters
  o Other locations as appropriate

This may include small tests of change to begin, with care coordination roles defined and carried out as defined in legislation today.

As an example, embedding care coordination in emergency medical services would involve:
• A paramedic paired with an appropriate Care Coordinator resource
• The Care Coordination would be responsible, upon contact with an appropriate patient/client, for intake to initiate/update an Integrated Care Plan, coordinate service needs, and delivery of service at point-of-care where appropriate/possible
• These functions could be delivered in the patient/client’s home, in response to EMS calls received via 911 (unscheduled non-emergency medical needs), including calls from patient residences. A small PDSA cycle could be completed in Year 1 to test the concept.

2) Test direct referral method for accessing community-based hospice palliative care.
Facilitate direct referrals for people within the identified population who would benefit from in-home specialist care during the last 12 months of life or hospice placement within the last 3-4 months of life by:
• Sending referrals to these services directly to Hospice Niagara, at the same time as they are filed with the LHIN’s central intake;
• Expanding responsibilities for completing these referrals to include hospital discharge planners, nurses and professionals working in primary care settings; and,
• Designating eligibility decisions for specialized care to Hospice Niagara staff.

3) LTC placement initiatives
LTC eligibility and assignment is a complex process. This priority will explore opportunities to streamline the process in support of improved patient/client experience and system utilization, which may include:
• Reviewing legislation and identify opportunities for efficiency and standardization
• Review the LTC eligibility and assessment process (i.e. improve time to bed outcomes)
• Review placement legislation in the context of campuses of care

• Expediting the process for French language patients/clients to be placed with French language providers

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

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

Max word count: 1000

In Year 1, the NOHT-ESON will develop a phased plan to transition LHIN-delivered home and community care in keeping with Ministry direction. This will include a strategy to embed and enhance Care Coordinators in locations that align with population needs, and place an emphasis on primary care (including Family Health Teams and Community Health Centres), high density marginalized populations (e.g., those living in apartment buildings with high home and community care and emergency service use), emergency services, and other settings, as appropriate. We expect that embedding Care Coordinators in such areas will improve communication, ensure continuity of care, strengthen relationships with primary care and identify natural connections between services to address needs of patient/clients. We will prioritize care coordination for those with greatest needs, particularly the Year 1 target population.

The NOHT-ESON will develop a consolidated service inventory to identify programs and local expertise that draws upon existing and planned resource/systems and consultation with patients/clients, families and caregivers, given their knowledge of services and how they can be accessed. Additional items the NOHT-ESON will address within Year 1 will include developing plans related to:

- Maintaining the current integrated structure for Palliative Care Coordinators on Palliative Care Outreach Teams;
- Developing a review process to transition current home care caseloads, patient/client relationships, and embed an integrated care plan;
- Determining a host agency to which employment may be transferred;
- Analyzing and identifying trends and opportunities to address systems barriers and implementation of a number of additional small tests of change; and,
- Transitioning digital resources and scale existing provincial digital health solutions, in subsequent years, as per the Digital Health strategy outlined in Appendix B: Digital Health.

By increasing Integrated Care Plans, a person's care will be seamless, and each step in their care journeys will be planned and supports. Patients will know who they can go to when they need help navigating their care, or when things go wrong.

Currently, 19 of 33 NOHT-ESON partners have access to CHRIS. Niagara will expand the use of the CHRIS system to other eligible providers across the sectors, including integration with Clinical Connect viewer and myChart. The NOHT-ESON will make better use of CHRIS functionality to enable care coordination and care planning and to streamline transition of patients across care settings. Health Partner Gateway

(HPG) use will be expanded for planning the delivery of home and community care, managing referrals, and providing eNotifications to home and community care providers when their clients show up at an ED or are seen by an EMS. Additionally, we plan to use CHRIS/HPG's multi-authoring capabilities for creating, viewing and notifying providers of changes to a patient's Integrated Care Plan.

We will build on our experience and leverage current tools and data, and the Navigator to develop an OHT-level dashboard and benchmarks to measure performance in delivering integrated care. As we implement our models of care underpinned by our digital capabilities, we will establish best practices in coordinated care delivery. These best practices, benchmarks and the real-time information from the OHT-level dashboard will be used to identify quality improvement initiatives for each sector.

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
Through discussions amongst NOHT-ESON members we have identified the following legislative, regulatory, and policy barriers that may impede the ability to implement care redesign plans in the long-term. We offer the considerations listed below for review.

Legislative Barriers

With respect to care coordination, the Home and Community Care Act places restrictions on who can:
• Coordinate care (e.g., must be a LHIN employee);
• Complete referral processes (too restricted);
• Provide nursing care (must be designated); and
• Determine eligibility (too restrictive).

The Long Term Care Homes Act currently has a number of provisions and restrictions with respect to:
• LTC assessment, referrals, bed offers
• Patient choice and waiting in hospital
• Campuses of care (opportunities and restrictions)
• Who can determine LTC eligibility

Regulatory and Policy Barriers

The other regulatory and policy barriers identified to date include:
• Privacy and consent issues may limit the ability to involve all community support service organizations in home and community care
• Third party home care providers are not subject to the French Language Services Act
• Current contract terms related to evergreening of provider service contracts/not going to broad based procurement for home and community care on a regular basis. This can also limit the ability to open up third party contracts to allow for changes on service models, address service provider accountability, and ensure quality improvement.
• Policy and practice of holding agencies accountable to meet the French Language Services Act
• Sustainable funding models for community sector and Indigenous-specific service providers
• Labour/collective bargaining/labour supply:
  ☐Collective agreements and transitions thereof
  ☐24/7 work schedules (constraining ability to work/provide services on weekends)
  ☐Introduction of standards and legislation to address labour shortages

Ontario Health Teams
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APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

The Playbook defines virtual visits as traditional clinical care interactions and follow-ups between patients/clients and providers, conducted through digital channels like video visits, audio calls and electronic messaging. Given this definition we provided 11,132 clinical interactions virtually through OTN in 2018/19. These services include, but are not limited to: patient/client assessments, mental health services/assessments, post-discharge follow-ups, etc. We plan to build on these existing capabilities to further expand virtual care offerings for Niagara's Year-1 population by:

• Expanding OTN services at Niagara Health (NH) to offer clinical intake services, and coordinated transition plans. Last year NH offered 9,960 virtual interactions and our goals is to increase these by 2-5%. We will work with OTN to utilize their Virtual Care Advisory Service to scale our current OTN services through evidence-based best practices to integrate the virtual visits and digital self-care tools into our models of care to meet the needs of our patients/clients. Virtual visits will be an option for patients/clients and will be encouraged for adoption by the primary care physicians, caregivers, PSWs, AHPs, and nurses that deliver care for patients/clients. The services will be focused on not only providing an alternate care delivery channel but also improving a patient/client's ability to self-manage their care. The increased adoption will improve patient outcomes and experiences, while ensuring efficient use of healthcare resources, seamless transitions and improving provider experience. NH will take a lead in scaling its current services by including an OTN tile/icon on their Navigator Platform as part of the next release of their current NH Navigator Program (NHNP), increasing the adoption of proven virtual care services for the Mental Health population. We have identified an adoption target of 750-1000 clients

that will virtually access care. This is aligned with Niagara Health's response to the Ministry's Call for Applications for Patient Digital Identity Access and Authorization (IAA).
• Sharing OTN services and other resources in the St. Catharines and Welland community with other mental health and addictions community agencies for both adults and children to reduce wait-times in accessing virtual care services, allowing for a reduction in number of ED visits.
• Scaling the use of services like Bounce Back and Big White Wall across the region to enhance virtual care offerings for the delivery of mental health and addictions services.
• Expanding and coordinating the Crisis Intervention and Support services with other services/programs for the Year-1 population with mental health illness and are in crisis, and requiring increased care. This will not only increase the utilization of services but will also help deliver integrated care for the patients/clients in crisis, reducing the probability of ED visits or unnecessary hospital admissions, while delivering care in a less acute and more cost effective care setting.
Niagara OHT will build on the success of the above implementations by scaling them through 'proof-of-concept' projects by sector or by organizations. We will work with our partners to identify pilot sites for new roll-outs. One of the key principles in selecting the pilot sites will be to have representation across all sectors to enable delivery of virtual care services across the continuum of care for the selected Year-1 population.

We plan to use a "mentoring program" to enable our partners that don't have virtual care capacity/capabilities by pairing them with partners that currently have these capabilities, have reached a mature state or are ahead in implementing virtual care solutions. Where possible, we will pair the learning partners with a mentor organization from the same sector, enabling knowledge transfer around leading practices and enabling standardization of services and processes. To build sustainability, the mentor organizations will select a lead from each site to champion the solution implemented, provide change management support and quarterly knowledge transfer and be a SME for the solution to help guide the implementation at other sites. The mentor sites will encourage partners with no virtual care capabilities/assets to explore cost-effective ad value based procurement by leveraging an extension of their mentor site's licensing from existing contracts), leveraging contracts from other entities (even if outside our OHT), or utilizing systems from the Ministry's Digital Health Catalog (for example – OTNhub, OTNconnect, eVisits to Home pilot).

Given the volumes through OTN services, eVisit and other implementations, and the planned implementation of NHNP and expansion of OTN services, we are confident that Niagara OHT will meet its target of providing virtual care for 260 patients/clients in Year-1, and will extend its target by an additional 2-5%.

Niagara OHT partners will work together towards the goal of achieving the Ministry targets, and are committed to working collaboratively to increase digital health capabilities and capacity through:
• Joint training and educational sessions on current implementations and how they benefit patient experience and outcomes. The different partner organization sites will take turns teaching others and sharing lessons learned, and
• On-site demonstrations, conferences, webinars, etc. to promote leading practices identified by a Digital Governance body.

The low-cost initiatives outlined above will drive high-value and sustainability in our health system, building trust and goodwill amongst partner organizations across sectors and motivating them to deliver patient centered, digitally enable integrated care.

We will measure the success of our plan to expand the use of Virtual Care through the key measures outlined below:
• Number of active users: to measure adoption rate and compare progress towards our target
• Reduction in hospital admissions and/or 30-day inpatient readmission rate, effectively measuring the impact of expanded virtual care offerings
• Reduction in ED visits: witnessed reduction in incident volumes for transports to hospital through EMS's virtual care services
• Number of people utilizing our Walk In Wait times tool
• Patient/client satisfaction in receiving care virtually

We may also track the below metrics as resources allow:
• Patient Reported Experiences and Outcomes (PREMS and PROMs): will be measured through the NHNP and patient/client satisfaction surveys to identify quality and performance improvement initiatives to improve coordinated care delivery
• 7-day physician follow-up post-discharge
• Cost of care delivered: compare them to historical costs for the patient population now accessing virtual care to assess potential reduction in costs

2.2 Digital Access to Health Information

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

Max word count: 1000

In early 2019, Niagara Health Navigator program (NHNP) was announced, Ontario's first digital health ecosystem designed to protect patient privacy and security while connecting patients to their health data, care providers and innovators for secure, convenient, single-sign on access to digital health services in Niagara. NHNP is a patient-facing, fully white-label mobile Health Navigator™ application with an integrated Digital Wallet (part of IDENTOS FPX product) that allows citizens to establish their identity, access a range of healthcare (e.g. virtual care), and share and view their health information (e.g. EMR, HIS, provincial digital health assets).

We have developed comprehensive plan for implementing NHNP as a part of our IAA submission to the Ministry. Through our research, planning and previous partner experiences we recognize there could be a few challenges with the implementation of NHNP and we have pro-actively developed a plan to mitigate them:

- Privacy and Security: This is a key concern for patients with regards to accessing and sharing PHI. NHNP is designed to provide capabilities for user identity verification ranging from low-to-very high assurance levels by layering multiple forms of ID verification and authentication into a single digital wallet. We have developed this in partnership with local Ontario innovators who are leading the market for patient digital identity and access management. IDENTOS Inc. provides a citizen-centric authentication, authorization and consent solution that is backed by a peer reviewed public specification built on the User Managed Access (UMA 2.0) protocol. They have partnered globally with SecureKey Technologies, integrating their federated identity model that leverages trusted organizations for remote identity proofing, authentication and validation, conveniently from a mobile device.

- Digital Governance: We plan to establish a Digital Governance body that will develop our OHT's digital health strategy and roadmap, support joint investments, and identify/establish standards for implementation and adoption/change management. They will also develop a harmonized privacy and security model, which will have a standardized Privacy and Security Agreement and a cyber security blueprint. This will be developed in collaboration with OHT partners that will provide care for the selected 10-15% of Year-1 population accessing their PHI. The harmonized privacy and security policies, procedures and practices will be in compliance with eHealth Ontario's Electronic Health Record Privacy Policies and EHR All-in-One Security Policy, and privacy and security policies associated with current digital health assets. We also plan to leverage OntarioMD's Privacy and Security training and resources to develop these standards. We plan to understand the OCAP standards and in long-term integrated them into standards established by the Digital Governance body.

- Patient education: A leading cause of minimal patient adoption is the lack of knowledge/education. We are making this a priority in our implementation plan, leveraging multiple avenues to educate patients:
  - Town halls: At launch and every new release we will conduct a town hall/webinar for the Niagara region to educate the population on the NHNP, how to use it, and the safety and security it offers in accessing their PHI. Recognizing that we are focusing in Year-1 on complex patients, we will host every town hall through a webinar for online access;
  - Continuous promotion and communication: We will develop a continuous promotion and communication strategy to educate the patient population on the functionality available to access their health information, especially the Year-1 target population; and
  - Primary Care Physicians, PSWs, AHPs, Nurses, and Caregivers: As our focus for Year-1 is on complex patients and they rely on their caregiver, PCP, PSW, nurse or family member to provide them care and more than often access their PHI, we will ensure that they are educated on the functionality. Through this, we will gather their buy-in to further educate the patients, enabling patients to access their health information and self-manage their care.

- Interoperability: NH in partnership with IDENTOS and its technology partners will leverage an open system design, built on open standards, to enable interoperability.

- Scalability: NHNP is designed to support a variety of identity proofing, including making use of existing trusted credentials to reap the scalability and cost savings benefits of federated identity models. Our OHT is also in the early stages of deploying two other patient focused solutions: Sunnybrook's MyChart and the EMHware for digital access by patients. The MyChart Patient Portal is in its final stages of implementation at Niagara Health and Hotel Dieu Shaver, with a go-live in this fiscal year with an adoption projection of 2,115 patients/month. See Appendix L: Health Navigator Ecosystem.

We will integrate patient-facing digital health applications into NHNP, and the applications to be deployed for October 2019 are primarily focused on information sharing and communication: Emergency Room wait time data, Contact Department Information, "Rate Your NH Experience", "Thank a Staff Member", "Express a Concern", and Public Information Channels. This release is the foundation upon which additional Patient Facing Apps requiring a digital identity and requiring access to PHI will be built. The future releases will include services like Patient Check In, Registration, and integration with EMS services.

In addition to the above planned implementations, we are also currently investigating the feasibility of a partnership with eHealth Centre of Excellence to integrate with their System Coordinated Access program to provide patients access to their referral information.

Based on current utilization in addition to the above plan (including MyChart, and Health Myself Patient Portal), we are confident that we will meet the Ministry's target of 10-15% of our Year-1 patients/clients having the ability to digitally access their health information i.e. 780 patients will be able to digitally access their health information in Year 1.

2.3 Digitally Enabled Information Sharing

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

Max word count: 1000

We have identified some key critical success factors and a plan to implement them to digitally enable sharing of patient information across providers:

• Scaling existing provincial digital health solutions: Currently, 16 of Niagara's OHT partners have access to CHRIS. Niagara will expand the use of the CHRIS system to other eligible providers across the sectors, including integration with Clinical Connect viewer and myChart. We will make better use of CHRIS functionality to enable care coordination and care planning and to streamline transition of patients across care settings. Health Partner Gateway use will be expanded for planning the delivery of home and community care, managing referrals, and providing eNotifications to home and community care providers when their clients show up at an ED or are seen by an EMS. Additionally, we plan to use CHRIS/HPG's multi-authoring capabilities for creating, viewing and notifying providers of changes to a patient's coordinated care plan (CCP).

• Ensuring privacy and confidentiality of data: We have seasoned experts that can manage privacy and security programs required to support multi-provider service delivery as a Health Information Technology provider, governed by PHIPA. We will use their knowledge and experience with the underlying policy and standards within the province (including eHealth Ontario) to support partner organizations to deliver a robust IAA program by developing a minimum data set and data sharing agreements. We will leverage the guidance provided by the Ministry in the Digital Health Information Exchange

Policy to develop a minimum data set, enabling the HSPs to access trusted PHI in a frictionless, reliable, and consistent manner.

To enable the secure sharing of health information we will ensure that all partner organizations that access PHI held in provincial digital health assets will have appropriate data-sharing and legal agreements in place between digital health delivery partners, relevant Health Information Custodians (HICs), patients, and any other party involved in the access and disclosure of PHI.

We also plan to work with the Ministry to enable expanded access to the Clinical Connect viewer, a provincial viewer used to access historical patient record level data when patients are in an organizations' circle of care, for non-traditional healthcare providers in the community. There are some partner organizations in the N-OHT that are classified as non-HICs (according to PHIPA), yet are critical partners to ensure the health and wellness of our population. We will require support from the Ministry to assist in clarifying data access, exchange, data use and disclosure for non-HICs as well as between HICs and non-HICs. Ideally, we feel that an implied consent approach would be suitable to manage privacy. If expressed consent is required for every patient in the circle of care, this will put a significant burden on all providers to meet the operational process requirements.

Under PHIPA, two or more HICs can apply to the Minister for an order permitting all or some of the applicants to act as a single HIC. This could be an alternative solution, where we could try and explore a grouped consent for non-HICs by having a HIC be designated consent on the behalf of the group. This group could be viewed as a single HIC with respect to OHT operations and would provide a convenient way to respond collectively to access requests, etc. If we take the grouped HIC route, we will develop agreements between among those HIC and non-HIC participants to clarify operational roles and responsibilities.

• Enabling information sharing and interoperability: The N-OHT also plans to explore leveraging the Niagara Health Navigator as a secure platform for information sharing and enabling interoperability amongst our partners. The solution is centered on an Authorization Server implementing the Federated Privacy Exchange (FPX) specification, an extension of the User Managed Access (UMA 2.0) open standard protocol. This particular authorization server enables granular data control by users, introduces an interoperable hub, and spoke architecture that supports a cooperative governance model for connected parties serving users on the network.

We are actively engaged with eHealth Ontario to enable access to existing provincial data assets such as the Provincial Client Registry and others over time as use cases and population needs arise. Our existing Navigator program underpinned by our IAA service will enable a number of important digital services, including Patient Registration, Digital Immunization Record Management, Mental Health Virtual Support and Integrated Comprehensive Care.

We plan to scale the EMS App by hosting it on NHNP and will be available for providers through the single sign-on digital wallet.

• Enabling population health analysis and management: We plan to have the ability to query pooled data and anticipate implementing a robust business intelligence (BI) platform to capture, document, and report on patient data to further inform our understanding of our OHT's population and their needs. The data will be use to understand the population at an integrated care delivery or OHT level across partner organizations, and will help inform care planning, identify the cost drivers and tracking costs for a patient across their episode of care, and gather insights to improve the integrated care pathway design to enhance patient experience and outcomes. We also recognize that as our community grows, a dedicated team will be structured to analyze the resulting data and provide trends, design proposals and solutions, and more detailed population health needs.

• Providing a platform for cross-provider communication and collaboration: In addition to the above plan for ensuring that patient information is shared securely and digitally across the providers for the purposes of integrated care delivery and planning, we are also exploring other options e.g. Microsoft Teams and eConsult platforms. These two-way communication platforms could enable increased cross-provider communication and collaboration, especially amongst physicians and specialists, allowing a faster communication, expedited advice and care delivery for patients, and a secure platform to share health information. In the long-term, we plan to integrate these platforms on the Navigator to enable providers and patients to use the same platform for sharing health information. This will be enabled by developing and assigning appropriate user roles and access to providers and patients.

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

We currently use three methods to drive quality and performance improvement initiatives:

• Using performance data collected over time: Our partner organizations have implemented various digital tools to collect performance data. We will leverage this data to identify trends and opportunities for improving quality and performance in delivering care. A few key examples are:
  • Balanced scorecards and CRMS
  • eCTAS: provincial tool for triaging ED patients
  • Oculys: used to manage bed assignment, availability and overflow
  • BIRT Analytics: open source technology platform used to create data visualizations and reports
  • Connexall: provides improved communication between porters and EVS, decreasing number of phone calls for coordination

• Benchmarking data collected internally with performance reports from provincial organizations: Most partner organizations use their performance data and compare it with provincial performance reports from agencies like CIHI, HQO, CCO, and InterRAI to identify quality and performance improvement initiatives, especially in program development

• Collecting experience and outcome data from patients/clients: A few partner organizations are using digital tools to measure patient experiences and outcomes to identify areas for improving quality and performance:
  • Ontario Perception of Care – an evidence based client experience survey for mental health patients
  • Greenspace – allows clients to electronically self-report on their outcomes
  • Patient/client surveys – allow patients to capture their experience and outcomes after a care interaction with providers
  • HPCO-SharePoint – allows for clients to measure the impact of service on their care
  • EMHware

We will build on our experience and leverage current tools and data, and the Navigator to develop an OHT-level dashboard and benchmarks to measure performance in delivering integrated care. As we implement our models of care underpinned by our digital capabilities, we will establish best practices in coordinated care delivery. These best practices, benchmarks and the real-time information from the OHT-level dashboard will be used to identify quality improvement initiatives for each sector.

The best practices will be developed by standardizing assessments to measure consistency and quality in care delivery for each sector. We will also explore opportunities to standardize common digital systems/tools across providers/sectors to drive consistency in integrated care delivery at the OHT-level, benchmark performance, and utilize data collected to drive performance and quality improvement initiatives.

Further, we will collect patient/client experience and outcomes through digital tools like Niagara Health Navigator App to identify areas of improvement in our models of care. This coupled with the performance data collected from each partner organizations, and benchmarking data from provincial agencies like CIHI, Ontario Health (HQO, CCO), and others will be used to:
• Assess the appropriate level of care to better meet the needs of patients (for example – providing care and rehabilitation in the community/home for post-surgery hip and knee patients rather than minimizing their activity by keeping them in the hospital), and
• Create feedback loop for information sharing amongst providers to improve care coordination and delivery.

The above process will enable us to identify targeted areas for improving transitions in care, quality of care delivered, efficiency in delivering care, and establish a continuous learning process across the OHT.

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
Not applicable.

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

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

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