Niagara Ontario Health Team - Équipe santé Ontario Niagara (NOHT-ESON)

Year 1 Plan Executive Summary

Our Attributed Population (at Maturity)

Our attributed patient population includes 364,720 residents of Niagara Region, as well as an additional 23,046 residents from other communities, for a total of 387,766 Ontarians.

Our Year 1 Target Population

In Year 1, we will target the top 5% of people who use the services provided by members of the Planning Table and Collaborators, which includes high-users across both health and social services, recognizing the unique barriers to health for Indigenous, Francophone or otherwise marginalized people. People will benefit from an integrated care approach as they are often served by multiple organizations across the health and social service system and are at risk to experience fragmented, uncoordinated care.

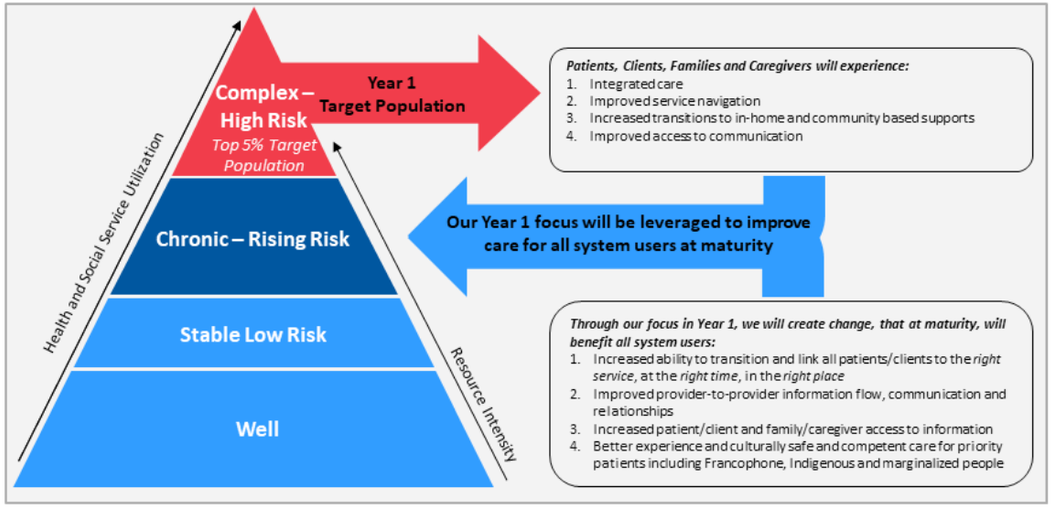
People within this 5% typically are experiencing one or more of the following:

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).

Our Year 1 Priorities

1. Improving care coordination and system navigation
2. Improving relationships, integration and communication with primary care providers
3. Identifying barriers and strategies to improving care for people with complex needs
4. Improving the patient/client experience



Our Key Initiatives

Integrated Care Planning
Our approach is a "wrap around" model of patient/client care that provides a coordinated, interdisciplinary team of health and social service providers, based on patient/client needs, and assigns a lead coordinator to ensure seamless care coordination and system navigation.

Transitional Care Navigation
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.

Care Coordination in Primary Care and Other Settings
We will embed LHIN Care Coordinators into settings where patients/clients would benefit from Integrated Care Plans and other coordinated services due to their complex health and social care needs.

Digital Health
We 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.

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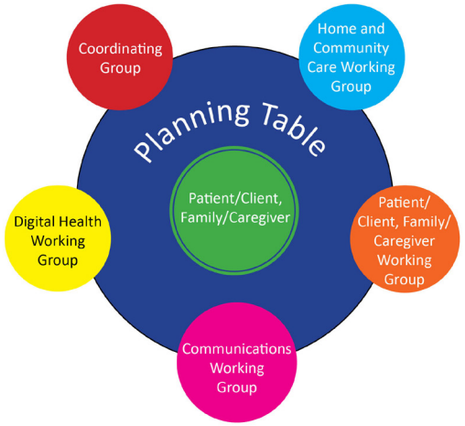
Our Year 1 Governance and Leadership Structure

The governance and leadership structure for Niagara-Ontario Health Team - Équipe santé Ontario Niagara is our Planning Table which is comprised of our:
Partners;
Collaborators;
Patient, Family and Caregiver Representatives.

Our governance model will function using a Collaborative Governance approach characterized by shared, consensus-based decision-making. Our governance model will continue to evolve through our planning.



Currently the NOHT-ESON has created five working groups to further our work in targeted areas:

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

We have 35+ participants at the NOHT-ESON Planning Table that include a broad range of health and social service organizations as well as patients/clients, families and caregivers.

In Year 1 How We Will Measure Improvement

1. Reduction in 30-day inpatient readmission rate;
2. Reduction in rate of hospitalization for ambulatory care sensitive conditions;
3. Reduction in avoidable emergency department visits and hospital admissions (ED visit rate for conditions best managed elsewhere);
4. Reduction in frequent ED visits (4+ per year) for mental health and addictions;
5. Increase in 7-day physician follow up post-discharge; and
6. Improved patient reported experience measures, provider reported experience measures, and patient reported outcome measures.

Vision of the NOHT-ESON

To deliver a full and coordinated continuum of care for patients/clients. As a Team, we will work to achieve common goals related to the quadruple aim:

1. Improved patient/client, family and caregiver experience;
2. Improved population health;
3. Reduced health system costs; and
4. Improved provider or care team wellbeing.

NOHT-ESON Guiding Principles

1. **Commitment to our Patients/Clients/Caregivers/ Families and to the Quadruple Aim**
2. **Authentic Partnership and Co-design**
3. **Collaborative Culture**
4. **Population Health, Equity and Access**
5. **Coordination and Integration**
6. **Spread and Sustainability**
7. **Innovation and Excellence**
8. **Commitment to Quality Improvement**
9. **Creativity/Continuous Learning**
10. **Commitment to a Journey**
11. **Digital Transformation**