Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

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

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

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

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

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

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

Participation in Central Program Evaluation

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

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

Additional Notes

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

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

Ontario Health Teams
Full Application Form

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Lori Marshall
	Title: President & CEO
	Organization: Chatham-Kent Health Alliance
	Email: LMarshall@ckha.on.ca
	Phone: 519-437-6006
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Lori Marshall
	Title: President & CEO
	Organization: Chatham-Kent Health Alliance
	Email: LMarshall@ckha.on.ca
	Phone: 519-437-6006

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 its self-assessment the Chatham-Kent Ontario Health Team (CKOHT) proposed population was 110,000 people based on the combined population of Chatham-Kent (CK), Walpole Island and surrounding communities known to access care with local providers. The Ministry data package confirms the CKOHT attributed population as 105,241 people, with 81% living in the community of Chatham-Kent. Therefore, there is a high degree of alignment with the attributed population.

Year 1 and Longer Term Opportunities:

• CK has significantly higher primary care attachment rates compared to other areas of the province. With all three (3) Family Health Teams (FHTs) and the Community Health Centre (CHC) joining in the CKOHT there is an opportunity to make an impact on the attributed population.
• There are approximately 89,000 patients rostered to the CKOHT primary care signatories based on self-reported data from the 3 FHTs and CHC.
• CKOHT partner organizations have existing infrastructure and processes that will create synergies to enhance capacity for quality and performance improvement across the continuum of care. A community of practice will be formed including project management, decision support, business intelligence, epidemiology among others.
• As part of a population health approach, existing partnerships and integrated care models (e.g. Health Links, Drug Awareness see section 2.4 for details) will be leveraged to support the Year 1 Population (Y1P) and will be evaluated and informed by other evidence-based strategies to support the entire population at maturity across the continuum of care.
• Alternate Level of Care (ALC) rates are among the lowest in the province (11.7% compared with 17.1% provincial average in August 2019 report). CKHOT partners are committed to continuing innovative ways to avoid Hallway Medicine.

Year 1 and Longer Term Challenges:

Where people live, learn, work and play and outside the health care system are a primary focus towards holistic wellbeing.

Residents of Chatham-Kent have challenges with the social determinants of health:
• High rates of social and material deprivation, high rates of modifiable risk factors (e.g. obesity, low intake of fruits/vegetables, inactivity), and high incidence/prevalence of chronic disease.
• Higher rates of unemployment and lower than average income levels at under $40,000/year and more people accessing social assistance at 10%
• Over 20% of adults with less than a high school education
• Increased burden of responsibility for working-age population who care for seniors and youth
• Erie St. Clair (ESC) LHIN region (which includes CK) has the highest use of prescription opioids in Ontario

The residents of Chatham-Kent also experience challenges with respect to accessing care compared with the rest of the Province:
• High total hospital days (or higher than expected hospitalizations) and discharges per capita
• Higher rates of Hospitalizations for Ambulatory Care Sensitive Conditions
• Higher rates of Emergency Department (ED) visits per capita
• Higher rates of ED visits Best Managed Elsewhere (in alternative primary care settings) reinforcing the opportunity for avoidance of hospitalization.
• Very high rates of post-acute mental health and rehab total days per capita
• Approximately 67% report lower access to after-hours primary care and fewer physicians per capita in rural areas.

These challenges reinforce the opportunity for improved chronic disease management across the continuum and the development of strategies to avoid hospitalization.

In Year 1, the CKOHT will employ an approach for its target population supported by local knowledge and aligned with information from RISE. The CKOHT will be proactive in meeting and managing the needs of the attributed population by integrating both “in-reach” and “out-reach” services. As the CKOHT matures, it will move towards a population health approach with a focus on upstream efforts to promote health and prevent diseases to improve the health of populations and the differences in health among and between groups (Ontario Public Health Standards).This will require the CKOHT to address the broad social determinants of health impacting patients’ abilities to live well and to broaden formal partnerships. This will optimize integration and coordination of key strategies across the continuum of care, with upstream prevention and promotion efforts that support persons across the lifespan.

A few examples of the CKOHT’s experience and capacity in population health

include:

Chatham-Kent Public Health has championed many initiatives to improve health and reduce health disparities and will be a key partner that will guide the CKOHT in moving toward a population health approach. Examples of successful initiatives include creating a cross-sector leadership network to advance areas that impact people's quality of life and partnering with the CHC and Aboriginal Health Access Centre (AHAC) to implement a low-income senior's dental program. This program provides access to both preventative and restorative dental services and will result in a reduction of unnecessary hospital visits and prevention of certain chronic diseases.

The CKCHC also brings understanding and competencies in working from an equity lens in health care with priority populations. For example, their collaboration with the local Adult Language & Learning organization to support access to primary care for all new high risk immigrant or non-English speaking newcomers in CK and their partnership with Truly Green (local agricultural business) to support on-site primary care clinics for their temporary foreign workers who would otherwise not access health care services.

A further example is the collaboration between local EMS and the Municipality's Housing Services, providing on-site urgent and preventative clinics for isolated seniors living in subsidized housing (see section 2.4 for more information).

By working with both health and non-health sector partners, the CKOHT will support the attributed population by collaborating to advocate that healthy choices are possible, creating supportive environments that prevent disease and protect people from threats to health, and ultimately address the social determinants of health that inhibit the attributed population in staying healthy.

Building on the existing knowledge and competencies, the CKOHT will work to create awareness and understanding of how to apply/embed a population health approach in serving the attributed population and Y1P as well as the tools available to enable its practice across the continuum.

See Appendix 1 for a complete list of acronyms used throughout this submission.

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

CKOHT Year 1 Population

The CKOHT year one target population will be adults aged 55 plus that have one or more of the following criteria met: Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Angina, Diabetes, Dementia, and/or are complex, as per current Health Link definition (Provincially this is 4 or more chronic diseases). CK Health Link partners also have the ability locally to extend the program to complex individuals who are difficult to serve and access a number of resources regardless of the number of chronic conditions.

Palliative patients remain an important subset of the population for partners of the CKOHT as demonstrated by current common quality improvement plan initiatives. (See Appendix A, A.1. - OPCN, NPs integration with CK Hospice etc.)

It is estimated that the Year 1 population will be approximately 11,000 people.

This Year 1 population (Y1P) is aligned to the population proposed in the Self-Assessment.

Rationale for Year 1 Population:

The CKOHT partners directly serve the majority of the attributed population. This experience creates a collective understanding of this population – the health status as well as systemic and social barriers provided the initial scope for older adults as a target population. The initial self-assessment population was validated by a review of the data set provided by the Ministry of Health.

Demographics and Health Status:

The CKOHT serves a population that is aging more rapidly than other regions in Ontario and with the number of people ≥75 years old doubling in 20 years and a life expectancy of 79.6. As well, of individuals 65 plus living in CK:

• 61.6% are overweight and obese
• 77.1% did not meet the recommended daily intake of fruits and vegetables
• 10.4% reported smoking daily
• 19.5% exceed the low-risk drinking guidelines for chronic disease
• 13.3% were living in low income
• 5,470 live alone
• 1,690 live alone and in low-income
• Individuals aged 65 to 75 in CK, have higher rates of hospitalizations due to cardiovascular disease, ischemic heart disease, cerebrovascular disease, stroke, respiratory disease, lower respiratory disease, and chronic obstructive pulmonary disease when compared to Ontario
• Individuals aged 75+ in CK have higher rates of mortality due to cardiovascular disease, respiratory disease, lower respiratory disease, and COPD when compared to Ontario
• Higher use of ED services

Utilization and Cost Drivers
A review of the Ministry data package was undertaken by a cross-sector/organizational team of data, quality and performance improvement specialists to further understand health care costs and utilization of the CKOHT attributed population and identify key opportunities. Highlights of this review include:
• CK has a higher proportion of the attributed population aged 55+. This minimum age was identified for the Y1P focus based on lessons learned through the Health Links work (which focused initially on high users of the health system), and the opportunity to have a greater and more proactive impact on the 'emerging at risk population' – a key strategy to impact hospital avoidance by supporting people earlier on in the disease trajectory.
• Beyond age, the CKOHT identified three factors to help refine the proposed Y1P: risk (e.g., complexity of care), health care expenditures and avoidable hospitalizations
1. Risk: Complex patients/complexity of care - the 55+ population that is difficult to manage and define; typically eligible for the health links approach based on existing criteria
2. Avoidable hospitalizations: Data revealed the CKOHT was performing poorly on the hospitalization rate for ambulatory care sensitive conditions (ACSC). The CKOHT extracted data from hospital systems to identify top the top diagnoses; confirming that patients 55+ with COPD, Heart Failure, Angina, and Diabetes were contributing significantly to this indicator.
3. Health care Expenditure: Based on the Ministry of Health's (MOH) cost information, the top Health Profile Groups (HPG) that constitute the largest health care expenditures was Dementia. Other top costs were considered for Year 1, however due to an inability to match definition used by MOH with data collected within existing Electronic Medical Records (EMRs) more analysis would be required to expand to these groups.

Size:
At maturity, the CKOHT will provide services to the 105,241 attributed population,

which is inclusive of residents of CK, Walpole Island First Nation and surrounding areas as well as a few out of jurisdiction communities.

Of the attributed population there are 39,663 enrolled individuals aged 55 plus, which was deemed too large to feasibly support in year one. Based on a review of population health, health care utilization, and costing data, as well as opportunities to leverage key strategies and partnerships already in place in CK, a common opportunity around hospital avoidance was identified. Therefore, this rationale was used to initiate a further refinement of the proposed year 1 target population.

To estimate the size of the Y1P, the CKOHT elected to leverage its high rate of patients attached to primary care. The family health teams and community health centre initiated a query within their EMRs for enrolled patients aged 55 and over with one or more of these conditions. The LHIN's Home and Community Care program also cross referenced their data set to identify any anomalies in the Y1P proxy identified. As such, the number of enrolled patients who match the above criteria results in a Y1P of approximately 11,000 people. The CKOHT recognizes that this is a proxy and that due to increasingly unattached patients, there is a plus/minus factor that could easily apply to this number.

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
  In general, the Chatham-Kent (CK) community has poorer health status when compared to the rest of Ontario with:
  •More smokers (>22% of the population)
  •Consumes fewer fruits & vegetables at 26%

[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.

•Low activity levels with more obese/overweight people at 63% of population
•High rates of chronic disease with a higher percentage of people with arthritis, diabetes, asthma, hypertension, mood disorders and COPD
•Higher use of ED services and rates of hospital admission
•A region (Erie St. Clair LHIN) with highest use of prescription opioids
•High rates of unemployment and lower than average income levels at ≤$40K/year
•More people accessing social assistance at 10%
•Over 20% of adults with less than a high school education
•Increased burden of responsibility for working-age population who care for seniors and youth

More specifically, the CKOHT recognizes the need to address inequities impacting on priority populations: individuals who are vulnerable, marginalized, economically and/or socially disadvantaged in addition to those living with complexities, comorbidities, chronic disease and poor health outcomes. From an equity perspective, the following priority populations within the Year 1 Population (Y1P) need personalized, culturally appropriate approaches and sustained care relationships inclusive of Indigenous people; Francophone populations; caregivers with complexities; the rainbow community (including HIV positive); Low German population; those living with mental health complexities and addictions; non-English speaking newcomers, immigrants (especially Syrian refugees) and temporary foreign workers; persons challenged with literacy, intellectual and/or cognitive barriers; and individuals that face barriers to care due to racialization, discrimination, homelessness or isolation.

Indigenous populations
The CKOHT catchment includes Walpole Island and Delaware First Nations. Indigenous persons may live on-reserve or off-reserve in rural or urban settings. As per the 2011 National Household census, only 6% of the total Indigenous population were 65 and over, due to significant lower life expectancy related to increasing prevalence of complex chronic conditions as compared to non-Indigenous populations. Based on self-reported 2016 census data for Indigenous persons aged 55-64 years, 26.2% live in low income. This is true for the 65+ Indigenous age cohort. Strikingly, the prevalence of low-income is higher in males (39.5%) than females (15.2%) for those who identify as Indigenous aged 55-64 years. For Indigenous persons aged 65+, the prevalence of low-income is higher in females (33.3%) than males (15.2%). The 2011 Indigenous-led Our Health Counts study revealed the following access to care barriers: long waiting lists for health services, lack of transportation, unaffordable direct costs, unavailable doctor, and lack of trust in health care providers.

Francophone populations
The Francophone population is dispersed with pockets in three designated

areas (city of Tilbury, township of Tilbury East and Dover Township) as well as within the city of Chatham. It accounts for 3% of CK's population (2016 Census), with 2,970 individuals (based on the IDF). It has a higher proportion of seniors (65+ years old) than the general population (34% vs. 18%).
In 2012, the ESC/SW French Language Health Planning Entity showed that 40% of Francophones live with at least one illness or chronic condition. Arthritis, cardiovascular conditions and hypertension were the most common health conditions reported. The 2013-2014 Canadian Community Health Survey confirms this and notes that the rates of arthritis and of people with two or more chronic conditions are significantly higher among Francophones than the general population.

In the Entity's 2014 study, participants from CK reported having a comparable average income and a slightly higher median income than Anglophones. However, the average income was 6% lower for persons aged 45-65 years. For persons aged 65 and over, the average income was 13% lower as compared to 2006's results.

Other populations
Many temporary foreign workers are employed within the agricultural communities across CK, with the Municipality of CK actively recruiting and welcoming newcomers and immigrants to the community. The Low German population interacts with several program areas and often requires a tailored approach due to linguistic and access barriers as well as unique cultural and religious beliefs/practices.

Other factors
CK's geography has an urban centre and rural pockets throughout, which creates social and geographic isolation along with transportation barriers and other access issues for a significant proportion of the population. Disadvantaged individuals impacted by social risk factors such as low income, low levels of education, low literacy and unemployment are critical considerations.

Poverty is a significant challenge. For persons aged 55 to 64 years in CK: 16.3% live in low-income; 17.6% live alone and 43.4% live alone and in low-income. For persons aged 65+: 13.3% live in low-income; 27.7% live alone; and 30.9% live alone and in low-income. 34% of persons aged 65+ who live alone spend 30% or more of household income on shelter.

Based on local equity analyses it was also noted that CK residents living in highly materially deprived areas (when compared to those living in lower materially deprived area) have a significant higher rate of hospitalizations for COPD, ischemic heart disease (IHD) and diabetes and rate of deaths due to COPD and IHD.

Within the CKOHT geography, the urban city of Chatham (especially east Chatham), north CK (e.g. Wallaceburg) and Walpole Island are identified as areas with high levels of material deprivation and higher rates of chronic diseases.

Health inequities are real. Having good socio-demographic and race-based data will assist in planning to equitably meet the needs of vulnerable populations. As an example, CKCHC is mandated to collect the following socio-demographic data including: sex, gender identity, sexual orientation, religion, racial or ethnic group, country of origin & year of arrival, homelessness, disabilities, mother tongue, preferred language of service, household income & persons supported and highest level of education obtained. CK's primary care teams are committed to collect this necessary equity and population based-data to inform population health planning and for stratification to further address health disparities as care teams intersect within the OHT.

All CKOHT partners are committed to consider these unique needs in delivering service.

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

With a history of extensive collaboration, and leveraging existing partnerships such as the CK Health Links, the proponents of the CKOHT identified and committed to an inclusive team development process while maintaining a manageable and achievable

[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

scope.

Exploring Partnerships: Self-Assessment

An education event in April 2019 brought 80+ individuals from patient advisors and board members, to administrators and physicians together to learn about health system transformation in other jurisdictions. This session confirmed interest in pursuing a CKOHT, solidified the vision, defined the Year 1 Population (Y1P), informed metrics and committed to leverage Health Quality Ontario's (HQO) patient engagement framework. At that time, an invitation to participate was presented to organizations with 4 different options:
1. Keep us informed; our organization will continue to be involved and supports the CKOHT.
2. We are committed to ongoing work toward the CKOHT in the short-term and anticipate becoming a full participant in the future.
3. We are ready, can attest to sound financial position and will contribute information to strengthen submissions as a full partner to the CKOHT submission.
4. Thanks for keeping us informed; we look forward to receiving updates but will not be actively participating in the process.

Organizations that were "ready" to proceed completed the Self-Assessment.

Phase 1 Partners –Year 1 Population
Following submission of the self-assessment, the team continued to build on its momentum. Another engagement session in late June with 80+ individuals offered a further opportunity to organizations to participate in the CKOHT. Upon receipt of the invitation to proceed to full proposal submission, 3 more organizations formally signed-on to become a part of the team.

The CKOHT is now comprised of 14 partners from different sectors across the health care system (see table 2.1.2).

The CKOHT is well positioned to serve the identified Y1P and attributed population at maturity. A wide range of providers are involved with an indication from many LHIN-funded health service providers to join in the CKOHT by maturity. All 3 FHTs and the CHC in CK have been formal partners in the formation and development of the CKOHT from infancy, creating a unique circumstance for this OHT as the majority of enrolled patients seek care from one of these organizations.

Growing the CKOHT to Maturity
As the OHTs evolve, the CKOHT will continue to welcome new partners in order to encompass all possible avenues of a patient's care journey.

The CKOHT process of ongoing onboarding coupled with open invitations to self-identify readiness will continue. The CKOHT is positioned to respond to need, interest and onboarding of new partners today and over time. For instance, collaborators have

been involved in the work streams' efforts for this submission. The key challenge in membership is anticipated to be around physician/provider sign-on and engagement. The CKOHT is pleased with its initial group of participating physicians and recognizes the need to continue to build on preliminary relationships with Community Support Services, Solo Practitioners and Long-Term Care partners for the Y1P through to maturity.

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

The CKOHT has long-standing working relationships within its membership. Formal and informal partnerships have resulted in a readiness for a CKOHT approach. While not all partners have collaborated on one specific initiative, cross-pollination has occurred between partners in one or more of the following key examples in the areas of integrated care, bundled care, population health, shared services and joint procurement:

Integrated Care

Health Links

Health Links, established voluntarily in 2014, is the most significant and longstanding example of this team's previous work in a formal capacity to advance integrated care, shared responsibility and population health. Partners in Health Links include all members in this application along with various collaborating community agencies.

Health Links focuses on the top 1-5% of patients with complex medical conditions and high users of Emergency Department (ED) and hospital services. Health Links prioritizes client-centred improvements to the health system, resulting in better care coordination, higher quality care, and cost effectiveness.

Effective strategies were implemented and maintained, including;

- eNotification: enabling Home and Community Care (H&CC) and primary care to receive an electronic notification when a client presents in the ED, on admission and at discharge from hospital to community.
- Health Link Coordinated Care Plan (CCP): A tool that lists patients' medical issues, health service providers, medications, etc. that can be easily shared with providers in hardcopy format.
- Home Visits: embedding home visits for health links patients to ensure timely resolution of barriers.
- Community of Practice: intensive case managers/front-line staff in primary care meet to learn from each other, understand community supports available and scale innovations derived from discussions regarding challenging cases.
- Community Paramedicine Program (CPP): Further described below

In addition, a Medication Reconciliation Program was trialed, but not sustained, between Chatham-Kent Health Alliance (CKHA) and Thamesview Family Health Team (TFHT) as patients transitioned from hospital to home. This demonstrates that partners are nimble enough to pivot from strategies that do not achieve the quadruple aim.

At its outset, Health Links partners used largely existing resources to create the embedded care coordination model now in place in CK. See sections 3.3.1 and Appendix A.1 for more information.

Successful outcomes of this program include:
• 839 new CCPs developed in the CKOHT geography since inception representing 16% of the target population of 5,340 individuals
• 20% decrease in ED visits of target population
• 82% patients report timely access to primary care
• 100% primary care attachment rate
• Sustained approach using intensive care managers and imbedded H&CC Clinical Care Coordinators (See Appendix A, A1 and A2)
• Improving & Driving Excellence Across Sectors (IDEAs), an improvement-focused partnership that led to the creation of evidence-based cross-sector care pathways to support people living with Diabetes, COPD, and/or Congestive Heart Failure (CHF).

Community Paramedicine Program
In 2015, the CPP was piloted to augment patient care in the community for seniors living at home, reduce 911 calls and reduce ED visits by engaging patients with limited access to the health care system. Through collaboration with primary care, CPP focuses on wellness assessment, medication administration, point of care testing (POCT), vaccinations, and vital sign monitoring both in-person and remotely using technological approaches. The service includes non-emergency calls and regularly scheduled visits for clients with chronic health conditions (e.g., Diabetes, COPD and CHF). Supported by medical directives for POCT in the home, the CPP communicates to determine a viable course of medical intervention for each client. Partners include: the Municipality of CK, Chatham-Kent Community Health Centre (CKCHC), Canadian Mental Health Association Lambton-Kent (CMHA LK), all 3 FHTs, CKHA, ESC LHIN H&CC, Fanshawe College, Interdev Canada, and the SW Ontario Regional Base Hospital Program. Success led to annualized funding as there was a 51% reduction in ED visits, 64% reduction in hospital admissions and 74% reduction in hospital bed days in the pilot. There is an 81% reduction of calls to 911 since base funding for this model of care was implemented.

Access Open Minds
In 2015, ACCESS Open Minds (ACCESS) opened its doors in CK and is the only site of its kind in Ontario. While not part of the Year 1 Population, ACCESS is still an example of existing partnerships in the CK community and cross-sector collaboration offers an innovative “one-stop shop” for young people aged 11-25 and their families looking for mental health support. Since the centre opened, access to mental health services for youth reach has increased by 68%. Service and community partners include but are not limited to CMHA, Chatham-Kent Children’s Services, CKHA, CKCHC, Police Service, Public Health, and School Boards. This program is provincially recognized and is referred to as a proof of concept in the MH&A sector.

Intensive Hospital to Home:
The implementation of this program, in compliment to other key interventions, has resulted in significant reductions in Alternative Level of Care (ALC) numbers and rates within hospital; whereby patients (who would otherwise have remained in hospital) with high intensity needs are supported in community on robust service plans. As

well, the implementation of Integrated Discharge Planning at CKHA, with CKOHT partners LHIN H&CC, March of Dimes and Alzheimer Society of Chatham-Kent, minimize ALC and optimize bed capacity. As a result of these collaborations, the total ALC rate for ESC LHIN has decreased from 16.7% to 12.6% in three years. This program has enabled ESC LHIN to have the lowest ALC acute rate in the province for three consecutive months in F2019-2020.

Bundled Care

Hips and Knees
CKHA is a bundled care holder for Hips & Knees and has recent experience in managing the complexity associated with single-funder and gain sharing practices that supports an integrated health care delivery of services. In CK, bundled care is driven by patient choice with increased access to where outpatient rehabilitation can be provided. With over 40 clinics available to service patient needs, bundled care partnerships have increased complexity in tracking where patients access services and the subsequent invoicing required for financial oversight. As well, predicated on the use of eShift for home care, the model aims to reduce costs across the continuum. The CK bundle partners negotiated transparent cost arrangements to drive efficiencies for the system and maintain positive patient outcomes, including the Chatham RAC's 30% diversion rate from surgical procedures. Overall, the process identified future gain sharing opportunities as the CK model matures post implementation. Also see section 5.5.

Population Health

Drug Awareness & Harm Reduction:
A focus on drug awareness and harm reduction has been an ongoing community effort for many years. In 2014, a group of pharmacists and physicians met to discuss a fentanyl patch return protocol which grew to include the Police Services, Medavie EMS, representatives from the CK Drug Awareness Council and CK Public Health (CKPH). By 2015 CK had a fentanyl patch return protocol in place, including information for patients and families, communication forms between prescribers and pharmacists, documentation forms to support the returned patches and education across the board to support this important initiative. Patients and families using fentanyl patches acknowledge this significant public safety issue. This has resulted in an overall reduction in fentanyl patch prescriptions across the community.

In 2017/18, CKPH completed an opioid use and harm situational assessment, involving over 30 community partners and 25 people with lived experience who identified a need for a more coordinated approach to substance use focusing on upstream (prevention), midstream (build community capacity to address) and downstream interventions (support people who use opioids). A standardized medical cannabis program currently at TFHT is also being expanded across primary care (see section 3.2).

This same grass roots approach to problem-solving has led to widespread education and support of EMS, police and fire services in the use of naloxone kits. Additionally, CKPH provided naloxone kits in the ED. Collaboration between CMMA and CKHA departments of psychiatry and emergency medicine led to the opening of a Rapid Access to Addiction Medicine (RAAM) Clinic in 2019 to better help patients and families dealing with addictions.

Shared Services

CKHA has a long standing relationship with Transform Shared Services Organization (TSSO). TSSO was formed in 2013 by the five hospital corporations in the Erie St. Clair LHIN region to provide back-office support in the areas of Information Technology/Management, Supply Chain and Project Management. This is relevant CKOHT experience in the governance of shared services.

Sharing digital health services and assets has resulted in individual hospital data centres being moved to a hosted regional data centre. This has driven savings by reducing the physical footprint, number of servers and resources required to support the digital health needs of the hospitals. This model can be easily expanded to include other HSP's and the Ontario Health Teams that get established in the ESC LHIN.

For approximately 2.5 years, CMHA LK and CKCHC have enjoyed a shared finance team. With an Integrated Director of Finance/Chief Financial Officer that reports to both the CEO of CMHA LK and the Executive Director of the CKCHC, an integrated finance team has developed critical mass necessary to ensure necessary staff coverage, improved retention to highly skilled professionals, improved reporting and analytics, improved performance and accountability and as well as ensure business continuity through staff transitions at a lower cost.

Since 2014, CMHA LK and CKHA Mental and Addictions services have advanced collaboration, worked to reduce barriers to services and eliminate duplications through a variety of innovative service offerings and planning initiatives. Innovations include: integration of mental health crisis teams to create a single cross organizational team; shared single point of access for all community mental and addictions services; integrated management/supervisory positions; shared training and access to psychiatry; joint deployment of staffing resources in response to surge/pressures on acute care capacity through enhanced "hospital to home care in support of early discharge/intensive community treatment"; and, co-location of materially all CKHA outpatient and community mental health and addictions services with CMHA community mental health services in the City of Chatham in a community setting in close proximity to the hospital. This innovative partnership is governed by a Memorandum of Understand/Collaboration Agreements between CMHA LK and CKHA.

Procurement

Through the shared services approach, TSSO has achieved year over year savings in supply chain of $6 million for the hospitals of the Erie St. Clair LHIN. For example, in 2019/20, CKHA was able to hold the line on supplies costs well below the level of inflation due to its relationship with TSSO.

A further example of Value-Based Health Care projects is the Medical Supply End to End Management process conducted by TSSO that supports CKHA, ESC LHIN Home and Community Care, CKCHC and CK Health Links. The three phased initiative (Phase 1 – Contract Optimization; Phase 2 – Fulfillment Centre and Data Automation; and Phase 3 – End to End Automation Partners) was created and implemented becoming the first successful integration of supply chain processes between hospitals and home and community care in Ontario (See Appendix A, A1). The project outcomes include:

• Annualized savings of 30% off medical supplies costs – translating to $1.3 Million CAD, redirecting funds back into patient care
• End to End supply chain automation from Provider Order to Invoice payment, eliminating redundant manual data entry and improving data accuracy
• Data visibility enabling analytics and data driven decision making
• Product Standardization to Hospital and Primary Care, improving the continuity of care as patients move from hospital to home/community care
• Inventory management, reducing diversion and waste, improving recall management and accountability
• Accurate patient case costing
• Improved patient outcomes stemming from supply chain visibility across the continuum, and the ability to leverage products within the hospitals to avoid expensive patient re-admissions due to a lack of specialty or non-formulary product visibility

Informal to Formal Relationships

The CKOHT Partners are fortunate to serve the same community and share many patients/clients. A small community with extensive collaborative efforts means that most partners have worked together in some capacity while many have worked together on initiatives over many years. The shift with the CKOHT is to formalize what have often been informal, collaborative efforts among organizations/teams and/or project based work to an articulated partnership with shared governance and performance outcomes.

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

A review of the patient/provider referral networks provided by the Ministry affirmed the CKOHT understanding of its traditional and attributed populations relative to flow and care patterns. Although no real surprises emerged from the data set provided by the Ministry, it did enrich the understanding of it and offered some additional areas for further consideration, such as how to identify or serve those not identified as enrolled within the Patient Enrollment Model (PEMs).

Overall and per the OHT data file, the CKOHT data indicates a very strong alignment between the current membership and the provider networks with over 80% of patients enrolled in primary care. This is a very high enrollment rate and provides a strategic advantage for the CKOHT to have significant impact within the primary care environment.

The data identified physician costs as highly matched for primary care and reasonably matched for secondary care. CKHA is the only hospital within the local Municipality with sites in Chatham and Wallaceburg and as a result, the data represents reasonable alignment with flow and care patterns with majority of the CKOHT attributed patients accessing community hospital services locally while others, either due to acuity or specialization (Tertiary/Quaternary care) or choice (other OHTs), receive care elsewhere. For example, CKHA does not have advanced neurosurgery or cardiac programs and therefore, all patients requiring brain or cardiac surgery would access care elsewhere (the proposed Western OHT). As well, CKHA is a satellite for Oncology and Nephrology of both London Health Sciences Centre and Windsor Regional Hospital, which may contribute to specialist costs being attributed to specialists in other jurisdictions. Finally, there are select services that could be provided within a community acute hospital setting but were not in place during baseline collection in 17/18. For example, the hospital is currently working to expand its Urology service, which is anticipated to see an increase in secondary care attachment rates in the coming years.

Overall, the data did not identify any new or unforeseen membership needs; it did affirm the need to work with tertiary centres in Windsor and London as well as to continue to keep communication channels open with neighbouring OHTs. To address the real and ongoing need for alignment with tertiary and regional centres, CKHA's CEO, along with peers from across the Erie St. Clair and South West LHIN's

participated in an information sharing discussion on OHTs in September. There is currently a proposed regional approach to acknowledge and support appropriate consideration for patients that seek specialist care outside of their natural OHT without compromising or complicating the roles or funding of various OHTs within the southwest.

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

In Year 1, the CKOHT plans to provide integrated care to 30% of its Year 1 Population (Y1P) or 3,300 individuals. This estimate is based on the following factors:

• The CKOHT can map its Y1P to approximately 11,000 individuals rostered within the 3 FHTs, CKCHC and Home Care, with an estimated potential total Y1P slightly higher to accommodate for additional unattached patients who meet the criteria

• Approximately 3,000 of these individuals are currently receiving care through existing integrated programs such as: Alzheimer Society's First Link Program, Primary Care Hospital Discharge Process, Community Paramedic Program, ESC LHIN Home and Community Care supports and Behavioural Supports Ontario (BSO) System Navigator.

• Expansion to the full 30% will come from:

- Primary Care Chronic Disease Management Programs for CHF, COPD, mental health and diabetes will be expanded to support Y1P who do not currently belong to a team-based primary care practice.
- Expanded integrated care coordination capacity within the system, such as the realignment of resources to increase care coordination within community organizations (increase of 200 potential patients) and the Intensive Hospital to Home program with integrated discharge planning, provides the CKOHT with confidence to sustain and enhance performance for the Y1P
- A current state assessment completed to identify existing resource types within each partner organization and to determine gaps in building integrated care strategies

In order to provide care that is fully and actively coordinated across the CKOHT partners, a fundamental shift to realign care across organizational lines that will encompass the patient's journey must occur. This requires creating a common vision and principles and building trusting relationships. (See Home and Community Care Appendix A, A.1).

Applying the tools and practices of Experience-Based Co-Design and in alignment with the proposed governance structure (Appendix 3) and patient engagement framework (Appendix 4), the CKOHT will leverage sub-committees to develop appropriate working groups to enhance key priority areas such as system navigation, digital health, effective transitions and care coordination to develop care protocols and pathways. Building on the initial mapping of CKOHT Y1 proposed strategies across the continuum (September 2019 current Health Human Resources Inventory, Appendix 5), rapidly implement a series of process and experience mapping exercises with representatives of CKOHT partner organizations and patient advisors to assess existing strategies against known gaps and patients' needs to create a comprehensive plan on how best to provide integrated care for the Y1P.

The CKOHT will create information protocols to share patient data and to coordinate care plans, ensuring criteria is established so that the right individuals receive the right level of support at the right time as well as mobilize the use of digital health

enablers.

Finally, a joint commitment amongst CKOHT partners to understand the existing supports and services available, standardize processes, reduce duplication and reallocate resources to address gaps has already started to occur through the Full Assessment engagement process.

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

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

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)
See supplementary Excel spreadsheet				
Interprofessional team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				

Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				
Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

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

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

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

Max word count: 500

Membership and service expansion within the CKOHT will occur through a phased approach to reach full and coordinated continuum by maturity at Year 5. As the attributed CKOHT population expands so too will its membership. Following the terms formalized through constituted Collaboration Agreement (see section 4.2), the proposed plan to achieve maturity is:

Phase 1: Year 1 (Y1)

The Y1 Population (Y1P) is: adults aged 55+ that have 1 or more of the following criteria met: COPD, Heart Failure, Angina, Diabetes, Dementia, and/or are complex,

as per Health Links definition.

Membership: Existing CKOHT partners with effort to expand participation of other relevant organizations, such as additional Long-Term Care Homes, retirement homes, assisted living and select community support services, such as seniors' centres.

In Y1, for home and community care (H&CC), the CKOHT will rely on existing contracted relationships with Service Provider Organizations that are currently held by the Erie St. Clair LHIN. The CKOHT supports a provincial framework to guide these relationships in the future.

CK is classified as underserviced and unattached patients are currently estimated at 15%. In Y1, a system navigator will help to support these individuals through their health care journey (See Appendix A, Home and Community Care). The CKOHT commits to exploring solutions for unattached patients to access primary care. This includes effort already underway for a comprehensive physician recruitment plan to support existing and future patient needs. Further, clarity is required regarding compensation models to support physician involvement in non-patient related activities of the OHTs.

Phase 2: Year 2 (Y2)

The Y2P will grow to include all adults over 55.

Membership: Continued effort associated with Y1P with broadened focus to include any organization or service geared to older adults such as seniors' centres across the municipality, recreational centres etc. As well, Phase 2 will include strategies to build awareness and involvement of partners and collaborators, such as Children Services, who will be critical to the Phase 3 populations.

Identified Challenges for expansion from the Y2 to maturity includes the need for clarity on:
• H&CC service providers, including the impact of provincial system changes on resourcing stability and performance
• Funding impacts for organizations' ability to innovate or change due to existing legislation or funding agreements

Phase 3: Years 3-4

Using updated data, plans will begin to identify and prioritize populations and services by age group for all adults (25-54) and youth (under 25).

Membership: Onboard all remaining organizations providing services to adults and expand to agencies whose mandate is youth focused. Focus will shift to exploring relationships with community and social services. This phase offers significant opportunity to create new partnerships with collaborators from the education sectors,

such as community colleges.

Phase 4; Year 5 (Maturity) and Beyond
In Y5, the balance of all adults and youth will be added along with any organizations that have emerged in niche areas or that have had previous barriers to integration removed e.g. changes to legislation.

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
Currently, all but 3 family physicians in Chatham-Kent have signed on to support the CKOHT (which includes one solo physician). There are three solo physicians in the CKOHT network who are currently not involved at this point. To date, all primary care providers in Chatham-Kent have been invited to attend previous OHT planning/engagement sessions, including the September 2019 clinician engagement event. Moving forward, there will be plans to ensure the 3 solo physicians are invited to the table whenever primary care providers are invited to be a part of the co-design, planning and implementation phases. Physician champions will also be identified through the Primary Care Council, to reach out to these three colleagues as well as any newly recruited family physicians, to provide information and education on the OHT model, and continue to have an open invitation to bring them on as supporting partners.

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 CKOHT has demonstrated a broad and inclusive approach to engagement. This is a strength of this team.

In April 2019, over 80 participants from CKOHT partners and collaborators created and affirmed the vision, "Achieving the best health and well-being together", the proposed Year 1 Population (Y1P) and the following principles to guide the CKOHT:

• Develop and create a person-centred model that wraps around health and social services with the client.
• Build for the uniqueness of the CK community.
• Be bold and innovative in design. Trust one another to take risks.
• Leverage existing assets intelligently; build for maturity, not Year 1.
• Use an evidence driven approach and be willing to continuously improve.
• Integrate the full system and spectrum of care, including community and social supports.

(Patient advisors (PAs) led development of further patient-centred principles documented in Appendix A, A1).

Participants identified system challenges, as well as possible solutions and existing assets to support the work ahead. With the assistance of an external facilitator, ten key challenges were identified that need to be considered for moving forward in the first year and in developing a roadmap for achieving maturity (See section 6.4).

A governance workshop was facilitated by a neutral third party in June for the administrators, governors and PAs of the self-assessment signatory parties to establish the framework and next steps in developing a governance model. This work continued through the submission process with a dedicated governance and leadership stream supported by independent legal counsel. A clinician engagement session was also facilitated by a consultant in September with over 80 family practitioners and nurse practitioners in attendance.

The CKOHT's collaborative approach led to the development of a Steering Committee to guide the full submission process. Each organization had an equal seat at the table and it was co-chaired by a patient advisor, a primary care physician lead and the hosiptal CEO. The group divided the proposal themes into six work streams to support the submission. Representatives of participating organizations and CKOHT's Steering Committee acted as work stream leads and writers for various aspects of the submission; the streams also had a minimum of two PAs at each table. All partners and potential collaborators had the opportunity to participate in aspects of the submission. In total, over 90 people were directly involved in work stream activity to create the final submission (Appendix 2) as well as many more who offered input and insights to shape the future CKOHT. A few individuals were dedicated in-kind from partner organizations to then pull the various components together into one cohesive document. This significant and inclusive effort to establish the CKOHT embodies how the future of health planning and service delivery will be different.

The Diversity and Equity work stream recruited PAs from partner organizations and populated their membership on various work streams. The work stream itself included representatives from Walpole Island, French Language Planning Entities, the Municipality, LHIN indigenous and francophone leads, Mental Health Networks, Children Services, Adult Language and Learning and three PAs. Engagement activities leveraged existing meetings including the Prosperity Roundtable, Local Immigration Partnership, Indigenous Health Planning Committee (IHPC), the Community Leaders' Cabinet (26 Executive leaders across sectors), and multiple networks.

In total, 12 community presentations and discussions of the CKOHT took place prior to October 9 with additional forums scheduled.

A specific Francophone community engagement session was also held on September 11 (Appendix 6); information about the engagement and its findings have been captured in section 3.7.2. The French Language Local Planning Entity has also formally identified itself as a supporting organization.

As per the call to action in the Truth and Reconciliation report, the CKOHT supports "Indigenous Health in Indigenous Hands" in that health care for Indigenous people should be managed by Indigenous-governed organizations. See section 3.7.1 for details on the CKOHT's approach to indigenous communities and process being followed to achieve support from First Nations. As well, on September 20, the CKOHT presented to the local Indigenous Health Planning Council (IHPC). This engagement reaffirms the directions as per the London's Chief Council's Declaration on Health Care and formal health policy directions which are forthcoming. The IHPC supported embedding the various indigenous frameworks, guides, care paths and resources to be implemented into service delivery models as per their recommendations and echoed that it was imperative for cultural competencies to be developed for culturally-based care.

On August 12, 2019, The Municipality of Chatham-Kent moved to “participate as a phase one community partner in the Chatham-Kent Ontario Health Team full application process". As Chatham-Kent Public Health is embedded within the Municipal structure this engaged both Public Health and Riverview Gardens, the Municipal run long-term care home that has 320 residents. As well, on October 7, the following motion was approved by the Municipal Council following a presentation: "Whereas the goal of the CKOHT is to bring together health care partners from all sectors… and Whereas by endorsing the submission of the CKOHT application, Council is agreeing to participate in ongoing discussions to co-design a local system for the community, and Whereas, all partner agencies will continue to function within their own governance structure, therefore Be it resolved that the Municipality of Chatham-Kent endorse the CKOHT full application…and that the Chatham-Kent Mayor be authorized to sign the necessary documents…”

A communication plan was developed to support internal partner and external community needs. In early September, the CKOHT’s website www.ckoht.ca and twitter feed @CK_OHT became active, providing digital forums for information sharing and ongoing engagement.

This was a participatory process that achieved consensus with the culmination of the effort presented at a joint meeting of all CKOHT partner Boards of Directors where the following motion received unanimous support:
“That the Board of the (Organization Name) endorse the Chatham-Kent Ontario Health Team full application and support the Board Chair to sign the full application for submission by the deadline of October 9, 2019.”
The CKOHT will continue with public engagement following the submission in preparation for development of a Strategic Plan in Year 1.

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

Top Three Performance Improvement Opportunities

The CKOHT attributed population is aging with higher rates of chronic disease, more seniors living alone and higher rates of hospitalization (see Section 1). CKOHT performance exceeds that of the province in many indicators provided by the Ministry with some notable exceptions. Based on the health status of both the attributed and Year 1 populations (Y1P), baseline performance results, and the key enablers to an integrated system, the following are the top 3 opportunities for significant improvement in Year 1 and beyond:

1. Avoidable Emergency Department (ED) visits

The following measures point to greater reliance on the ED by Chatham-Kent (CK) residents than the provincial average:
a. Rate of CTAS IV/V Visits per 1,000 enrolled patients is 176.0 for CKOHT vs

Ontario's 140. 2.
b. Avoidable ED visits rate for the CKOHT (9.0 per 1,000 attributed population age 1-74) is more than double the Ontario rate (4.6 per 1,000).
c. Timely access to primary care is less in the CKOHT than Ontario (36.8% vs 44.7% respectively of those who were able to schedule same day/next day appointments when sick).

The rationale for choosing this improvement opportunity is to ensure patients receive the right care in the right setting at the right cost. This will improve the patient experience and reduce costs.

Improvement of ED utilization is expected through strategies with focused efforts to shift patients away from the ED by improving access to primary care, community in home visits, etc.

2. Rate of hospitalization for ambulatory care sensitive conditions (ACSCs)

In addition to avoidable ED visits, the Ministry performance data also points to a greater reliance on admission to hospital:
a. Hospitalization for ambulatory care sensitive conditions significantly exceeds the provincial average: CKOHT rate of 134 per 100,000 attributed population age 0-74 compared with 90.6 per 100,000 for Ontario
b. The trend line on this metric appears to be worsening from 2016/17 through 2017/18 for the CKOHT.

In order to respond to anticipated future demand, it is imperative that the CKOHT increase access to more appropriate ambulatory services.

3. Adoption of Digital First approach in Service Delivery

A third improvement opportunity relates to the identified need to embrace a digital first approach in service delivery redesign and to empower patients to increase their health literacy and self-management capabilities. Throughout the CKOHT engagement process, patient and family advisors repeatedly shared their desire to have greater access to both their own records and digital tools to improve access to care.

This relates to the Percentage of Ontarians who digitally accessed their health information in the last 12 months.

The CKOHT proposes to leverage existing assets with patient or family-facing functionality, such as CoHealth, SensoryTech to achieve gains. See sections 3.4, 3.5.3, Appendix A, A1 and Appendix B.

Team Assets

The overall approach to address the needs of the attributed and Y1P, as described in section 2.8, reflects an integrated and powerful combination of broad based preventative strategies with targeted interventions in select areas for select sub-sets across the continuum. From increasing awareness and participation in Master Your Health programs to creating virtual wards to support the frail/elderly post discharge, these collaborative and comprehensive intentional strategies to drive outcomes are notable.

Year 1 to Maturity Alignment

The above Y1P indicators also align well to the attributed population at maturity. The ED utilization for lower acuity CTAS scores indicates the ED is acting as a fail-safe to the system and potential misunderstanding of it and/or other options within the attributed population. The significance of the ACSCs is a reflection of the population that is ending up in hospital for services that can be managed outside of acute care and often at less cost. Finally, the imperative to consider digital approaches cannot be ignored. To move these 3 metrics requires focused, collaborative efforts across the system.

The Balanced Score-Card Approach
In its self-assessment, the CKOHT created a balanced scorecard for the system based on the Quadruple Aim. Through the process of identifying the opportunities for improvements in the Y1P and attributed population at maturity, it is believed that success can be measured and determined based on this broader set of metrics. These are also coupled with the additional metrics associated with digital health (see Appendix B for details of how digital solutions will support achieving key system measures). This is a companion to the ongoing commitment to quality improvement initiatives including the previously made and sustained commitment to palliative care via the common QIP strategies.

Population Health
• Cancer screening and influenza rates
• 90th percentile wait time from hospital discharge to service initiation by home and community care
• Hospital admissions for ambulatory care sensitive conditions

Care Team and Well-being
• % of acute care patients who had a follow-up visit with a health care provider within 7 days of discharge
• % of providers who rate their work satisfaction, regardless of measurement scale, in the top box/rank

Patient Experience
• % of patients who rate their health care experience, regardless of measurement scale, in the top box/rank
• % of patients or caregivers who utilized a digital health platform in the last 12

months

Reduce Costs
• Number of Emergency Department visits better managed elsewhere
• ALC rate for acute and post- acute
• Conservable medicine bed days

In addition to performance indicators noted above, the CKOHT also recognizes the opportunity to make improvements in the sphere of cultural safety and linguistic sensitive approaches to programs and service delivery models. For example, the intent of creating an Indigenous Navigator position to support transitions from hospital to home (See Appendix A, A.1).

As noted in section 5.2, 100% of CKOHT members are committed in principle to the quadruple aim (see Appendix 7) and will be accountable for the results on a common scorecard and the related improvement strategies. The formalized approval of the metrics and scorecard will be completed as part of the governance work ahead and in conjunction with the creation of the Collaboration Agreement, see section 4.2 for additional information.

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
Working together to Redesign Care and Change Practice – The What

It is through primary care that patients usually enter the health care system and it is a relationship that often continues through the patient's life. Therefore for the CKOHT to be successful it is vital to strengthen primary care leadership. CKOHT's model establishes primary care as the foundation of the integrated health care system. Physicians and Nurse Practitioners will be instrumental in ongoing design, planning and decision making. For this to occur, flexible meeting times and virtual attendance will be considered.

The CKOHT also needs to provide other opportunities where providers are able to share ideas and feedback without impacting access and patient care. Primary Care teams are already coming together to strategize for better alignment of programs and services, and standardization of tools performance metrics, and resources. Almost 75,000 patients within the CKOHT are currently enrolled within one of the 4 team-based primary care organizations. This unique feature of the CKOHT will be leveraged to better identify and serve the Y1P by ensuring their access to consistent high quality programs and services. For example, devising an electronic referral process to access Diabetes Education and expanding services through outreach locations in long term care, retirement residences, assisted living and family health teams.

As the CKOHT comes together to further integrate the local health care system, partners will look at key areas where there is the greatest opportunity for improvements to expand care coordination, system navigation, safe transitions and increase self-management. Building upon the preliminary current state inventory and enhancing digital platforms (e.g. Healthline 211), the CKOHT will create a comprehensive repository of resources and services available within our community. This process will be useful in further identifying gaps and opportunities in Y1 as well as in future phases toward maturity.

Finally, strategies for hospital avoidance and/or improved patient flow may also be found in the hospital itself. The development and expansion of ambulatory care clinics supported by specialists may also reduce ED visits and avoid admissions for ambulatory care sensitive conditions.

Working together to Redesign Care and Change Practice – The How

All CKOHT partners are delivering high quality, evidence based health care within their respective organizations. The CKOHT recognizes that for the most part coordination still lies within individual organizations and their teams. The CKOHT has had good success on a smaller scale with partnerships like Health Links. These strategies aim at a more integrated approach between organizations but the accountability for deliverables still remain within each organization. With the creation of the CKOHT comes a common accountability system where the collective purpose and goals are stronger than the individual organizational objectives. See section 5.2.1, 5.3 and section 6.2.

A sound collaborative governance structure will enable the CKOHT's care redesign and change practices. There is already a common vision and principles that resonates with all partners. Efforts to fortify the existing strong relationships to ensure the CKOHT's foundation remains one built on trust, equity, respect and a common purpose. The collaborative leadership style will include a "bottom up" approach where everyone has a voice to create change and ideas come from all levels of the patient's experience coupled with input from front line providers and senior leaders.

The patients and caregivers need to be the focal point for the redesign in care. Through planning and development, patients and caregivers will be strong collaborators throughout this process every step of the way. Ensuring meaningful engagement and welcomed participation through structures, processes and a common language free from health care system jargon and acronyms. The CKOHT will create a culture of inclusiveness whereby the language used in all OHT activities is communicated to meet all levels of understanding. Through the provision of standardized (where possible) resources to support patients and caregivers and the tools needed to allow them to best self-manage their health with increased confidence.

In keeping with the principles of Experience Based Co-Design, the CKOHT will form working groups to plan mapping exercises to refine, and where necessary build, processes that flow between organizations reallocating resources as necessary. Inclusion of non-phase 1 partners such as long term care organizations, senior residences and centres in these planning sessions will support a more comprehensive pathway as well as creates a further mechanism to invite them to consider when/how to participate in the CKOHT. The CKOHT will work toward using digital platforms to create common referral processes, standardized screeners and wait management systems.

Together, the CKOHT will establish criteria for system navigation recognizing that the Y1P has different needs and preferences. Patients will know who to turn to for navigation and not to have to repeat their stories multiple times throughout the health care journey. System navigators will have the information necessary to support patients each step of the way. To be able to accomplish this, the navigator roles with Home & Community Care (H&CC) Clinical Care Coordinators and Behaviour Supports Ontario (BSO) will expand (see Appendix A, A1 and A2). The Community Paramedic Program will be leveraged to provide system navigation and care coordination for patients belonging to solo physicians as well as involve CK's fire services for system navigation and health promotion activities as other social services and clinical assets in the field. The CKOHT will also work to identify orphan patients with no primary care provider to ensure they have access to a system navigator if needed. System Navigation is offered within Primary Care Team currently and will need to be included in the expansion plans.

It is acknowledged that there is some great work being done in Ontario. With the intention of not reinventing the wheel, the CKOHT will explore and implement best practices already occurring across the province that apply to the Y1P. An example of this would be current work being done around the spread and scale of a standardized Medical Cannabis program. The majority of the patients who have benefited from this program are seniors. TFHT has implemented a standardized Medical Cannabis program, utilizing an RN and Pharmacist to offer an alternative solution for providers to reduce the number of patients receiving new opioid prescriptions and reduce the Morphine Milligram Equivalents (MME) of patients with an active opioid prescription.

Patients in this program have seen an 80% reduction in a recorded pain interference score and an 89% reduction in a pain severity score. This model is also being rolled out by CKFHT and TDFHT. This Collaboration was led by Primary Care Lead: Addictions & Opioid Strategy, Dr. Blake Pearson.

Working together to Redesign Care and Change Practice – The Tools

All CKOHT organizations are committed to sharing information to improve care for patients. In order to achieve this, all partners need to have access to the same platforms and digital tools where information can easily be shared. The CKOHT will also invest in technology to make it easier for virtual patient visits as well as virtual meetings and case conferencing with care providers. CKOHT's commitment to enhance patient access to their own records and the associated targets, is contingent on overall improvement in digital assets and systems across the CKOHT. See section 3.5.3 and Appendix B for more details.

This process ensures that in year 1, CKOHT partners better understand what services each organization currently provides, gaps in services within the local system, where duplication may exist and clarity around where care coordination is within the basket of services provided by an organization. The enhanced or new pathways will ensure that care is coordinated throughout the CKOHT achieving safer and more effective handoffs during transitions. Duplicated services will be eliminated where possible to streamline and reallocate resources to expand access of key Y1P services across the CKOHT (see 6.5). Through education, all team members will have the knowledge of the various professional designated scopes of practice and ensure regulated health professionals are practicing at top of license. This will allow the CKOHT to increase its capacity by having the right individuals in the most suitable roles for system re-design.

It is important to enable formal and informal links and processes for care coordinated across multiple organizations. The CKOHT will utilize crisis lines, Telephone Health Advisory Service (THAS) and after-hours services to expand care coordination for the year 1 population.

Working together to Redesign Care and Change Practice – The Targeted Outcomes

Based on the approach, interventions and tools described above, the following targets are proposed for Year 1 based on the improvement opportunities identified in Section 3.1.

1. Avoidable Emergency Department (ED) visits

The Avoidable ED visits rate for the CKOHT (9.0 per 1,000 attributed population age 1-74) is more than double the Ontario rate (4.6 per 1,000). It is expected that at maturity, the CKOHT rate has improved significantly and is at or better than the Ontario average. In Year 1 (Y1), it is proposed that this metric be improved by 5% or 8.8 visits 1000 enrolled patients.

Timely access to primary care is less in the CKOHT than Ontario (36.8% vs 44.7% respectively of those who were able to schedule same day/next day appointments when sick). It is proposed that this metric also improve by 5% in Y1 to be 38.3%.

The CKOHT partners commit to maintaining or improving the performance of indicators that are currently exceeding the provincial average and align to the role of primary care such as follow-up with a health care provider 7 days post discharge for acute patients by any mode (i.e. in person, virtual or phone).

2. Rate of hospitalization for ambulatory care sensitive conditions (ACSCs)

Hospitalization for ambulatory care sensitive conditions significantly exceeds the provincial average: CKOHT rate of 134 per 100,000 attributed population age 0-74 compared with 90.6 per 100,000 for Ontario. It is expected that at maturity, the CKOHT rate has improved significantly and is at or better than the Ontario average. In Y1, it is proposed that this metric be improved by 10% or 120.6 per 100,000. This more aggressive target than the ED visits is based both on strategies in primary care and enhanced specialist clinics in hospital as well.

3. Adoption of Digital First approach in Service Delivery

In Year 1, Chatham-Kent Health Alliance (CKHA) is implementing a new Cerner electronic health record in collaboration with the other hospitals in the Erie St. Clair LHIN. This implementation will be supported by Transform Shared Services Organization (TSSO) and will involve a significant number of the CKHA staff and physicians and TSSO staff.

Therefore, it is proposed that in Y1, the “percentage of CKOHT residents who digitally access their health information” be a metric in discovery. Strategies will ensue following the Cerner installation. It is too early to know how this timing will compare with the Y1 start date at this stage.

4. Other Outcomes and Metrics – Balanced Score Card

Patients can be vulnerable during times of transition from one health care organization to another. Partners will work together to ensure the proper information is communicated and supports are put in place prior to patient transitions between hospital, LTC, primary care and H&CC. When possible, patients will receive the care they need in their community by providing eRehab services for hips and knees and Virtual Wards for Palliative and other patients.

There will be a joint accountability between partners to achieve these collective impacts. Everyone involved in a patient’s care journey will have all the information they need to meet the patient’s health care needs and expect to ensure the transition between organizations is seamless and collaborative.

Individuals involved in patient care re-design efforts will be responsible for similar performance metrics including but not limited to patient and care provider satisfaction.

Collectively, all CKOHT partners are vested in achieving the local priority indicators associated with the quadruple aim as well as the system level indices as forthcoming by the Ministry which will comprise the collective balanced scorecard. Where performance currently exceeds the provincial average on the Ministry performance metrics, the CKOHT targets sustained or enhanced results.

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

The CKOHT will build on its experience and innovations in care coordination and system navigation to expand and improve service to the Year 1 Population (Y1P).

Experience

Health Links provides a long-standing demonstration of how the CKOHT partners coordinate care across organizations to improve outcomes. The result is increased access to timely information, community resources, and smoother transitions across settings. The CKOHT will build on this success in Y1 through a shared accountability for care coordination. Furthermore, additional enhancements will be achieved with the initiation of the coordination/navigation pathway for Francophones and an indigenous navigator to support First Nations.

More recently, transformational change is occurring in the care coordination space with a pilot project between the Chatham-Kent Family Health Team (CKFHT) and a community-based OHIP funded rehab clinic supporting musculoskeletal care. Enhanced collaboration and earlier rehabilitation is resulting in decreased opioid prescriptions, decreased falls and improved patient outcomes. In Y1, the team will expand this collaboration to other primary care teams within the CKOHT.

In Scope Year 1

A goal of CKOHT in Y1 is to ensure there is an identified single patient navigator for every individual who requires intensive case management, through a virtual hub referral process. To enable this, CKOHT partners will optimize assets for enhanced patient support within budgetary and contractual confines.

In Section 2.7, the CKOHT identified that it will provide integrated care to 30% or 3,300 of the 11,000 individuals in the Y1P. To enable this integrated care, the CKOHT will expand the number of Clinical Care Coordinators (Cl CC) from the LHIN Home & Community Care (H&CC) from 3 to 5 FTE positions, ensuring intensive care coordination is available for complex frail older adults within each primary care team (See Appendix A, A2) Based on current experience, these coordinators can support a caseload of 40-60 patients. In addition, 10 FTE H&CC Care Coordinators are currently assigned to and supporting over 1,300 patients on CKOHT physician rostered caseloads. The CK Community Paramedic Program (CKPP) will continue to provide coordinated care access for solo practitioners as well as linking them to team-based care at Chatham-Kent Community Health Centre (CKCHC) with a caseload of 170 patients. Behavioural Supports Ontario (BSO) will be expanding with two

additional navigators who will manage 60 patients each by end of Y1. In total, there is a deliberate plan to support 1,900 of the 3,300 patients in Year 1. The remaining CKOHT partners will assess their capacity and will continue to explore opportunities to embed care coordination into additional organizations to further support connections for sub sets within the Y1P (e.g. dementia).

The CKOHT will leverage existing resources of partners that currently offer 24/7 on call services within the region including Westover, Canadian Mental Health Association (CMHA), March of Dimes, Alzheimer's Society and LHIN H&CC in-office team. Enabling these partners direct access to H&CC Service Providers to coordinate services for urgent matters between 2000-0800hours supporting patients that need access to urgent support through a face to face home visit will mitigate demand on hospital services. This will contribute to reduced ED visits that can be managed elsewhere and potentially fewer ambulatory care sensitive condition admissions.

In Y1, the CKOHT will explore the ability to use consistent screening and assessment tools to coordinate care among primary care, Chatham-Kent Health Alliance (CKHA), Geriatric Mental Health Outreach Teams (GMHOT), H&CC, BSO, CMHA, and CKPP among others. This will ensure clear communication and understanding by all providers, diminishing the need for patients to tell their stories multiple times.

The CKOHT will work toward expanding the H&CC waitlist management system for primary care and H&CC services for its Y1P. Towards maturity, all partners will have access to waitlists to collectively address these issues through ongoing monitoring and capitalizing on efficiencies.

At Maturity
By maturity, expansion in the number of interdisciplinary health care providers who have the ability to complete care coordination plans with the implementation of a common platform to Client Health and Related Information System (CHRIS) (See Appendix B, 2.1) will allow for improved information sharing across the care continuum in the CKOHT.

At maturity, 24/7 care coordination for those who require intensive case management will be established. The team recognizes that there will be a requirement to develop strategies to facilitate exceptional communication processes, standardize care pathways and co-design a 24/7 on call system to achieve this goal.

Other Examples of In Scope Care Coordination Services:
• Promotion of cost effective ways to connect with patients including clinics for patients who can travel, use of OTN/PCVC to support virtual assessments and home visits when required
• Geriatric Mental Health Outreach Team - this service provides navigation and enhances the quality of life for older age adults with complex mental health needs living in a long-term care home, retirement home and community.
• Nurse led Outreach Team – On site assessment and management of acute illness

and injury to reduce the need for transfer to ED.. At maturity phase, the role will evolve to assist with transitions of care from hospital to LTC.
• Rapid Access to Addictions Medicine (RAAM) Clinic - Drop-in clinics for patients looking to be connected with treatment for high-risk substance use and addictions
• Rehab – navigation in bundled care pathways to reduce Hospital LOS for strokes and orthopedic patients receiving hip or knee replacement surgery.
• Primary Care Innovation Collaborative (PCIC) Best Care – Primary Care program that optimizes chronic disease management through integration of primary care and self-management programs in the care pathway to support improved health outcomes and health literacy and confidence in self-management.
Example of Out of Scope Services:
• Utilize mobile clinics to provide programs/services to rural/remote areas (e.g. mobile flu clinics, BP clinics etc.)

The CKOHT will know its care coordination is successful when communication and collaboration amongst primary care, community support services, Hospital and H&CC is seamless and processes are coordinated across multiple organizations. Additionally, an increase of patient reported outcome measures (PROMs), higher patient satisfaction, improved patient safety, a reduction in unnecessary ED visits and readmissions to hospital will demonstrate success.

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.

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The CKOHT recognizes that the health care system is complex and that patients, families, caregivers and providers often find it confusing, inefficient and difficult to navigate. The team is committed to developing a local health care system that is easier to access where patients know where to turn to when they have questions or need assistance. Multiple entries within the health care system affirms the importance of intersection amongst partners to allow patients, families and caregivers to experience seamless transitions throughout a patient's care journey.

For the Year 1 Population (Y1P), the CKOHT will build on systems currently in place (examples described below) and will explore different models and services of system navigation among community organizations. The team will also evaluate current capacity and attempt to standardize the system navigation processes and pathways for the patient. Additionally, the CKOHT will develop a working group to help plan and improve better system navigation using co-design and experienced-based design methodologies.

In-scope services include clinical care coordination and intensive case management for the Y1P. Further supports are required for care coordination in hospital and after hours to ensure 24/7 access across the CKOHT partner services.

The CKOHT will provide a system navigator/care coordinator for its Y1P that meet the criteria set out for intensive case management. This will ensure the patient knows who to consult for help navigating between primary care, hospital, Home & Community Care (H&CC), retirement home, long-term care, hospice, and community services. For example, building on the Clinical Care Coordinator/Case Management services that support Health Links patients.

There are several examples where system navigation currently exists as a mature function in Chatham-Kent. The Alzheimer Society's First Link is a referral program designed to help newly diagnosed dementia patients and their families and caregivers receive the services and support needed as soon as possible. First Link Navigators connect with other service providers to ensure wrap around care. Most importantly, First Link Navigators follow-up after referral to ensure uptake and education is being provided. Similarly, the CKOHT will work towards the standardization of other care pathways to provide better system navigation and capitalize on available after hours care.

In Y1, 24/7 navigation will continue through H&CC for persons who require support through ESC LHIN contracted Service Providers and expand by leveraging other existing resources. In-hospital navigators will work with community system navigators/care coordinators to smooth out transitions for patients between hospital, primary care, hospice, retirement home, community services and LTC. The system navigators/care coordinators will stay linked with the patient during their entire care journey until the support is no longer needed by the patient and/or the caregiver.

To operationalize a robust 24/7 on call system within existing resources, the CKOHT will work with those partners who already offer 24/7 on call to coordinate services for urgent matters between 8:00 PM and 8:00 AM. Clear and safe transfer protocols will be established. The CKOHT will also leverage the Telephone Health Advisory Service (THAS) providing an after-hours service where a registered nurse will provide advice about urgent health care concerns.

Clinical Care Coordinators integrated in the 3 FHTs and CHC collaborate with primary

care health link case managers/primary care teams to enable a better patient and sector experience in addition to navigation and coordination of services. Digital enablers including e-notifications and Health Partner Gateway (within CHRIS) are utilized to support navigation and bi-directional communication. Although H&CC service providers are on-call 24/7 there is a gap of care coordination to directly link and coordinate services beyond 4:30 pm.

To help bridge this gap, patients will be able to access In-Office Care Coordination to assist with System Navigation 8-8, 7 days/week to answer questions and provide guidance on best point of access to care. This will continue to evolve through to maturity into a collaborative triaging system and educational strategy to help patients determine the most appropriate place/time to receive care. Referrals will be made to a patient's primary care provider and vice versa.

At maturity, the CKOHT will look to expand various navigation services until able to provide 24/7 navigation for the entire population. The goal is to have a system navigator/care coordinator for all patients who require intensive case management, with access to the patient's health information.

The CKOHT will work towards a collective sharing agreement amongst partners to enable seamless access and care transitions for the patient. The team will link primary care with current community navigation supports and develop pathways to the most appropriate support agency (CK Housing, Community Navigators, Canadian Mental Health Association (CMHA), ODSP/OW, H&CC).

Resources such as 211 and the healthline.ca are comprehensive digital health and community information networks and will play a pivotal role in 24/7 system navigation for patients. Currently, all providers in the CKOHT have access to these tools. The CKOHT will work toward having all organizations update/utilize the website to promote local community resources and community education programs.

The Team also recognizes the value and support that community pharmacists play in supporting patients with complex needs. The CKOHT will start the discussion on how to engage and use this community resource that is typically available evenings and weekends, and operates 7 days a week.

Additionally, the team will continue to engage the Schulich School of Medicine & Dentistry, Family Medicine Residency Program (Chatham teaching site) and explore opportunities where this training program can add value in providing care and services in an OHT model.

The CKOHT will leverage information from Municipality of Chatham-Kent's survey to identify social determinants that impact health in the community. The team will invest in solutions that address access to food, transportation and safe housing.

The success of system navigation processes will be realized when all OHT partners

capture PROMs (patient reported outcome measures) along with improvements in quality, satisfaction and efficiency. A successful navigation system will be able to be expanded as the CKOHT's population and membership grow through to maturity while meeting the mandates of the quadruple aim.

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

CKOHT members share common goals, values and principles and understand the need support smooth transitions to the appropriate level of care.

Current Initiatives

Beyond care coordination, the following are examples of how transitions and continuity of care are provided:

- Primary care supporting patients post-discharge by prioritizing follow up connections within 7 days of discharge from hospital
- Embedding LHIN Clinical Care Coordinators and home and community coordinators within primary care organizations in collaboration with primary care Health Link case managers
- Use of screening tools (HARK, Blaylock, LACE) for high risk patients in acute and primary care
- Behavioural Supports Ontario (BSO) provides transitional supports in LTC homes from hospital or community. This process is dependent on First Link Navigators and Client Intervention Social workers from Family Services Kent. This link provides warm handoffs and improves relationships with patients and their caregivers. BSO expansion is currently underway increasing the number of BSO Clinical Care Coordinators supporting Chatham-Kent (CK) (See Appendix A, A2).
- In November 2018, LHIN Home & Community Care (H&CC) developed a Virtual Ward model for eShift palliative patients, with 4 of these 15 regional beds in CK. This model successfully decreased missed care rates, leaned admission processes and improved the patient, caregiver and provider experience. Adding Virtual Ward Beds to CKOHT-wide digital patient flow systems will help inform partners of available beds within the system. The CKOHT will look to scale this model and its technology to other programs.

Planned Initiatives – Year 1

The CKOHT partners, including patients and caregivers, will conduct service level mapping to better understand current care transitions, identify gaps, improve efficiencies and reduce duplication. To date, some transitions of care have been mapped, resulting in established algorithms and streamlined referral processes to support a seamless patient experience (e.g. Geriatric Mental Health Outreach Team (GMHOT) to BSO; Emergency Department (ED) to community Mental Health and Addictions) assessing improved capacities to coordinate more effective transitions.

In future phases, the goal is to implement the process of having a system navigator/care coordinator complete a visit with Chronic/Complex Patients prior to hospital discharge with the team, to ensure a smooth transition to community/ long term care (LTC), outpatient treatment, and/or support.

Innovative strategies that assist with transitions include e-Notification, H&CC electronic referrals, interdisciplinary Coordinated Care Plans, Intense Hospital to Home plans and 24/7 access to Telephone Health Advisory Service (THAS). CKOHT will standardize tools and strategies across providers: medication reconciliation, care plans, communication, checklists and care conferencing. The team will implement Health Quality Ontario's Hospital transitions leading practices such as provider to provider direct hand off; follow up within 2 days by a healthcare provider; standardized care plans; and hospital admissions including input from primary care (see Appendix A, A1, A2 and Appendix B).

Falls prevention is an integral part of the transition and will be prioritized for the Y1P. Primary care referrals to outpatient rehabilitation facilitate an important role from both a reactivation and quality of life standpoint while reducing downstream care costs.

CKHA will establish an innovative hospital ward without walls in Year 1; a hospital that is in the patient's home residence to improve access, patient experience and will create additional capacity in a cost-efficient innovative manner. The ward will expand on the proven success of the eShift Platform in community Palliative care and eRehab to develop a "virtual hospital" ward for Frail Elderly Acute and Elderly post-acute patients who are considered Alternate Level of Care (ALC).

Instead of remaining and decompensating in hospital, appropriate ALC patients will be discharged home using eShift directed care. By leveraging current home care contracts under hospital governance and coordination, these patients can be safely discharged home while recovering, waiting for admission to LTC or other destination. This may result in fewer applications to LTC or retirement homes/supported living environments as patients will have time to recuperate in their home environment while assessing what their next level of care requirements/options may be. This model achieves the right patient in the right bed with the right services. The virtual ward will reduce length of stay (LOS), creating capacity and flow within the hospital. These patients will be less likely to return to the ED or be readmitted as the hospital will continue to share care in the home. This innovative model complements existing

strategies and yet remains distinct, in large part due to the supportive role of the hospital-based Most Responsible Physician (MRP).

At Maturity

At maturity, the CKOHT plans to establish criteria and a process to implement hospital readmission teleconferences with 72 hours with involved partners to inform the circumstances that lead to readmission and generate team-based solutions to ensure a safe and successful discharge reducing 30 day readmissions for same condition.

Furthermore, community providers will have full access to primary care EMRs through the implementation of processes that enable safe and smooth transitions at every touch point with regular contact between primary care.

Partners will identify improved reporting processes to primary care when services are being provided in the community. This ensures that all patient experiences and information relative to their care are populated back into their EMR and accessible to care partners. This will reduce patients' having to re-tell their story multiple times throughout their care journey.

The CKOHT will aim to capture the linguistic identity of the patients to ensure smooth transitions to service providers who can speak the language of those patients, leveraging professional certified interpretation services for all clinical visits.

Measures of Success

The CKOHT currently performs well in the access and effectiveness domains identified in the Ministry baseline data. The following performance indicators are expected to further improve with enhanced transitions:
1. Wait times for first home visits from hospital and community,
2. Acute care patients who had a follow up with a physician within 7 days of discharge,
3. Alternate Level of Care days,
4. 30-day readmission rate for selected conditions,
5. Hospital stay extended until home care services or supports are ready,
6. Patients in hallway beds.

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

CKOHT providers will scale and spread existing self-management and health literacy initiatives while working with patients and caregivers to develop meaningful, individualized goals to increase their skills and confidence.

Existing Self-Management and Health Literacy Tools

• "Master Your Health" is an evidence-informed, six-week chronic disease self-management program offered by some current CKOHT partners.
• The Alzheimer Society offers a specialized self-management program; the "First Link Learning Series" enabling patients and caregivers to become informed regarding dementia and what to expect during the course of the disease. Support Groups and counseling are tailored to the patient's journey with resources to manage their own health and education on services.
• Behavioural Supports Ontario (BSO) uses Regional Education Coordinators (REC) to provide best practice customized education and supports to caregivers, LTC and community.
• Diabetes Education Centres (DECs) have decentralized outreach locations across the community providing evidence-based diabetes education and support self-management for all persons diagnosed with diabetes. DECs also support indigenous health offering on-reserve clinics on Walpole Island First Nation.
• Chatham-Kent Public Health (CKPHU) focuses on the health literacy of the

community by increasing knowledge and competencies at a population level with respect to the importance in maintaining a healthy weight, limiting alcohol consumption, not smoking, and proper sleep.

Year 1 Initiatives

Partners will align chronic disease management programs so that no matter which team a patient belongs to, they will receive a standardized offering with common goals and performance metrics.

In Year 1 (Y1), resources for the "Master Your Health" Program will have a centralized referral intake process that is opened to the CKOHT's full attributed population. There will be one communication plan, one calendar and promotion of all events. This includes an automatic referral for patients discharged from hospital with chronic disease. The CKOHT will expand this approach to other education programs open to the public and promoted as a CKOHT education program regardless of location.

The CKOHT will align DECs by creating one electronic referral process and standardize documentation and communication. The team will explore expanding these services to include LTC, retirement residences, assisted living and FHTs. The DEC decentralized concept will also be explored for other services.

Flexibility

The CKOHT recognizes that health literacy impacts a person's ability to navigate the healthcare system, including filling out forms and engaging in self-care and chronic disease management. Evidence shows that the attributed population is most likely to experience low health literacy (older adults, racial and ethnic minorities, people with less than a high school degree or low income levels and non-native speakers of English). The CKOHT will promote resources such as thehealthline.ca with an inventory of resources to support health literacy. The team acknowledges the need for some flexibility e.g. smaller groups or individualized solutions.

An inventory of cultural resources will be created to leverage services from all agencies in order to provide access to culturally appropriate care (e.g., French-speaking Dietitian, Traditional Healers). The CKOHT will leverage current resources to provide cultural training to providers on prevalent populations in the community.

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
The CKOHT recognizes the invaluable contribution caregivers play in the health care

system. CHOHT partners will be informed by caregivers to develop the tools and supports necessary for them to be successful in their roles.

Caregiver Distress: Alignment with Attributed Population:
With an aging, co-morbid population the demand for caregiving is increasing and becoming more complex. This is especially true in Chatham-Kent (CK) where the prevalence of seniors and individuals living with multiple chronic conditions is higher than the provincial average. CK also has a predominantly rural population with 60% of residents living in rural communities. This can lead to even greater challenges for caregivers including reduced access to resources, transportation issues and social isolation.

Existing supports for caregivers:
• Westover Treatment Centre (WTC) offers a weekend family program for family/friends of in-house clients who are living with addictions. WTC also offers a 7-day co-dependency program funded residential program for those affected by someone else's use of alcohol and other drugs and an aftercare program entitled Recovery Support that welcomes family members to attend along with the client.
• Thamesview Family Health Team offers Care for the Caregiver Group – a support group for caregivers of loved ones with any chronic condition, illness, cancer, injury, and/or disability (open to the public).
• LHIN Home and Community Care coordinates access to respite supports for caregivers.

Year 1 Initiatives:
The CKOHT will work with patient/family advisors to build upon the supports and tools currently available for caregivers. The following will be explored in Year 1:
• Link with the Change Foundation to access resources and understand best practices.
• Analyze current caregiver support programs and develop strategies to fill gaps such as rural access, overnights, bathing supports etc.
• Identify substitute decision makers and record in patients' medical records.
• Share information on transportation services available to take individuals to their appointments and attend programs/services
• Provide access to supports for addressing burnout and distress.
• Provide access to system care navigators and education coordinators. Support patients and caregivers through navigation, counselling, education, in-home respite and nursing support across all of CK.

Maturity

At maturity, the CKOHT will:
• Pilot a standardized assessment tool for caregivers during primary care visits (i.e. Caregiver Distress Index).
• Explore feasibility to expand adult day programs in rural communities.
• Offer new services in communities by expanding the patient's medical homes where

team-based health care providers will deliver medical care in the individual's community.
• Enable caregivers the opportunity to participate remotely in patient's appointments and treatment plans through virtual care conferencing.
• Enable caregivers to support patients receiving care at home with technologies such as Telemedicine, Telehomecare and eShift (See Digital Health supports Appendix B).
• Use a digital patient relationship platform (Co-Health) to conveniently access information and resources to manage and coordinate care, allowing caregivers to access important information about the care of the patient.
• Expand role of municipal community navigators to scale and spread social prescribing for patients and caregivers.
• Explore the opportunity to create/develop support for Francophone caregivers

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
Alignment of Attributed Population and CKOHT Partners

Approximately 85% of the CKOHT attributed population is attached to team-based primary care, a solo-provider or is a resident in long term care.

The CKOHT Year 1 Population (Y1P) of 11,000 patients is mapped to one of the 4 team based primary care providers or is accessing home care services; therefore, the Y1P are patients of the existing CKOHT partner organizations. This offers a distinct advantage to the CKOHT in identifying and tracking patients throughout their journey.

The Principles – Developing and Sustaining Trust between Patients and Care Providers

Partners recognize that not all within the Y1P will want or need the same level of care coordination or system navigation. Decisions regarding the level of individual coordination and navigation will be made between the patient and their provider using guidelines co-designed by the team. For example, patients who are self-advocators and feel confident self-managing may need minimal navigation to connect with the healthline.ca while other more frail and complex patients might require their own system navigator.

Having a better holistic view with what is happening with the patient through their health care journey will strengthen the relationship between the patient and their provider. For example, collaboration between hospital and primary care demonstrates provider awareness of the patient's journey and follow-up contact will allow patients to feel that their provider cares and understands what's happening to them.

Mechanisms and Processes

Electronic Medical Records (EMRs) will provide the primary data sets for Quality Improvement and Decision Support Specialists from partner organization to identify and track Y1 patients. This information will be shared amongst health care partners with a joint commitment to ensure all care information regarding the patient will be shared and stored with their primary care provider.

Tools

To identify, track and follow-up appropriately, the CKOHT will use common data sharing tools. The patients' care path can be illustrated through various on-line platforms such as Clinical Connect, CHRIS, eNotifcations, Coordinated Care Plans and EMRs. A priority in Y1 will be to ensure all partners have access to these platforms.

Integrated delivery systems require strategic alignment and an appropriate set of measures to effectively structure, monitor and evaluate performance and outcomes. Areas that have already begun aligning performance measures include Health Links reporting for all Health Links partners and developing common primary care program standards and evaluation methods. In the first year, the CKOHT will implement and monitor new performance outcomes related to care coordination, system navigation and effective transitions utilizing existing platforms.

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 CKOHT supports the call to action in the Truth and Reconciliation report: "Indigenous Health in Indigenous Hands" and believes that health care for Indigenous people should be managed by Indigenous-governed organizations. This applies to leadership, needs assessment, program planning and delivery, evaluation and governance frameworks.

Honouring this commitment is essential to "walking the walk" of reconciliation. The London District Chiefs' Council devised the "First Nations' (FN) Declaration on Health Care" (May 12, 2019) reinforcing the foundations of the First Nations' inherent rights to self-determination and collectively proclaims the First Nations' jurisdictional authority over health care issues affecting and/or impacting FN communities and their members. Currently, the respective Band Council Resolutions are in process and the overarching Health Policy is being devised by the Indigenous Secretariat. This Policy will outline the respective engagement strategy, consultation processes, duty to accommodate, involvement, funding considerations and governance structures. The CKOHT will uphold these expectations/accountabilities once received. Proponents of the CKOHT have also reached out to the local Walpole Island (WIFN) and Delaware First Nations. WIFN is not a part of the London District Chiefs' Council.

The regional Indigenous Health Planning Committee (IHPC) expects health and community providers to embed the Indigenous culturally based integration model into their service delivery. IHPC has created Indigenous Care resources for partners (guide, care path, CCP, etc.) to ensure culturally-based anti-oppressive care is provided. Developed by Indigenous communities, and drawing on regional Indigenous peoples' history, the Cultural Structural Model focuses on issues of health equity and determinants of health that are specific to Indigenous people and communities. It

affirms Indigenous rights to health and to determination in health from Indigenous perspectives. It supports reconciliation, healing, community development and recovery of Indigenous communities' authority and rights to self-governance and determination. By embodying the principles of this framework, the CKOHT will develop and enhance trusting relationships with Indigenous people, families and communities to create lasting systemic change.

It is recognized that this change will take time. This is not a Year 1 strategy, rather something that will begin then and will continue through to and past maturity.

At maturity, the CKOHT partners commit to embody allyship with Indigenous healthcare providers and the people they serve:
• Recognizing the distinct and specific histories, needs, legal rights and constitutionally protected rights of Indigenous peoples.
• Ending systems of colonization and oppression that undermine Indigenous rights to determination in health.
• Applying the principles of respect, inclusion, accountability and equity.

To fulfill this commitment, the CKOHT partners will ensure that:
• Governors, staff and clinicians complete online Indigenous Cultural Competency Course currently funded by the LHIN (or equivalent) to improve understanding of culturally safe practices.
• Initiate meaningful dialogue with partners and communities about Indigenous-specific health inequities and oppression.
• Planning activities are inclusive of Indigenous-governed health centres and/or Indigenous health leaders to direct the Indigenous health services in the region.
• Action plans include reference to transferring control of services provided to Indigenous clients back to Indigenous people and communities, without offloading the burden of cost.

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 CKOHT recognizes the additional stress language barriers place on patients and is committed to actively providing services in English and French, respecting the

provisions of the French Language Services Act. It will actively work with Francophone communities, the Erie St. Clair (ESC)/South West (SW) French Language Health Planning Entity and the local French Language Services Coordinator to design, adapt, implement and evaluate services to meet the needs of the Francophone population.

At a September 2019 engagement session, 18 participants reiterated their desire, need and right for health services in French; most were bilingual seniors. One participant reported that being able to speak French with her oncology nurse lifted a weight off her shoulders and alleviated her anxiety. Knowing that she could talk to someone who understands her and can explain things in her language reassured her. The CKOHT recognizes that although it is about a medical issue, encounters with patients fall into the social realm. In other words, it is not about the medical terminology, it is a human interaction.

Participants expressed that they want the following from health providers:
• Services in French at all access/registration points
• A French-speaking professional to accompany patients throughout their journey and smooth transitions between services.
• Available services in French easily identified, e.g. the bilingual wicket at Canada Customs.
• Easy to use information system where people can find the information they need, when they need it.
• Virtual tools to deliver health promotion and prevention activities.

A common CKOHT French Language Services Plan will further address patient feedback and meet legislative requirements.

In Year 1, the CKOHT will develop a plan that all member organizations will adopt. The delivery of services in French will be based on the principle of active offer to ensure French language services are clearly communicated, visible, available at all times, easily accessible and equivalent to the quality of services offered in English.

Training will begin in Year 1 and will be scaled and spread to all by maturity.

By maturity, the French Language Services Plan will include, without being limited to, the following elements to increase access to services in French:
• Cultural competency training of staff, volunteers and board members
• Active Offer training developed by the Réseau du mieux-être du Nord de l'Ontario
• Cultural and Linguistic Sensitivity Training developed by the ESC and SW LHINs
• Identification of the linguistic identity of patients at first contact
• Capture language preference information in a prominent location in the health information system
• Identify existing bilingual human resources and volunteers
• Recruit bilingual human resources and volunteers with preference given to bilingual candidates when all other competencies are considered equal

• Build partnerships with French-language colleges and universities and host bilingual trainees
• Offer French language training to staff
• Use of over-the-phone professional interpretation services as required as direct services are preferred.
• Encourage the use of available tools and resources, such as the Community of Practice for Bilingual Professionals
• Create referral pathways for Francophone patients

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

In recognition of the diverse populations within Chatham-Kent (CK) as described in section 1.3, the CKOHT partners are vested in promoting holistic wellbeing (including physical, mental, social, emotional, and spiritual) through population health planning, community development, and support for the social and structural determinants of health.

Specifically, through its members, the CK Welcome Network helps connect new or any residents to the people and services that can assist with a variety of settlement or immigration issues. Businesses and organizations join the Welcome Network by demonstrating they meet a variety of criteria around Cultural Awareness and Cultural Sensitivity. They provide information on the Welcome Network to their staff who then assist anyone seeking information about the Welcome Network and refer them to settlement supports on the LivingCK website or through Adult Language and Learning programs with the Municipality.

The CKOHT partners are committed to embedding the Alliance for Healthier Communities Model of Health and Wellbeing as well as the Indigenous Cultural Structural Model & Care Guides in care and service delivery. These documents support services that are community-governed and grounded in community development; based on the social determinants of health; are anti-oppressive, culturally safe, and accessible; are inter-professional, integrated and coordinated; demonstrate accountability and efficiency; and respond to population needs.

In Year 1, the CKOHT will assess how these frameworks may be applied to specific vulnerable subsets of the Year 1 and at maturity attributed populations. Working with collaborating organizations in the social service sector will be helpful to support these populations as well.

Furthermore, the partners will champion health equity by making it a strategic priority, take specific actions to address multiple determinants of health on which the organization can have a direct impact, decrease all forms of discrimination and oppression within each partner organization and develop and/or enhance partnerships to improve health equity at the societal/population level and recruit for diversity. For example, the agencies will work to employ the principles of "Active Offer", social prescription strategies, commit to cultural and linguistic sensitivity training for their teams, offer services and/or access to certified professional interpretation to support non-English speaking individuals and seek to recruit diverse multilingual and rainbow staff representative of the client populations that are served.

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

"As a patient, we have been involved from the beginning" is a principle central to the CKOHT.

Principles

Grounded in the Ontario "Patient Declaration of Values" developed by the Minister of Health's Patient and Family Advisory Council (PFAC), the CKOHT is co-designing a health care system with and for its communities; a system reflective of the unique needs of all patients, including Francophone and Indigenous peoples. The CKOHT has incorporated the evidenced-based practices of quality improvement and experienced-based co-design. For example, the CKOHT has adopted the principles outlined in Health Quality Ontario's patient engagement framework coupled with resources from The Change Foundation regarding patient recruitment, engagement and co-design considerations.

Current Approach

Patient advisors inclusive of patients, family members and caregivers have been involved in all CKOHT engagement sessions held in April, June, September and October 2019. These sessions were on diverse topics with different participants ranging from clinicians to board governors. This underscores the patient partnership commitments and an understanding that this perspective is a must vs. a nice to have at every step of the way.

Many of the CKOHT partner organizations have experience with Patient and Family

Centred Care with robust Patient, Client and Family Advisory Councils/Structures of their own. Patient Advisors (PAs) were recruited from the Phase 1 CKOHT partners and were involved at every step of the Self-Assessment and Full Proposal development. A total of 24 PAs contributed their voices and invaluable wisdom to the Steering Committee and each of the six work streams. A Patient Advisor serves as Co-Chair of the Steering Committee. The principles of partnership, learning, empowerment, transparency, responsiveness and respect are evident in this approach.

These patients and caregivers were engaged with primary care providers, staff and leaders in identifying value added activities and programs, change ideas, appropriate and meaningful measurement and evaluation criteria. This will ensure that the "needles" the CKOHT is trying to improve upon are meaningful for patients and indeed positively impact the quality of their care experience. Refer to Appendix 4 for the detailed driver diagram outlining the CKOHT's patient engagement framework and incorporating HQO's patient engagement framework.

CKOHT also believes in targeted engagement to reach a diverse range of perspectives beyond the dedicated PAs. In the full proposal development, this included approaches across the multiple health and social service agencies (e.g. Prosperity Roundtable Lived Experience Group, Chatham-Kent Local Immigration Partnership Table, Indigenous Health Planning Committee, LHIN PFAC, hospital PFAC, Canadian Mental Health Association- Lambton-Kent client advisory committee, Chatham-Kent Community Health Centre client advisory committee, Tilbury District Family Health Team PFAC, etc.). This provided diverse representation and engagement in planning from across the rural and urban geography, Indigenous, Francophone, care partners, persons living with mental health and addictions as well as marginalized populations.

Clinicians like physicians and nurse practitioners are key partners in co-designing a health care system that addresses the needs of all patients. They too had representation on the Steering Committee. An engagement session that was attended by 80 clinicians also included PAs and the shared interaction helped strengthen the application.

Year 1 and at Maturity
It is understood that inclusion of the patient voice will continue to be an expectation of all aspects of CKOHT planning, monitoring and evaluation processes going forward.

Similar to the proposal development Steering Committee, the CKOHT's transitional governance structure to be established in Year 1 will include PAs as representatives in this decision-making body. Representative(s) at the governance table will also sit on a larger formalized CKOHT Patient Family Advisory Council (PFAC) which will be established to ensure open lines of communication. These PAs bring with them first-hand experiences with the health care system, and the passion needed to successfully design a strategy to improve access to care and make the system easier

to navigate for everyone.

In addition, targeted independent population based focus groups will continue to shape this work based on their preference for face-to-face engagements (e.g. Francophone, Indigenous, Low German, etc.). This supports the patient-centred approach in meeting individuals “where they are at”.

The official website (ckoht.ca) as well as social media channels offer effective and timely communications regarding CKOHT progress. Communication is anticipated in both official languages at maturity (English and French). Partners are excited to engage with communities through these avenues and look forward to hearing patient stories and ideas that will help guide the work.

Furthermore, to ensure that all persons have opportunities to provide feedback, the CKOHT partners will use a wide variety of feedback methodologies including, but not limited to, digital tools, comment boxes, regular evaluations, patient/client/caregiver satisfaction surveys, client experiences, focus groups, open houses, health fairs, community forums, needs assessment, etc. to further understand individual’s experiences and areas for improvement. Listening to patients and evaluating the process and outputs of patient engagement activities through direct feedback at regular intervals will ensure that patients are and caregivers have been meaningfully engaged. It is anticipated that by maturity, these tools will be standardized and will include the ability to benchmark across OHTs.

Engagement efforts are really about ensuring the Chatham-Kent Ontario Health Team is successful in improving health care for the 105,000 people in its service region at maturity. A strong partnership between all health care providers, patients, families and community groups is key in developing a health care system that all can be proud of.

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

Evidence of Shared Vision and Direction – Health Links

The CKOHT shares common goals, values and practices. Many of these same organizations came together in the past for successful collaboration through the development of a regional Health Links approach to care. From the beginning of the CKOHT's development and planning, partners have endorsed and supported the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

CKOHT – Creating a Shared Vision

At an engagement session in April 2019, Patient Advisors, Clinicians, Governors and Leaders from the CKOHT Phase 1 and at maturity collaborating partners created the vision of the CKOHT: "Achieving the best health and wellbeing together".

There is interest in the community to come together to improve patient experience and provide better quality care. This was evident through the overwhelming response and participation during CKOHT engagement events before a decision was made to submit an OHT application. The uptake in the creation of the CKOHT was very positive and partners were excited about the opportunities ahead for patient care.

A pre-existing and established openness and willingness to collaborate, ensures all voices in the system (including patients and caregivers) are well represented, no matter the size of the organization. The CKOHT has considered and valued all input received from all stakeholders that have been engaged throughout the co-design process. Operational challenges related to governance and funding have not hindered the team's main focus of providing quality, patient centered care.

Future Planning in Year 1

The CKOHT recognizes a need to develop systems, structures and processes that will allow partners to further build trust and collaborative environments while embarking further on collective health system planning.

Health care providers will work together as a team to deliver a full continuum of care,

regardless of organization or physical location while identifying common goals related to improved health outcomes and patient and provider experience.

The CKOHT partners support the Patient Declaration of Values for Ontario: Respect and Dignity, Empathy and Compassion, Accountability, Transparency, and Equity and Engagement. These values have guided the planning and development to ensure organizations reflect on the values that patients and caregivers expressed as important features in their health care. This commitment ensures that patients are at the centre of everything.

The CKOHT has created a draft Strategic Management Framework model (Appendix 8), inclusive of a strategic plan to guide its work. The development of a strategic plan will be one of the first actions following the confirmation of a formalized governance structure supported by a Collaboration Agreement.

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

Decision Making Principles – CKOHT Full Proposal Development Steering Committee

From the beginning of this journey, the CKOHT partners have approached this work with a spirit of collaboration and equality of all members. A Steering Committee was stuck to approach the full proposal development with the following principles:

Guiding Principles (from the current Steering Committee Terms of Reference)
Decision-making is guided by the Patient Declaration of Values for Ontario:
• Respect and Dignity
• Empathy and Compassion
• Accountability
• Transparency
• Equity and Engagement

The commitments, endorsed by all partners, guide the work of the CKOHT. These commitments will continue to evolve as partners work collaboratively together:
1. Focus on keeping people well and supported to live in the community.
2. Focus on the whole person and family within their context.
3. Address barriers to health (e.g. social determinants).
4. Evolve primary health care, as well as community and social services and supports, as strong foundations of the health system.
5. Ensure coordinated care, seamless transitions for clients/patients/residents/care partners and families.
6. Expand access to inter-professional and inter-sectoral team-based care for clients with complex needs.
7. Share leadership and advance collaborative governance relationships.
8. Engage clients/patients/residents/care partners/families and providers in our work.
9. Work with and for Francophone and Indigenous populations to address health disparities and provide quality services, while working to address the unique health needs of all equity seeking groups.

The Steering Committee established a Governance and Leadership work stream to explore options for collaborative leadership and shared decision-making. Options were reviewed and recommendations made to the Phase 1 partners for a Year 1, Transitional Governance Model (Appendix 3).

Year 1 Transitional Governance Model – Collaboration Steering Committee

Central to the success of this model is the creation of a Collaboration Steering

Committee, governed by a Collaboration Agreement that has yet to be drafted. Drafting and execution of the Agreement will be the responsibility of the Collaboration Steering Committee. This work is intended to commence immediately following the proposal submission. The target date for completion of the Agreement is December 31, 2019 to ensure that a structure is ready to be enacted with Ministry approval of the CKOHT.

In developing the Collaboration Agreement, the aforementioned principles will guide the development of the Agreement and/or inclusion in the Agreement.

Collaboration Steering Committee Composition:
As the Year 1 decision making body, membership-representing Health Care Organizations, on the Collaboration Steering Committee will be limited to most senior executives (CEOs and EDs) or their designates, Patient/Client, Family Caregiver Advisory Panel Leaders, and a Primary Care Advisory Panel Leader (see below CKOHT Patient/Client, Family Caregiver and Primary Care Council for greater detail). Membership on the Collaboration Steering Committee will be limited to parties to the Collaboration Agreement.

Organizations that have come forward to participate as full Phase 1 partners – by signing the self-assessment and/or the full proposal submission, in addition to clinician and patient/client, family and caregiver representation – will take the responsibility of leadership during this transitional phase of the OHT.

It was deemed that the number of partners in Phase 1 provides for breadth of scope and is of a reasonable size to all for full membership at the Steering Committee. It is acknowledged that as additional organizations join the CKOHT, a process will need to be developed to create a more representational membership model for the Steering Committee to ensure that the size of the Committee remains functional. The Steering Committee will achieve this objective in year 1.

It is also imperative that there be a link to each partner's organizational governance: A Council of (Board) Chairs representing all partner organizations will be established. The primary objective of the Council of Chairs is to ensure communication and alignment of the CKOHT Steering Committee to the work of each partner's Board of Directors. At a minimum, the Council will meet annually.

Collaboration Steering Committee Mandate:
The Steering Committee will identify areas for integration patient/client care (priority populations) and develop implementation plans that may involve a subset of team members:
• Year one priority/target population
• Planning for year 2 and beyond priorities
• Adherence to the Ministry's requirements:
• Enable the development of a strategic plan
• Enable the development of a common brand

• Ensure patient engagement
• Ensure engagement with primary care
• Develop plans for evolving governance to single fiscal and accountability framework

Decision-making:
The Governance and Leadership work stream recommend that the collaborative and voluntary nature of the environment that has led to commitment and endorsement of the CKOHT demands that a consensus building approach, using evidence to reach decisions, be adopted and be the primary method of decision making.

Consensus does not require that all parties agree, but can all support a decision. In addition, for some decisions where a majority or super majority is acceptable (e.g. election of a chair), voting with 1 member 1 vote will be applied.

Dispute resolution:
Disputes can happen at the Team Member (corporate level), within the Leadership Group/Governance Council, or within a specific Project.

Escalation process:
• Dispute avoidance through good communication/meeting management processes
• Exchange of issue statements between disputing members
• Referral to Steering Committee
• Referral to Board Chairs Council of (Board) Chairs
• Referral to mediation (non-binding)
• Disputing parties either accept outcome, or if they cannot do so, have a right to exit the OHT on sufficient notice (implications are you lose your seat at the Governance Council table) but would continue to participate in any integration projects, or,
• Binding arbitration as a last resort if all other mechanisms have failed.

Resource allocation:
From the beginning of the collaborative work in the OHT self-assessment process, the CKOHT partners have been committed to sharing responsibility and fairly sharing cost to support the OHT work. Partners have contributed resources including administrative support, project management, financial and performance analytics and decision support under the rubric of a secretariat function.

Management Structure:
Going forward the partners have agreed to formalize secretariat and coordination functions that will report to the Steering Committee. Next steps, to be completed by December 31, 2019 include:

1. scoping secretariat/coordinating functions required to meet the year 1 objectives of CKOHT;
2. inventory or resources available across the OHT partners' organizations that can be deployed to enable the secretariat function; and
3. identification of costing of any addition of secretariat/coordination resources

required.

Patient, Family and Caregiver Involvement
The CKOHT partners have undertaken an inventory of all patient/client, family and caregiver engagement strategies and activities used by the members. Each member organization nominated patient and family advisors (PAs) to work streams and the steering committee leading this application process. The Diversity and Equity work stream ensured that PA representation was reflective of the broad community's diversity and health care needs.

"Nothing about me, without me" is a principle central to CKOHT. The unique experience and perspectives of patients and families will continue to be incorporated through experience-based co-design in the CKOHT development and subsequent service redesign. PAs as well as a mixture of governors, administrators and primary care providers initiated the CKOHT process; unified the vision "Achieve better health and wellbeing together" towards transforming care in CK using an inclusive approach.

Going forward, the creation of a CKOHT Patient/Client, Family and Caregiver Advisory Panel is recommended. The Advisory Panel will have a mandate to provide advice directly to the Steering Committee.

The Advisory Panel will elect 2 members of the panel to sit as members of the Steering Committee to act as liaison and ensure that the voice of the patients/clients, family and caregivers is represented in the Steering Committee.

Active Leadership Engagement of Primary Care:
The CKOHT Steering Committee hosted a Clinician Engagement Session in September 2019. The session was attended by 84 clinicians, representing more than 90% of all of primary care providers in the catchment area. Primary care providers were asked how they wish to remain directly engaged in the leadership of the OHT, and clear and helpful advice was provided. Primary care providers strongly confirmed their willingness to continue to be engaged and provide leadership. Advice included ensuring transparency and clarity about time commitments and input sought from primary care providers; adequate notice of meeting times and time to engage peers; use of surveys for input; opportunities for leadership and mentorship of emerging primary care leaders; and, overall, to be treated as valued and respect partners. A significant challenge identified is compensation and/or locum coverage for clinical responsibilities to enable their ongoing clinical leadership participation.

The Medical Advisory Committee and Medical Staff Organization of the hospital were engaged for input. These groups stressed the need to determine how specialists will interact with the CKOHT. It is recommended that specialist engagement begin; however, priority is given to primary care engagement in year 1.

A Primary Care Council will be created to support the CKOHT. The Council will have a mandate to provide advice directly to the Steering Committee. The chair of the

Primary Council will be appointed to the Steering Committee to act as a liaison and ensure the voice of primary care providers is represented in the Steering Committee.

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

Current State and Year 1 Approach

The CKOHT is well positioned to share information electronically while evolving its information access capabilities and adoption. A service design approach is being implemented, which allows for iterative planning to address immediate needs, and simultaneously co-creating services that will be efficient and effective as the CKOHT continues to mature and evolve.

The CKOHT intends to leverage existing assets with a track record for success to support providers and their patients. First steps to address gaps have already been taken with the completion of a digital health tools gap analysis and supported by the existence of a regional data sharing agreement (DSA), which clearly outlines each party's obligations relative to safeguarding patient information (e.g. compliance with PHIPA, organization specific privacy practices, etc.). That being said, a key year 1 activity will be to review the DSA to ensure it meets CKOHT needs and to consider the CKOHT as a single Health Information Custodian (HIC) or equivalent to support the central management of health privacy issues.

Finally, the inclusion of Transform Shared Services Organization as a Phase 1 partner provides significant digital content expertise and support to the CKOHT that can be leveraged in the future.

Current Digital Asset Analysis and Actions
The full current state assessment is attached as Appendix 9.

Of the 14 partner organizations, 83% receive Health Report Manager (HRM) Reports and 100% receive eNotifications.

Clinical Connect and Provincial Assets
The CKOHT aims to quickly improve information exchange and digital health adoption by filling gaps identified above. At present, 64% (9/14) of the CKOHT partners are HICs with legal authority to collect, use and disclose personal health information (PHI) for providing health care. These organizations already have access to ClinicalConnect™. St. Andrew's Residence and Westover Treatment Centre will be scheduled for adoption early in year 1. Although parts of March of Dimes services qualify for partial access to ClinicalConnect, a more detailed review of their needs alongside access restrictions will be undertaken.

Within ClinicalConnect, 17 priority data sets are already integrated through the work of the cSWO Program over the past five years. These are listed below:

- Admissions
- Allergies
- Blood Bank
- Home/Community Care
- Census
- Face Sheet
- Immunization (Gap)
- Lab
- Microbiology
- New Results
- Orders
- Pathology
- Patient Summary
- Hospital and Home Meds
- Primary Care
- Radiology
- Transcription
- Visits

An early assessment of available data in ClinicalConnect by the CKOHT indicates Immunization data is a key data gap in the current state.

Similarly, while the deployment of provincial repositories via ClinicalConnect is underway, (OLIS, DHDR, DICS, acCDR, pcCDR) there are still several gaps to be considered and closed in Year 1 to enable the full data set to be shared amongst OHT partners.

Note: 5 of the 14 partners do not have MOH approval for access to provincial assets. These issues will need to be further explored and data sharing options and recommendation developed.

Looking at partner point of service (PoS) solutions across the health sectors, several opportunities to help build digital maturity have been identified.

100% of hospitals in the ESC LHIN and many neighbouring LHINs already contribute data to ClinicalConnect. These hospitals are now focused on a Hospital Information System Renewal (HISR) project, called e-VOLVE, which will improve the hospitals' digital health maturity and set a new foundation for further growth and expansion of digital health services. Chatham-Kent Health Alliance (CKHA) has a go-live target of June 2020 with e-VOLVE. In Year 1, the CKOHT will work together with e-VOLVE and CKHA to identify community services that may be implemented and/or extended outside of the hospital walls to benefit the Year 1 Population (Y1P) and digital maturity of the CKOHT.

Primary Care EMRs
Across the four primary care organizations, there are four distinct EMR instances and three EMR vendors. Primary care is largely siloed data today with the exception of Thamesview FHT, which was one of four FHTs province-wide to participate in the cSWO Primary Care Data Sharing (PCDS) pilot; and whose data is now viewable in ClinicalConnect. While the PCDS pilot is on hold, pending broader provincial planning, expansion to the other three FHTs in CKOHT would greatly improve information exchange within this OHT in a shortened timeframe. Future consideration of these PoS instances may offer standardization and increased efficiencies in terms of integration (in/outbound), licensing, and cost savings, and will be explored in Year 1.

Sharing of patient medication reconciliation information amongst the CKOHT organizations is an example of improving transitions of care and improving both patient experience and patient safety. In year 1, an early objective is to enable/increase access to medication information stored within the primary care EMRs and draw on source medication information from the Digital Health Drug Repository (DHDR), which will result in a more complete, consistent and safe medication reconciliation process. This current gap is evident from the preliminary workflow review attached as Appendix 10.

Other Digital Health Solutions
Health Report Manager (HRM) with eNotification will also provide primary care practices with timely access to patient reports from within EMRs. Likewise, ESC's legacy HRM Readiness (ESC Labs) tool provides similar functionality as HRM, and appropriate transition/migration plans will be developed to support the OHT in year 1 alongside evolving provincial assets. Wherever possible, gaps in accessing these tools will be closed.

To date, significant investments have been made to support the creation of 135 care coordination plans in Chatham-Kent. The value of care coordination is realized today and realignment with CHRIS care coordination tools will be planned effective October 23, 2019.

Patient Data Flow
Appendix 10 provides an example of patient data flow within the Tilbury District FHT (TDFHT). The data flow indicates that while some information is obtained electronically, there is still a portion received from non-electronic formats including paper and faxes. Appendix 11 provides an additional view of how the patient experience is supported by digital health solutions to improve patient safety, patient experience and effective and efficient delivery of care. While there are many effective digital health solutions in place to support sharing of information within the CKOHT organizations, there are a number of gaps, as identified in Appendix 9, which need to be closed to further enhance information sharing and the patient experience.

Immediate Opportunities
1. CKOHT will look for early opportunities to improve care coordination and documentation between transitions in order to avoid “double documentation”, and to avoid errors due to missing or incomplete information.

2. Similar to primary care, each of the community sector organizations have their own information system. Today, only records from Home and Community Care (H&CC) are viewable in ClinicalConnect. Other key community data sources as well as data sharing opportunities will need to be investigated in Year 1. In the meantime, current patient information sharing practices will continue.

3. Many of the CKOHT partners have already completed the provincial privacy and security assessment, education and training for access to provincial data sets, which helps to ensure the protection of PHI. The CKOHT plans to continue with this process for the remaining partners in gaining access to provincial assets in Year 1, as well as for those organizations who are awaiting approval for access.

4. ClinicalConnect, provincial repositories, and ONE ID deployment, supported by privacy and security assessments, education and training has been provisioned through the cSWO Program, with TransForm as the local delivery partner in the ESC LHIN since 2014. Deployment of these solutions to additional organizations and closure of gaps within existing organizations continues to be an immediate opportunity.

5. Strong change management and adoption regional capacity, capabilities and methodology, strengthened by an underlying benefits evaluation program has been fundamental to EHR adoption over these past five years. Funding to support the continued access and adoption is in place until the end of March 2020 through the cSWO Program. Planning is required to identify how change management and adoption (CM&A) consistency and continuity will be maintained through this transition

to maintain a strong digital health change management and adoption delivery model within the CKOHT and regionally in Year 1.

6. Additional opportunities to expand information sharing across the CKOHT team members exist through:
a. EMR consolidation
b. Expansion of primary care data sharing solutions to allow sharing across all primary care organizations within CKOHT
c. Contribution from and access to immunization data by all CKOHT organizations
d. Contribution of results to HRM by additional organizations
e. Review and revision of data sharing requirements and agreements
f. Provincial policy changes, e.g., PHIPA updates and additional HIC types approved for access to provincial assets.
g. Provincial standardization of assets and data gathering

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

Transparent Sharing of Performance and/or Compliance Issues:
During the self-assessment process, an attestation was provided by the Erie St. Clair LHIN regarding the financial health of the proponents of the CKOHT. This gave partner organizations the confidence to continue to work together towards the full proposal document.

A survey of CKOHT Phase 1 partner organizations was completed and confirms that the partners have minimal current issues with governance, financial management, etc. Based on this self-reported methodology, concerns that have been addressed include:

• The Chatham-Kent Community Health Centre in 2012-2013 and 2013-2014, (prior to current leadership and Board of Directors), had deficits in the amount of $348K. Despite attempts, the deficit is unable to be forgiven by the Ministry and has resulted in the organization operating on a line of credit to mitigate resultant cash flow issues. To prevent further future deficits, new financial monitoring and oversight processes have been established along with significant training of the skill-based Board. At present, the deficit can be reduced through the application of non-constrained fundraising/donations.

• March of Dimes - Organizationally MODC has MSAA agreements in 13 LHINs. In 2018 the ESC LHIN issued a Performance Improvement Plan (PIP) for the Chatham/Sarnia programs. The PIP was based on the delay of implementing the Hub and Spoke Model, shared services with LHIN Home & Community Care resulting in persons being over served and to ensure a collaborative approach in addressing the wait list management for Congregate Care Home.

• Chatham-Kent Health Alliance (CKHA) was placed under provincial supervision as a result of governance and cultural issues in August 2016. The hospital emerged from Supervision in 2018 as a single corporation (previously 3 organizations), established its new governance model and welcomed its inaugural Board. This process also strengthened financial controls and policies. A number of leadership and structural changes ensued including a new CEO and leadership team in 2017, who continue to

strengthen the commitment to accountability. CKHA currently maintains a positive financial position with increased staff and patient satisfaction scores year over year since 2017. CKHA foresees no negative impact of this experience on its participation in the CKOHT and in fact, sees the integration experience of 3 hospital corporations to 1 as advantageous.
• St. Andrew's Residence, Chatham, had deficits in their LHIN funded Community Support Services in 2016-2017 ($32K), 2017-2018 ($6K) and 2018-2019 ($30K). This deficit was addressed by application of surplus funds from other business centres in the organization. As a charitable not-for-profit organization, the Board of St. Andrew's Residence have made the decision to financially support these critically necessary community services when a deficit occurs. To prevent further deficits in the future, financial monitoring and oversight processes have been revised and adjusted.

Process in Future
Partner organizations are expected to be fiscally sound and demonstrate accountability.

Formalized accountability structures are part of the proposed collaborative governance model, with specific mechanism for ensuring performance and compliance to be contemplated in conjunction with the drafting of the Collaboration Agreement (see section 4.2).

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

Background

Data driven decisions are at the CKOHT's core. The majority of CKOHT members have dedicated supports in areas such as: quality improvement (QI), performance, decision support (DS), evaluation, project management and leverage tools with predictive features. These skills are integral to establishing and supporting best practices, enhancing organizational competencies and building a culture of continuous improvement. In addition, the Erie St. Clair LHIN historically provided data across all sectors including population health data. The Secretariat described in section 4.2 that will support the Collaboration Steering Committee will draw from these resources and experience.

CKOHT Experience

To identify CKOHT members experience and examples of performance and quality improvement (QI) a survey was conducted with all members.

79% of CKOHT members ranked their experience in QI and performance as excellent or good and 21% ranked average.

Members' experience in QI includes developing processes and measures to assess progress year to year, identification of performance targets, ensuring the voice of the patient is captured, adoption of evidence-based practices, and the allocation of staff time and budget/funds to support learning. Areas of shared improvement (cross sector and enabled through analytics and decision support) include:

• Sub Region Accountability Table improvement projects (aligned to key priorities within the sub region)
• Population Health Solutions work – partnership including LHIN, Hospital, Public Health etc. – allowing further drill down capability for population health and healthcare utilization data to support/ drive improvement
• Common data sharing agreements and community of practice groups

71% of CKOHT members stated that they have experience leading successful cross-sector or multi-organizational improvement initiatives. Examples include:

• Three Family Health Teams (FHTs) participate in regional Primary Care Innovation Collaborative, which designs programs and pathways for regional initiatives and has shown tremendous improvements in outcomes and quality of life for COPD patients.
• FHTs share QI and DS resources providing consultative and analytical support regarding the collection, interpretation, analysis and presentation of data to help

teams ensure that clinical information management practices support best practice standards. For example, the adoption of Tilbury District FHT's effective hospital discharge follow-up process by over 20 FHTs in Ontario. The teams won a "Bright Lights" award at the annual Association of Family Health Teams of Ontario Conference. Currently, collaborative efforts are focused on standardizing the development, delivery and performance indicators for Programs/Services among FHTs.

• Chatham-Kent Community Health Centre (CHC) involvement in building a Learning Health System that includes: data standards, performance metrics, dashboards and reporting, data governance, research and timely evidence as well as culture for improvement as a sector using BIRT (business intelligence reporting tool within the Alliance for Healthier Communities sector) and collection of socio-demographic data to fully understand who we are serving in the marginalized populations.

• TransForm Shared Services Organization is leading a LHIN-wide transition to Cerner. As a partner, Chatham-Kent Health Alliance has over 140 people currently participating in the organization's single largest clinical transformation project. The work is grounded in the concept of improving the patient experience, adopting and enhancing existing processes, such as work done through the Cerner provincial reference model, and driving quality improvement initiatives like implementing common, electronic evidence-based order sets, care pathways etc.

Opportunities to improve system performance and enhance integrated care were hallmarks of the approach used to engage partners in the development of specific strategies to drive improvement for Year 1 Population such enhancing access to primary care and reducing ambulatory care sensitive conditions (See sections 3.1 and 3.2).

7% of CKOHT members ranked their data capabilities as excellent, 29% as good, 43% as average and 21% as fair with several organizations indicating no dedicated data analytics staff. However, there is strength in data analytics across the continuum and from a system lens, as demonstrated by the collaborative work done to support the submission. Population health, healthcare utilization, and costing analysis to drive improvement, has been leveraged to enable improvement and an understanding of value for money in key areas.

Building on the collaborative efforts above, the CKOHT will formalize this work over time to leverage resource capacity that presently exists. During the implementation phase the following strategies will be assessed to determine the best way to support the CKOHT, these include: creating a centralized pool of resources/back office support, agreed upon standard approaches and tools, evidenced-based practice learning forums, common indicators for member to measure against, predictive analytics, creation of common tools and training in areas of continuous improvement. As the CKOHT moves forward leveraging successful models of data analytics (population health and health care utilization) – it will be imperative to further evolve the focus to strengthen understanding of cost and value for money – given the goal of reinvesting in front line care.

79% of CKOHT members stated they had experience in mentoring or coaching others for quality and performance improvement or integrated care.

100% of CKOHT members are committed in principle to the quadruple aim as a common scorecard for shared results against key objectives, supporting continuous learning and accountability to improve performance and integrated care. Further work to formalize the process will be undertake as part of the governance efforts for implementation.

To address system-wide quality improvements, the CKOHT leveraged and customized existing frameworks to make the CKOHT quality improvement enabling framework (Appendix 12). This framework is a comprehensive approach to QI intended to drive continuous learning, inclusive of: Leading, Building System Capacity, Applying Evidence in Design, Person Centered, Enhancing Health Information System, Engaging and Motivating.

Partners are accustomed to the annual Quality Improvement Plan(QIP) process and as such, can use the framework to co-design strategies that address the needs of the Year 1 Population and drive system-level performance outcomes as identified by the data set. These tools combined with common QIP metrics in year 1 will facilitate integrated and focused efforts toward quality improvement.

Furthermore, the QI framework is embedded as a critical enabler to the recently created strategic management framework – a continuous cycle that drives toward our vision of “Achieving the best health and well-being together” through oversight of the CKOHT strategy and outcomes.

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 CKOHT commits to ongoing patient, family and caregiver engagement through the establishment of a Patient and Family Advisory Council. This builds on the active involvement of 24 patient advisors (PAs) as part of the full proposal development. (see Section 3.8).

86% of the partners have formalized processes to act on patient, family and caregiver feedback; providing input at all organizational levels from governance, strategic planning, policy development, organizational practices as well as programming design. Partner organizations have PAs embedded in their governance structures (e.g. Board Directors; Board Quality Committee representatives (e.g. Canadian Mental Health Association Lambton-Kent (CMHA LK)) as well as in operational decision-making architecture.

In all strategic planning processes within the CKOHT partners, PAs are included in the development of the strategic directions. Furthermore, PAs review of all patient-facing materials and conduct comprehensive reviews of evaluations and client survey feedback; making improvement suggestions.

For example, Chatham-Kent Health Alliance (CKHA) launched their refreshed strategic plan in 2018 using patient exemplars and patient involvement in the various town hall forums across CK. PAs actively participate in the recruitment of leadership positions within CKHA (CEO, VP, Director, Manager) and sit on all Program Councils. PAs have provided valuable input regarding signage, way-finding and physical plant re-design and all policies and patient materials are reviewed by PAs.

To further illustrate co-design efforts, based on feedback from the Rainbow Community, Chatham-Kent Community Health Centre's (CKCHC) client advisory committee endorsed making all washrooms gender neutral. In addition, various programs at CKCHC are facilitated by client advisors (e.g. Community Cuts) whereby they receive direct client feedback regarding programming.

All Quality Improvement Plans (QIPs) include engagement and review by PAs. QIPs are informed by patient experience. Currently, partners measure this in different ways e.g. NRC Picker Survey at CKHA, CCEE Survey for Home & Community Care; standardized patient experience survey within primary care. Partners also use website feedback, comment boxes, focus groups and evaluations from programs/services. QIP patient experience is targeted for improvement year over year and this is integral for ongoing monitoring in the proposed quadruple aim indices. Patient feedback provides valuable insight for quality improvement initiatives within established formalized and informal processes across all CKOHT partners as learning

organizations. The partners look forward to a more standardized process in the future.

Across Chatham-Kent (CK), all QI projects impacting patient care/service delivery include patient representation. CK's collective QIP indicator regarding palliative care quality improvement initiatives spanning acute care, primary care, LTC and home & community care is underway. The CK Health Link conducted 2 comprehensive experience-based co-design efforts to enhance the approach and coordinated care planning. The COPD care pathway was designed by the CK community with patient and caregiver involvement in 2015. Building on this foundation, the IDEAS COPD project further demonstrated the effectiveness of this transitional care pathway achieving 20% reduction in ED visits for this targeted population.

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

Principles

CKOHT partners regularly engage with the broader community. This is evident in the methodology used to create the CKOHT and the intentional strategies implemented to achieve an inclusive and well supported submission. This will continue as the CKOHT evolves and through the creation of key documents, such as its strategic plan.

Community Engagement in Proposal Development

In the full submission proposal development process, staff, leaders, and patient advisors (PAs) collaborated to support a Steering Committee and 6 work streams. Using the expertise within the community ensures that the application is reflective of the high-quality programs, services and overall health care being provided across Chatham-Kent (CK) while identifying opportunities with those who deliver and receive the care.

CKOHT's hosted engagements included leaders, governors, primary care providers as well as patient and family advisors of multi-system organizations ranging from 50-100 participants/session. Inclusion of PAs at all 5 sessions (June-Oct) including health, social services and educational sector representatives underscore both the patient partnership and community engagement commitments as equal and valued partners in all aspects of care re-design. These shared learning and co-design events advanced collective knowledge and understanding of successes to build upon and proposed solutions to enhance care.

The CKOHT also engaged with the Chatham-Kent Community Leaders Cabinet in September 2019. This is a group of business and not for profit leaders who come together to support the Municipality's strategic plan. Presentations were also provided by CKOHT leaders to Municipal Council in June and October of 2019.

The Municipality of CK inclusive of Public Health, Emergency Services, Employment and Social Services, Riverview Gardens LTC as well as Housing Services has been extensively involved and signed on as a full partner following approval to move to a full submission. Participation of Municipal and Public Health staff on the various work streams is another testimony to the coalition leadership efforts coupled with in-kind supports/resourcing.

CKOHT engagement efforts are broad and inclusive: from a dedicated engagement session with Francophones in Pain Court through a consultation with the Indigenous Health Planning Committee to attending a recent Age-Friendly Committee. Input from these sessions has been incorporated into the submission, draft frameworks or planned interventions to the extent possible as this work evolves. As a collective, partners are connecting with their various committees internally and externally to further gather input into CKOHT's development. As for the Francophone community, CKOHT will liaise with the ESC/SW French Language Health Planning Entity to further engage Francophones in this transformation.

Year 1
The official website (ckoht.ca) and social media channels were launched in early September and are considered the start of next steps for Year 1. Feedback and further engagements will inform the future CKOHT strategic plan. These efforts are really about ensuring the CKOHT is successful in improving health care for the 105,000 residents in the community. A strong partnership between all health care providers, patients, families and community groups is key in developing a health care system that all can be proud of.

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
Among the CKOHT partners there are examples of successful cross-provider funding arrangements that have enabled the CKOHT to develop capacity and skills in the area of shared funding arrangements and accountabilities.

In particular, Chatham-Kent Health Alliance (CKHA), Home and Community Care (H&CC) and 40 clinics have partnered for a Hip and Knee pilot project beginning April 1, 2018. This pilot helped to inform the mandatory provincial program that began April 1, 2019 for all acute care hospitals providing hip and knee joint replacement surgery. This enabled the development of cross organizational processes that can be leveraged by the CKOHT. By collaborating with the partners, CKHA as the Bundle holder is responsible to report on the consolidated cost of all services within the bundle.

Similarly, there are other examples of pooling of financial resources to achieve shared objectives and enable better health outcomes including:
• Family Health Teams shared FTE's for the Cardiovascular Program and standardized care;
• Alzheimer Society of CK First Link – Care Navigator in collaboration with Behaviour Supports Ontario, First Response, H&CC, CKHA, EMS, CK Police, retirement homes and Neurologist.
• Health Links – Providing in-kind Intensive Case Management resources within Canadian Mental Health Association Lambton Kent (CMHA-LK), CK Community Health Centre (CHC) and 3 Family Health Teams (FHTs), H&CC

Members of the CKOHT work with community partners to address a number of other critical healthcare concerns where collaboration is essential and sustainability is only possible by pooling resources. Examples include:
• CMHA Supportive Housing – Funding for both rent supplements and staffing is provided by the MOH and Municipality to address the needs of the homeless or those at risk of homelessness. Municipality also provides funding to CMHA for Crisis Accommodation when housing is not available.
• Access Open Minds (ACCESS) is a collaboration of community partners committed to offering youth, ages 11-25, and their families mental health support. Administered by the CMHA, ACCESS is funded through a national CIHR research grant and from Youth Wellness Hub, the municipality, community businesses and private donations.
• Outreach programs administered between various members including a Nurse Led Outreach Program (CKHA and LTC); Geriatric Mental Health Outreach (CMHA and CKHA); and more.

Finally, the CKOHT members have a number of arrangements in place where partners pool resources to harness cost saving and efficiencies:
• Leveraging purchasing power through Transform Supply Services; a hospital funded supply management organization, see section 2,4
• Back office shared services and integration agreements; CMHALK, CKCHC, Alzheimer Society of CK,
• Shared facilities whether leased or in-kind

CKHA manages funding models for multiple sectors including the Hospital, Community Mental Health & Addiction, and Community & Support. Through coding and manual collection of activity, the team is able to support CIHI reporting

requirements including NACRS, NACRS lite, DAD, NRS, OMHRS & CCRS as well as OHRS reporting.

Finally, CKHA has recently recruited a new Chief Financial Officer. The interview panel for this position included a CKOHT partner as it is anticipated that this role will be a fundamental support to the CKOHT Secretariat in the future.

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

Building on the Momentum

There is much activity already underway among the CKOHT partners and an intent to continue moving forward. The implementation plan focuses on integrated care redesign and is themed to guide the CKOHT in its formation and Year 1 (Y1) deliverables focusing on:

Patient Care and Patient Experience–system integration and redesign through co-design
Governance & Management–predominantly structures and strategies
Equity–integrating and applying an equity lens in all facets
Digital–enhanced access to digital systems and records

Post-submission to Approval and/or December 31, 2019

• A post-submission meeting is scheduled to bridge current Proposal Development Steering Committee and future state transitional governance model ensuring momentum is maintained
• Detailed review of current risk registry and lead CKOHT partners in a collective risk assessment and prioritization activity using the Healthcare Insurance Reciprocal of Canada (HIROC) model, to inform planning and implementation activities
• Develop and execute the Collaboration Agreement by Dec 31, 2019
• Develop the process to form critical Councils including: Chairs, Primary Care and Patient & Family. Ideally, populated Councils would be ready to mobilize upon approval and/or January 1, 2020
• Detailed scoping of CKOHT secretariat support/coordinating functions and process to secure resources
• Conduct broad community engagement and other activities necessary to inform the creation of CKOHT's strategic plan

Post Approval / 30 Days

Phase 1: Accelerating the integrated design effort that will drive outcomes and formalizing the foundational structures/systems required to support this work to maturity. This Phase will take 6 months to complete.

Patient Care

• Strengthening primary care leadership with a Primary Care Council; formal mechanism to identify leaders and provide a forum for involvement of CKOHT physicians and nurse practitioners. Identify primary care leadership needs and develop plans to close the gap.
• Address system navigation through enhanced understanding:

- build on current state to achieve a detailed inventory inclusive of resources, programs and clinical points of contact among partners and collaborators. Ensure healthline.ca and 211's information is accurate.
- share information on transportation services and virtually-based care (e.g. OTN) to increase access for patients and caregivers
- create common language reference tools, e.g. acronyms list
- inventory current and best practice patient/caregiver tools to explore opportunities for standardization and adoption
- Establish and secure inclusive representation on priority area workstreams

• Engage primary care leaders to endorse and support the transition of select clinical care coordinators from Home and Community Care (H&CC) to primary care and community organizations to enhance access for Y1P to coordinated care planning
• Expand the Medical Cannabis Program within CKCHC, CKFHT and TDFHT to offer alternative pain management supports for the Y1P

Governance & Management
• Support redesign work through effective governance, mobilizing Steering Committee and Councils with established meeting schedules
• Initiate CKOHT's multi-year Strategic Plan inclusive key performance/indicator accountabilities
• Educate the Collaboration Steering Committee on key resources, frameworks and tools created or adopted by the CKOHT, e.g. the Indigenous Cultural Structural Model, Quality Enabling Improvement Framework and Change Management resources
• Initiate a review of legal and and data sharing agreements required to support proposed CKOHT directions and activities

Equity
• Survey partners on linguistic capabilities and equity training–e.g. identify resources that speak multiple languages and those with specialized training, such as Indigenous Cultural Safety, etc. to support equity-informed and inclusive planning

Digital
• Initiate the creation of a clear CKOHT digital roadmap
• Partner organizations will address digital health gaps by beginning the application for access to ClinicalConnect and CHRIS for all Phase 1 partner organizations to strengthen coordinated care planning

60 Day Plan
The CKOHT will focus on increasing understanding, expansion of services and partnerships to serve the attributed population.

• Patient Care Mapping/co-design prioritized integration opportunities (e.g. a standardized intake tool, consolidated referral assessment and refining selected complex care pathways, etc).
- Co-design by leveraging Experience Based Design principles

- Map strategies across the continuum to capture opportunities for standardization to improve outcomes
- Identify areas to reduce waste/duplication to achieve efficiencies
- Review and analyse existing research/evidence-based tools and best practices, processes and pathways
- Analyse options and make recommendations

• Expand access to existing services
- Create a joint calendar for self-management programs, e.g. Master your Health Self-Management and First Link Learning Services
- Telephone Health Advisory Service (THAS) for after hours access to primary care

• Continue building of trusting relationships with community partners, neighbouring OHT's including tertiary centres and clinical leads in the community

Governance & Management

• All Councils, Committees and Work Streams are meeting regularly
• Explore the single Health Information Custodian (HIC) model and intiate the application process. Determine a transitional information sharing strategy for this interim
• Implement the strategy management framework and performance measures for the Y1P establishing joint accountabilities
• Collect baseline data and populate the balanced scorecard with annualized targets Initiate process to identify and cascade tools for consistent and appropriate monitoring

Equity

• Partners will begin developing an overarching equity inclusive strategy consisting of:
- A training plan using various equity training modules to integrate into existing processes (orientation) and systems (e-Learning systems) wherever possible
- Focus on the Model of Health & Wellbeing (MHWB), Health Equity Charter, Indigenous Cultural Structural Model, Active Offer and Indigenous Cultural and Linguistic training course deployment

• Regularly reaffirm the commitment to working with the indigenous communities:
- use appropriate protocols as defined in the forthcoming Health Policy Directions from the Indigenous Secretariat
- follow engagement expectations and directions from Walpole Island First Nation as an unceeded territory
- Approach the Indigenous Health Planning Committee to support education on the locally created Indigenous Cultural Structural Model and Indigenous Care Guides/resources to further advance adoption across the care journey

• Create strategies and tools to promote hiring francophone and multilingual employees
• Explore how to support partners without interpretation contracts, e.g. pairing partners, to expand access to interpretation during clinical care interactions
• Begin drafting an overarching French Language Services plan
• Initiate the collection of sociodemographic data in FHTs

Digital
• Identify how to enable Patient Access to digital records as well as consideration for the adoption of PROMs (incorporating Ministry of Health (MOH) indicators)
• Experts and patient advisors to evaluate and plan the implementation of a patient portal, e.g. enabling EShift or implementing MyChart
• Explore CHRIS for effective communication, shared care and coordinated care planning

90 Days
Be immersed in the design stage of Y1 activities with a goal to have secured several quick wins using bottom-up approache/front-line clinical expertise.

Patient Care
• Design navigation criteria, centralized referral hub and related patient care pathways
• Pilot standardized assessment tool (e.g. Caregiver distress index) in primary care
• Close health human resources gaps by leveraging vacant position funding to support enhanced services hiring of an Indigenous Navigator supporting transitions from hospital to the community
- Collaborate with Palliative Care and Primary Care to explore 3 LHIN nurse practitioners to provide services 7 days per week
- Identify Patient Navigators for patients without a primary care provider

Governance & Management
• Complete privacy and security assessments for partners without existing processes
• Between 90-180 days, assess progress towards Y1 priorities and barriers to achieving milestones to inform Y2 activities, e.g. digital health;
• Initiate processes to secure resources to address year 2+ e.g digital health strategy, deployment plan and advanced analytics
• Knowledge transfer to CKOHT leadership on integrated care best practices within primary care to inform and/or adjust current and future plans

Equity
• Engage experts to develop a comprehensive cultural and linguistic safety strategy to guide Y1P activities (prioritized awareness & training) to maturity

Digital
• Y1 digital health gaps identified and plans for remediation put in place
• Work with Primary Care Council to explore the possibility and feasibility of a single EMR in primary care

6 Month Plan
Transition to Phase 2- Experiment and Execution.

Patient Care
• Common referral, assessments, navigation criteria and pathways as well as communication processes being piloted through PDSA cycles

• Wait list management will be fully accessible for all CKOHT partners for improved access to care
• Concentrate on expansion of services, by leveraging CKOHT resources, including:
  - exploration of expanded 24/7 primary care
  - optimization of and expansion of the current practice scope of Care Coordinators of Phase 1 organizations
  - a H&CC short-stay care coordinator redeployed to support ED diversion at CKHA
• Post Cerner stabilization at CKHA (June 2020), implement the virtual ward to support frail elderly patient discharge to home/community with support

Governance & Mangement
• Mid-year evaluation progress of metrics, outcomes and check-in for all streams to identify gaps, lessons learned and celebrate successes

Equity
Partners will continue designing CKOHT's mutifacted inclusive strategy, capturing remaining elements to address, and based on progress and new insights over 6 months.

Digital
• Enable the sharing of the H&CC virtual intake tool functionality and related information
• Contingent on 60-day outcome, MOH approves single HIC status for CKOHT
• New regional digital health service delivery model is in place
• MyChart or similar patient information sharing solution implementation plan developed
• Some Y1P patients have been accessing their health data
• Patient appointment scheduling solution in place for at least 2-3 CKOHT organizations
• Digital health reporting and measurement as defined by MOH is available

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
Principles and Background

The formation of OHTs will dramatically impact the way that health care is delivered across sectors. Bringing diverse organizations together under one OHT will improve the patient experience as they transition in care. For benefits to be fully realized, teams or providers need to be supported through the change process. Change management includes a range of activities that support and sustain change over time

at the individual and organizational level. Activities include communication, relationship building, increasing awareness, identifying champions, mapping workflows, standardizing processes, training, problem solving, providing ongoing support and soliciting feedback. The challenge is to move beyond the textbook and into practice.

Fundamental to good change management is an appropriate governance structure and supportive coalition leadership to lead the change. The CKOHT will move from its interim proposal development committee structure to a formalized, transitional governance model; moving from submission to reality.

The CKOHT also has many tools and resources to draw on for this work and will also leverage Ministry resources such as RISE for support. A strong foundation is in place with a confirmed vision, brand and communication strategy (www.ckhoht.ca). The strategic management framework (Appendix 8) will guide the next phases of planning. People commit to what they build. From the outset, the Phase 1 partners demonstrated commitment to the development of an OHT. This led to the involvement of over 100 individuals from across these and other organizations on various work streams to prepare the CKOHT proposal. This approach moved the proposal development from a shared document to the beginning of a shared journey. Co-creating allows all participants to share ideas and support the shift toward innovation, new practices and routines.

Change Management Activities Prior to Implementation of CKOHT

• Governance and Leadership: A Collaboration Steering Committee will be put in place with Agreements to provide clarity of ownership and accountability and a path for current and future partners, patients, providers and the public as needed.
• Communication: The CKOHT has a common brand and strategic communication plan. The initial focus of the communication strategy is to generate broad awareness of OHTs and more specifically, the vision and partners of the CKOHT. Ongoing efforts to provide individuals information about how the change may affect them personally; how they can become involved or ask questions; provide information on the expected benefits; and, ongoing updates on progress toward maturity are in development. This is applicable to staff and clinicians.
• Relationship Building: CKOHT's engagement activities facilitate collaboration and networking among the CKOHT organizations. Developing common language/meanings to support strengthened knowledge exchange among partners is underway. Consultation to build common understanding of OHTs across the South West region is also underway.
• Engagement: The CKOHT has adopted the HQO engagement framework as part of the Quality Improvement (QI) process to engage providers, staff, managers, and patients on possible gaps in patient journey. Patient advisors (PAs) were active on the Steering Committee and work streams to support the CKOHT submission. Targeted engagement of specific audiences, including with a diversity and equity lens, informed process and plans. Process mapping of how planned interventions meet the Year 1

Population (Y1P) needs as well as ability to affect outcomes is complete. A formalized and ongoing engagement strategy for implementation is in development.
• Champions: The CKOHT has a number of champions (clinicians, patients, administrators) in place to advocate for changes. These individuals are respected and have the ability to influence change through modelling, communication and creating new processes.
• Performance: The CKOHT has developed a common scorecard with shared accountability for Y1P outcomes and performance measures.

Year 1 Activities

• Standardization: Identifying opportunities for standardization to be achieved in Y1. For example, in primary care some of the proposed changes are to build capacity though expanded group offerings across all patients in the OHT. To share inter-professional health care provider across primary care to provide care to patients, regardless of their team's current available resources. With OHT approval and as part of the implementation plans, a working group will be established to focus on a gap analysis of the OHT and work towards implementing ideas documented through the submission process.
• Continued Communication – keeping all partners and the broader community informed
• Continued opportunities for networking and feedback – forums to share and discuss examples of evidence based practices that are working well and pain points that need further consideration
• Continued efforts to co-design the future state with extensive engagement including further mapping of the OHT initiatives and existing evidence-based pathways across the continuum to establish, optimize or validate care work flows and roles
• Sufficient training and support to enhance competencies and confidence
• For technology adoption – use Transform Shared Services Organization resources to support ongoing efforts to onboard / trouble-shoot issues for user confidence in new digital health technologies and training. Ongoing feedback process about the impacts of changes (based on evaluations) and the ability to refine and adapt processes and routines to improve workflow
• Continual cycle of the plan, do, study, act for process improvement

Primary Care Change Management

In addition to strategies noted above, the CKOHT will leverage the existing expertise among organizations and established relationships, such as Connecting South West Ontario (cSWO) Change Management and Adoption (CM&A) team. Members of the CKOHT are certified in ProSci Change Management using the ADKAR approach, which is widely recognized in the health system. These existing supports will be used to actively engage primary care providers in change activities to successfully support the formation of the CKOHT. Existing forums such as the Medical Advisory Committee and Medical Staff Organization of Chatham-Kent Health Alliance (CKHA) will be used to engage primary care and specialists. The team has existing resources

to support change management in 2019/20, which will be helpful in year one as well as with digital health on a go-forward basis.

Finally, it is imperative that some consideration be given on how to engage primary care and specialists in a manner that is respectful of their time.

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

Members of the CKOHT currently provide care to the full attributed population.

During Year 1 (Y1), members of the CKOHT who are providing existing services are committed to maintaining continuity of care and access for patients outside the Year 1 population (Y1P).

Further, there is a commitment when a process or standard operating procedure is established that quickly identifies better outcomes for the patient, provider, system and value for money (Quadruple Aim), partners will be advised of these opportunities, so that incorporation of a leading practice(s) can be implemented/scaled with any CKOHT population through the Plan-Do-Study-Act (PDSA) approach.

Through the ongoing identification of service gaps and commitment to support equitable access to care and resources, the Year 1 population will have a concentrated focus without service impact to the entire attributed population. Furthermore, the ESC LHIN Contracted Service Providers will continue to have Performance Management provided by the ESC LHIN Contracts team in Y1, ensuring that there is continued, contractual follow up with the organizations that have a legal obligation to continue to support the full Chatham-Kent population.

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

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

Max word count: 1000

(See Appendix A, A.4)

In preparation for the CKOHT application submission over 80 partners including patient advisors, governors, administrators, primary care providers and collaborators came together to review the envisioned future for the CKOHT. Within this meeting, participants worked together to identify system

challenges the CKOHT may face in achieving maturity. Ten key challenges were identified that need to be considered for moving forward in the first year and in developing a roadmap for achieving maturity. It is recognized that to address some systemic barriers complex multi-system approaches will be required and support from the Ministry to enact legislative or regulator changes will be needed. The ten themes that follow are in random order.

1. System navigation and care coordination: By maturity the plan for system navigators and care coordinators will be built on the Health Links care coordination model that is used for complex patients. This model is a 'one team' approach that can be implemented at an appropriate scale for the attributed population (from birth to death). Identification of resources to fully implement this model will be reviewed to ensure funding and policies support its implementation.

2. Care pathways: During a patient's journey, there are repeat assessments at each stage being completed. Policies need to be created that mobilize a single, shared assessment with a shared electronic system.

3. Transportation: the CKOHT attributed population is disbursed across a large geography with limited public transit, limited handicap transit and a limited ability to transfer patients. While implementing a digital-first model to bring care to individuals versus individuals to care will alleviate some of this barrier, it does not solve the challenge of patients living in a rural community with limited transit infrastructure. Linking with the Ministry of Infrastructure on rural needs are encouraged in order to support the uniqueness of the CKOHT.

4. Access to care: Current hours of operation do not align to all patients' needs. In phase one, an expansion on extended hours within primary care will be reviewed. Likewise, if patients access care from another primary care provider after hours then their home Family Health Team is penalized. The one exception to this is hospital emergency departments. This sets up a negative incentive for clinicians to encourage ED usage by their patients after normal business hours.

5. Data sharing, communication & privacy: Provincial privacy standards hinder the ability to share information across agencies. Policy, regulatory and legislative reforms are needed in order for the CKOHT to realize success and minimize barriers to patients in their care pathways. Moderation of PHIPA will enable the secure sharing of information. Ensuring health information custodians agreements have language that reflects data sharing, governance and address privacy concerns are needed. These changes will support the overarching security and privacy practices/policies that will be developed through the CKOHT.

6. System equity: Policies, funding and measurement are needed to ensure

equity considerations are being implemented and accurately measured to respond to local needs. Policy and funding allocations need to be reviewed at a Ministry and CKOHT level to ensure that individuals with diverse needs receive the services targeted to their needs.

7. Health literacy and self-management: There is a lack of understanding of patient's own disease/illness or their own condition.

8. Funding: Current funding allocation may not meet patient needs at maturity in order to provide system navigation to the full attributed population. Contracts and contract management will potentially impact on resources, participation and service delivery.

9. Workforce: Critical to the success of the CKOHT is the need for health care providers in all roles. Chatham-Kent is a rural community and competes to retain and recruit all care team members, including recruiting hard to fill specialty positions.

10. Implementation & change management: Large scale change in the health system from submission of the application to maturity is monumental. There is a sense of fear with the unknown, resistance to change and uncertainty of roles. Section 6.2 addresses plans for the CKOHT but engagement of provincial groups such as OMA to ensure common understanding and support of OHT is necessary.

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

The CKOHT has been working to create capacity and share resources to facilitate the provision of more integrated care to the attributed population. Several areas have been identified which could benefit from further support. The main requirement for non-financial support will be consultation and health human resources from our ministry partners, and provincial subject matter experts as the Ontario Health Team (OHT)structure is developed and implemented, and to support the partners as the team moves toward maturity.

OHT Development & Facilitation - As the CKOHT develops its plans and begins implementing the proposed model, partners recognize a need for support from organizations such as RISE in terms of training, capacity building, and preparing for the implementation of OHTs. This would include support in the development and implementation of the governance model and the processes to support the implementation process. External facilitation from RISE would be helpful to reduce

real or perceived biases of internal facilitation providers in important decision making including governance modelling, financial planning, etc. for Ontario Health Team models. Likewise, there is real potential for multiple OHTs to duplicate activities with external consultants.

Quality Improvement, Data & Decision Support- the CKOHT is founded on a continuous quality improvement approach, and would benefit from human resources and consultation from Health Quality Ontario further develop and implement the quality improvement strategies and support the implementation of the quality management framework as the CKOHT operationalizes toward maturity. To support the data required for the this approach, there is a need for support in performance monitoring and decision support. Partners would benefit from the support of the Health Data Branch, as well as ICES, to identify and collect appropriate data, analysis of diverse data sets, and would especially benefit from training on and development of predictive analysis capabilities locally. This type of data support would promote the ability to proactively pivot programming to meet the needs of the attributed population. The local data and decision support staff working with the CKOHT would also benefit from the regular receipt of datasets that can be manipulated to better support the partners in developing more targeted approaches for the management of particular conditions and development and validation of integrated care pathways.

Health Human Resources, Labour Relations - To meet the goal of a more integrated care system for the attributed population, there is a requirement for a more integrated workforce. Currently, there are many collective bargaining units within the CKOHT partner organizations, which may be or may perceive themselves to be, affected by the increasing integration and sharing of responsibilities between organizations. The CKOHT would benefit from ministerial or provincial support to manage labour relations as it relates to collective bargaining as integrated workflows are implemented. This would include, but not be limited to, the proposed changes to the existing LHIN Home and Community Care proposed system navigation functions. It is assumed that these supports will leveraged for the year one population with little change from the LHIN. In addition, there is a recognition that labour concerns may also lead to litigation or involvement with the Ontario Labour Relations Board which the CKOHT cannot currently support.

Home and Community Care – while each OHT proposal will include a plan for the future of home care it is understood that some degree of provincial framework would be appreciated to deal with such things as cross-border care, levels of care, basket of services, contract pricing etc.

Legal Counsel & Legislation- Legal resources would be of benefit from the ability to access legal counsel which would be representative of the partnership to manage complex legal, financial, partnership, and human relations concerns which may come to bear with health system integration.

Provincial OHT’s will require additional provincial support with legislative changes.

Some identified legislative changes which will be required for the increased integration of the health system regionally would allow for patient information sharing among partners engaged in patient care to facilitate a cohesive patient experience.

Policy, Privacy, Security & Risk Management- To prepare for an implementation of the CKOHT, the development and implementation of policies supporting the intention to develop an increasingly integrated system, which may include how organizations may share staff and resources, how information is shared, and how funding is allocated as the model shifts to a single funding agreement. The need for patient information sharing will be balanced with appropriate privacy and security of patient information. Identified is the need to develop appropriate privacy and security measures to ensure this balance. Consultation with subject matter experts to support the development of provincial or local policies, privacy and security measures, and risk management would support in designing models which minimize risk and maximize integration.

Information Technology & Digital Access- Information technology expertise will be required to enable digital and virtual health technologies to be shared. Though local resources can provide the bulk of the required support, from a provincial perspective, four OHT partners recognized as Health Information Custodians are not able to access provincial digital assets which would support information sharing in integrated care team.

Clinician Recruitment and Succession Planning- Chatham-Kent is recognized as an underserved community in terms of clinical resources. As a result, the team would benefit from dedicated time from Health Force Ontario Recruiters to support the attraction and the development of succession planning for clinicians close to retirement.

Population Health - As part of the CKOHT approach there is an increased appetite for population health and prevention. Consultation with Pubic Health Ontario to develop strategic planning for the implementation of preventative models and population health models would support planning for the care of the attributed population throughout the continuum from prevention to acute care.

Diversity & Equity- The importance of diversity is woven throughout the CKOHT and providing equitable service to all in the attributed populations is a recognized challenge for the CKOHT. The team has recognized a need to consult with Indigenous and Francophone services provincially to gain tools and knowledge including support with language services, training, translation, etc.

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

The partners undertook to create an inventory of health human resources at each organization. As part of the next steps, an analysis of gaps and opportunities will be conducted to leverage these current assets. See appendix 5.

Additionally, Appendix B 2.5 provides further information on the CKOHT's other digital health plans.

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 The CKOHT supports the development of a provincial strategy around Home and Community Care (H&CC) to ensure equitable access to a basket of services for Ontarians. Likewise, patients will cross OHT boundaries and therefore some policy

development will be required to ensure that locally developed solutions do not create new barriers to accessing these services.

The long term vision for the design and delivery of home and community care locally is to leverage resources (financial and Health Human Resources) of all HSPs within the CKOHT, ESC LHIN H&CC and the Walpole Island First Nation Home and Community Care program.

This is based on the following agreed upon principles:

Value Patient Engagement
• Patient/Caregiver voice will co-create the processes that need to be in place to support best patient health outcomes and experiences.
System Navigation
• Single patient navigator assigned at point of patient's entry into the health care system.
• Orphaned patients or those affiliated with solo practitioners will be assigned a navigator.
Comprehensive Care Planning and Delivery
• Holistic approach through Coordinated Care Planning (CCP)
• Self-management, self-directed care will be encouraged by all organizations.
• Patients will have 24/7 access to professional support—both virtual and the ability to support face-to-face engagements.
• Standardizing Communication expectations (who/what/when/where communication occurs) to support patient achievement of or changes in goals.
Local Talent
• Leverage existing HHR resources within the Chatham-Kent region.
Digital First
• Leverage Technology Platforms to support service delivery. OHT members will support common tools/digital platforms with access for all.
• Standardization of screeners/assessment tools and receipt/acceptance of same by all HSPs within CKOHT.
• Maximize use of current provincial assets e.g. CHRIS before entertaining new expenses
Achieve Outcomes
• Commitment to capturing and measuring patient outcomes/achievement of goals.
• Support achievement of quadruple aim outcomes within the CKOHT budgetary ceiling.

To achieve the transformative, efficient and integrated service delivery that will support the quadruple aim, and within the above principles, the following innovative service delivery models and performance oversight will be implemented.

A patient navigator will be identified at point of entry into the health system through a standardized intake screener and assessment tool (inclusive of the Ontario Palliative Care Network's proposed screener). Workflows will be developed to support any

organization being able to complete the screening tool which subsequently identifies what navigator the patient should be connected with. Patients will also have the option of completing their own screener (i.e. Assessment Urgency Algorithm) to self-navigate to OHT resources and to self-book an appointment with the most appropriate navigator to complete a fulsome assessment. If the patient/ caregiver are unable to complete the assessment on their own, additional support is provided, through the 24/7 navigation. This will ensure there is only one assessment being completed, trusting relationships begin to develop and the accountability to support the patient/caregiver to navigate and connect with the services is accomplished. (This process is already in place with March of Dimes Canada (MODC), CK EMS Community Paramedic Program (CPP) and Lambton Elderly Outreach (LEO) and will be adopted throughout the OHT). This may require re-orientation based on a patient's changing health trajectory. The navigator will be accountable for ensuring resources are in place via a coordinated care planning (CCP) approach to care. The CCP will be completed by enabling access to CHRIS database to all CKOHT providers.

In Year 1, the CKOHT will continue with the current Service Provider Organization (SPO) contracts for the delivery of care. At maturity, the partners envision the potential for a direct employment model that could see a fundamental shift in the attractiveness of the Personal Support Worker (PSWs) role as a career (see Appendix 13). The CKOHT was challenged to think about a model where 80% of PSW are full time employees vs. casual workers. In a direct employment model, PSWs could be assigned to multiple locations over the course of a shift. Individuals could go from delivering care in the home in the morning to relieving breaks of colleagues in hospital or long term care mid-day and returning to a home in the afternoon. This kind of model creates work-life satisfaction and has the potential to enhance continuity of caregiver in the home. Health Service Providers (HSPs) within the OHT, through an Expression of Interest process, could identify operational and structural frameworks in place to support direct employment models. Funds for direct care provision would be transitioned directly to the HSPs following an asset mapping process. This would enable direct support/oversight for service provision, eliminate administrative functions and ensure the provider is closely connected to the patient. This could also enable the patient/family to schedule their care directly with the PSW or health professional, promoting flexibility and self-management of the receipt of their care.

The CKOHT sees that enhanced utilization of non-traditional resources (Home Support Workers), expansion and implementation of innovative service delivery models (Family Managed Home Care, Virtual Ward, E-Rehab Integrated Discharge Planning, and Clinical Care Coordination) will enable all providers to practice at top of license. This may also reduce the complexity of transitions to/from services such as residential, long term, palliative and hospice care.

Innovative Service Delivery would support an expansion of the Clinical Care Coordination (CLCC) and Behavioural Support Services Care Coordination models by integrating the Case Management, Care Coordination and clinical nursing functions

into one role. The CLCC model has been tested and evaluated within the Erie St. Clair LHIN region, and has resulted in a 20% reduction in ED visits for the most vulnerable and complex patients, has demonstrated enhanced patient and provider satisfaction and ensures the Regulated Health professional is practicing at top of license. This eliminates the need to insert an additional provider (nurse) into the patient's circle of care and ultimately enables the patient to have a single navigator for support wherever they intersect in the health care system (hospital, LTC, primary care). Currently, 3 CLCCs are embedded full time within Primary Care Organizations (PCO) in CK and this model will be expanded in Year 1.

Funding reallocation from Home and Community Care (HCC) would occur to support an Indigenous navigator at Chatham-Kent Health Alliance (CKHA), who would connect patients with the H&CC Senior's Health promoter at Walpole Island and other culturally based Indigenous healing resources to support achievement of patient goals.

The model would include exploring H&CC's Nurse Practitioners to be embedded within PCOs and CK Hospice to enable efficient and effective utilization of resources, visiting patients in all care settings. The integration of NPs with CK hospice and deployment of this asset supports OPCN strategy. This model is similar in some ways to the existing Nurse Led Outreach Teams that are employed by the hospital to support Long Term Care.

H&CC's Hospital Care Coordinators will continue to support the Integrated Discharge Planning Model that was implemented in CKHA in June 2019. This model has eliminated the previous duplication of services, streamlines and clarifies accountabilities of health team members to support access and flow within the hospital and ultimately supports enhanced and safe transitions of patients from hospital to home. One navigator assigned to the patient throughout their care journey in hospital coordinates care conferences, etc. prior to the patient's hospital discharge so that there is shared understanding of goals of care, patients care team members and when services are expected to be provided. Information is recorded in the CCP and shared broadly with system partners. The patient understands who their navigator upon hospital discharge is and who can be called with questions/concerns. Patients also understand the scope of services and/or supplies anticipated to be needed on discharge. Utilization of technology assets (provincial and local) to facilitate timely care conferencing or innovative service delivery/models of care (OTN, virtual ward model, eRehab, eShift) will continue to be expanded to all health care organizations to ensure equitable access to care across the CKOHT. The full scope of services and regulated health professional services anticipated to be provided are known and planned prior to the transition.

Fulsome workflows will be developed to ensure that all CKOHT partners adhere to agree upon standards regarding what, to whom, and when updates to patient care plans are completed.

Medical Supply Chain Management—this is a fully automated end to end supply management system supported by Transform Shared Services Organization (TSSO) and would continue to expand to HSPs in CK whose patients have need to access medical supplies. Adding IV infusion and Medical Equipment into the Supply chain Management System for the CKOHT is envisioned.

Patient and Caregiver education needs are assessed and supported at each transition. An evaluation of the impact of these strategies to support patient and caregiver education will be completed regularly as part of the CKOHTs commitment in supporting the QI framework.

Finally, a long term focus on Medication Reconciliation that is planned and communicated with an assessment of the patient and caregiver's knowledge and understanding will occur with each transition of care. This will be enabled by leveraging the Drug Health Data Repository (DHDR) via Clinical Connect by all regulated health professionals by the end of Year 2.

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

Top priorities in Year 1 for CKHOT Home and Community Care:

1. Ensuring all identified vulnerable/complex seniors (aged 55 plus) are connected to CKOHT supports vis a vis a single point of contact—Patient Navigator.
2. Ensuring all patients who are homeless or unattached to a primary care practitioner are connected with a Patient Navigator.
3. Leveraging and spreading identified best practices to support achievement of quadruple aims:

• One Patient Navigator (March of Dimes Canada (MODC), Lambton Elderly Outreach (LEO)
• Expanding Clinical Care Coordinator and Behavioural Supports Ontario Care Coordination Model.
• Ensuring access for all CKOHT partners to CHRIS database to support Coordinated Care Plan utilization.
• Identify where latent capacity exists in the current system for Health Human Resources.
• Identification where duplication of services exist and eliminate (i.e. Integrated Discharge Planning Model at Chatham Kent Health Alliance; eliminate duplication of services provided by Community Health Centre and contracted Service Provider Organizations)
• Development of processes to support a senior's transition from a Mental Health and Addictions treatment centre to community leveraging patient navigators.
• Standardization of intake screener and assessment and utilization of common digital platform for intake.
• Medication reviews are completed by qualified health professionals during each transition or yearly otherwise.

The CKOHT year one target population will be adults aged 55 plus that have one or more of the following criteria met: COPD, Heart Failure, Angina, Diabetes, Dementia, and/or are complex, as per current Health Link definition (please see Section 1.2). To estimate the size of the Year 1 Population (Y1P), the CKOHT elected to leverage its high rate of patients attached to primary care. The Family Health Teams and Community Health Centre initiated a query within their EMRs for enrolled patients aged 55 and over with the targeted chronic conditions. The LHIN's Home and Community Care program also cross referenced their data set to identify any anomalies in the Y1P proxy identified. As such, the number of enrolled patients who match the above criteria results in a Y1P of approximately 11,000 people. It is

anticipated that 4,925 of these patients in Chatham-Kent will require some type of support from Home and Community Programs.

The CKOHT will innovatively deliver care to improve Home & Community Care delivery to achieve qadruple aim objectives by:
• Integrating H&CC leadership/front line staff within hospital, primary care and community sector to support access and flow and program acumen.
• Continued exploration and expansion of Clinical Care Coordinator and Behaviour Supports Ontario Care Coordinator roles to support frail seniors throughout their transitions in care.
• Rapid expansion of existing service delivery models that provide 24/7 access to care for consumers in Chatham-Kent that require ad hoc, unscheduled care.(Mobile Wellness, Mobile Assisted Living, Hub and Spoke models (i.e. March of Dimes Canada, Lambton Elderly Outreach)

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

Background and Principles

The Erie St. Clair (ESC) LHIN Home and Community Care (H&CC) leadership has been a fulsome partner in all CKOHT working groups in the initial Self-Assessment and Full proposal development planning.

It is important to note that the home care access and effectiveness indicators for the CKOHT attributed population exceed the provincial performance. This includes wait times for service from hospital and community and the Alternate Level of Care rate. The current relationships between the LHIN H&CC, Chatham-Kent Health Alliance (CKHA) and primary care have seen the successful implementation of such innovations as the Intensive Hospital to Home program, Clinical Care Coordination and Integrated Discharge Planning. These partnerships have led to the current system performance. It is critical that the process to transition home and community care to the CKOHT be done in a manner that builds on this spirit of collaboration and drives further improvements. This must also be done in a manner that does not destabilize neighbouring geographies that depend on some of the same resources but may not be at the same stage of OHT development.

LHIN Home and Community care resources are currently integrated with many organizations for patient care/program delivery within the Chatham-Kent (CK) area, and as such, the ability to transition resources would be a natural extension of the current strategic vision. A provincial framework is required to support any formal transition.

It must be reiterated that in Year 1, the CKOHT will leverage existing Service Provider contracts that are currently held with the LHIN H&CC. New initiatives such as the "Virtual Ward" may present opportunities to provide care differently but still within a provincial framework.

Care Coordination Resources

Clinical Care Coordinators have been integrated with CK Primary Care Providers (PCP) for over a year and support the most vulnerable patients affiliated with the PCP's patient roster. They complete CCPs in collaboration with patients/caregivers and system partners and a recent evaluation demonstrated significant patient and provider satisfaction, while reducing ED visits by 20%. The expansion of the Clinical Care Coordinators in Year 1 will follow this model.

Community Care Coordinators are also integrated with PCP in CK and support patients with stable health trajectories and are the subject matter experts in supporting patients/caregivers to navigate Long Term Care. Ninety percent of CK PCP patient rosters are now associated with Community Care Coordinator caseloads in CK, and they provide regular, onsite support to Primary care (1-2 x/week, depending on the organizations request). This is unique in CK as in many other jurisdictions, Care Coordinator caseloads are mapped to a specific geography whereas in CK, caseloads are mapped to match primary care. This will ease transitions to PCP.

Hospital Care Coordinators have moved into an Integrated Discharge Model in collaboration with CKHA. This enables clear accountabilities to support best and emerging practices for patient transitions into the community or alternate care settings, while supporting patient access and flow within the hospital walls.

Programs
There has been recent success with Home and Community Care collaborating with a Health System Partner, (Lambton Elderly Outreach {LEO}) leveraging a common intake tool, co-locating Intake Care Coordinators with LEOs Care Navigator, to ensure that once the referral is triaged, that it flows to the appropriate community organization, based on the acuity of patient care requirements. Although in initial phases, it has been embraced by staff and results in the patient/caregiver connecting in with the organization that will continue to collaborate with them to navigate to the needed service organizations for support. This is a model that could be scaled to other Health System Partners. Common intake tools and processes are necessary for the success of CKOHT.

Programs such as Intensive Hospital to Home to mitigate Hallway Health Care through the transition of patients at risk of being identified as ALC to community have been collaboratively created with Service Providers, acute care partners and internal front line staff and leaders of these organizations. The lowest ALC stats for acute care in the province can be attributed to the team effort and collaboration. As such, knowledge transfer of Home and Community Care programs occur at time of development and continue throughout the incremental improvements that are made in program's service delivery offerings.

Digital Assets
ESC LHIN H&CC has innovated in the Digital space heavily over the past several years and is committed to supporting the vision to leverage and provide open access to all CKOHT organizations to any digital platforms currently being utilized to promote efficiencies in care delivery (CHRIS, CCP, HPG). Access to eRehab or eShift digital platforms have already been enabled to patients, caregivers and staff at CKHA to support robust sharing of information and collaborative partnerships to ensure patient achieve their goals of care through service provision.

Local Knowledge and Expertise

The CKOHT partners are aware that much of the current expertise regarding H&CC sits with the LHIN H&CC. Unlike other partner organizations of the CKOHT, the LHIN will not have a role in future care delivery; therefore, any transition in Year 1 to maturity would benefit from exploring transitions in leadership and staff from LHIN H&CC to within hospital, primary care and community sector to support access and flow and program acumen transfer.

Patient and Caregiver experience partnerships (through the ESH LHIN Patient and Family Council—PFAC) that have heavily influenced Home and Community Care Programming and innovation, will also continue in Y1 to support knowledge transfer to the CKOHT PFAC. This will ensure that the patient and caregiver voice in creating and influencing quality improvement processes including ongoing assessment patient/caregiver system needs/responsiveness and opportunities for improvement based on patient experience is fundamental to all CKOHT planning activities. The chair of the ESC LHIN PFAC committee has been involved in the Self-assessment and Full Assessment planning for the CKOHT.

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
In order to effect the expected patient and system outcomes as identified broadly in the quadruple aim, a number of changes would need to be made to pave the way for efficient, equitable access to care within Chatham Kent.

The necessary organizational changes to support the CKOHT vision will require significant advice (legal and an experienced/seasoned Human Resources and Organization Development perspective) and change management resources to navigate the expected labour relations impacts. These impacts are related to current Health Service Provider (HSP) and Home and Community Care (H&CC) Collective agreements as well as the anxiety many HSPs have regarding the risk of becoming a unionized environment—an environment many have not had to navigate in their organization's lifetime.

Current Public Sector Labour Relations Transition Agreement (PSLRTA) legislation is not well understood globally and there will be a requirement to have significant support/resourcing to navigate the labour relations piece in order to mitigate any disruption of care to patients/caregivers.

Organizations with corporate infrastructures may not be as flexible/nimble in changing how they provide supports/services to patients in CKOHT. Corporate policies (provincial or national) may not support/be contrary to what the CKOHT membership has agreed to (e.g. type of assessments, one consent etc.).

The ability to move funding from one organization to another within an OHT to fund a patient need/new program/new resource may be restricted by organizations' Service Accountability Agreements (SAAs) with the Ministry and/or by the inability to move funding between different Ministries (i.e. MOH, MCCSS, MCSS).

Health Human Resources—duplication of resources and accountabilities have been identified between the Community Health Centres and H&CC. SAAs will need to be supported to be amended when duplication of resourcing and deliverables are identified.

Hybrid Models of support (intake/assessments, navigation etc.) will exist until OHT reaches full maturity (accountable for all patient cohorts). This has potential to cause instability within the system/parallel processes, which will be cumbersome to support. All agencies will still responsible for the populations that they serve until full maturity.

Home and Community Care Service Provider (SPO) Contracts remain unchanged/ever green. Provision in SPO contracts need to be revisited/updated to support enhanced accountability and performance of SPO organizations in Year 1 or the current performance challenges unintentionally transition to the OHT. Furthermore, the ability to transition SPO staffing assets to HSPs post Year 1, to streamline care/enhance the "basket of services" the CKOHT HSP partners can provide, will require dissolution of contracts and subsequent asset mapping to the HSPs.

Co-payment and the ability of a patient/caregiver to access needed care (ie Adult Day Programs) also needs to be revisited by the Ministry of Health so that equitable access to supports and services within CKOHT is achieved. Specifically, legislation supporting the ability of HSPs to require a co-payment for services (i.e. Adult Day Programs) would need to be amended, highlighted below:

Home Care and Community Services Act, 1994, S.O. 1994, c. 26
July 1, 2019
2 (1) In this Act,
• "adult day program" means a program of structured and supervised activities in a group setting for adults with care or support requirements; ("programme de jour pour adultes")
• "caregiver support services" means counselling, training, visiting and providing information, respite and other assistance to caregivers to support them in carrying out their caregiving responsibilities; ("services de soutien aux fournisseurs de soins")

Community support services

(4) For the purpose of this Act, the following are community support services:
1. Meal services.
2. Transportation services.
3. Caregiver support services. (See above)
4. Adult day programs.
5. Home maintenance and repair services.
6. Friendly visiting services.
7. Security checks or reassurance services.
8. Social or recreational services.
9. Providing prescribed equipment, supplies or other goods.
10. Services prescribed as community support services. 1994, c. 26, s. 2 (4).

Rules for charges for other services
(2) Subject to subsection (3), if an approved agency provides or arranges the provision to a person of a homemaking or community support service in accordance with the person's plan of service, the approved agency may require payment from the person for the service and may accept a payment made by or on behalf of the person for the service. 2016, c. 30, s. 40 (1).

Ontario Health Teams
Full Application Form

APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

Virtual Care Current State

Virtual Care Asset Analysis

An initial assessment of current virtual care offerings, summarized below and attached in full as Appendix 9 highlights the virtual care tools which have existing presence and deployment expertise in the CK region today.

Virtual Care Tools

(n=14) Current State	% Complete
OTN	57%
eConsult (eConsult Coe)	7%
eReferral (OCEAN)	28%
eSHIFT	21%
CoHealth	7%
Provider-Patient Messaging	7%
Online Scheduling	7%
ELIT Intake Tool (Referrals)	7%
HPG - Health Partner Gateway (Referrals)	36%

Current state also includes Transform Shared Services Organization (TSSO) that is a full partner of the CKOHT. TSSO has content expertise that will assist all partners in moving forward in this domain.

Virtual Care – Year 1 Approach and Plan

In year 1, the CKOHT is confident that is will meet the target of 2-5% of Year 1 (Y1) patients receiving digital care (220-550 patients total).

Initially, focus will be given to evaluating clinical priorities and closing gaps in the adoption of virtual tools and capabilities which are in a “ready to deploy” state. Many of the aforementioned tools have funded, on-the-ground capacity and capabilities to quickly promote increased access and adoption of virtual-care solutions across the CKOHT member organizations. It is assumed this capacity will continue to be in place during year 1. Refer to 6.10 for further information on the 30-60-90-180 day plan for addressing existing gaps.

As part of the Y1 gap analysis, virtual care solutions will be reviewed to determine how they may be used to improve availability of patient care. As an example, OTN telemedicine services may be used to support Francophone patients receiving care from a Francophone provider, should there not be a French speaking local provider. Similarly, CKOHT can explore the use of eVisit Primary Care solutions such as ThinkResearch’s solution to provide virtual patient care by secure video, audio or chat. Exploration with ThinkResearch will also provide an opportunity for CKOHT to collaborate with other OHTs in Ontario to build off of the solution currently in place in the Waterloo Wellington LHIN.

An example of augmenting virtual care within the CKOHT is the planned expansion of eShift technology provided by SensoryTech. This virtual care solution is a living example of how OHT team members will interact across the continuum of care to improve the quality, coordination and efficiency of care as it draws together healthcare providers from acute, community and primary care sectors. Currently used to support rehab and palliative care patients, it will be expanded to create a virtual ward solution for frail and complex seniors with COPD/CHF who do not need the physical resources of an acute care hospital but do still require hospital monitoring and support that cannot be supplied by today’s home and community care resources. The use of this technology will allow healthcare professionals to actively monitor high-acuity patients from home. The eShift approach will also help to proactively avoid readmissions after discharge through home-based care, monitoring and education. Patients can be safely discharged home while recovering, waiting for admission to long-term care or other destinations. The SensoryTech technology includes directed-care pathways and communication.

Additionally, an in-home patient record viewable through a portal accessible by clinicians, patients, family and caregivers provides a single-source of information about the patient record and care plan.

It is anticipated this virtual ward approach will reduce ALC hospital length of stays by 10 to 45 days for many patients, and will free up (up to) 10 hospital beds to help end hallway medicine at CKHA. It is anticipated that up to 200 patients per year will benefit, which will help meet the Y1 target of 2% to 5% of patients receiving a virtual encounter. Reductions in length of stay, emergency department visits and hospital readmissions are planned to provide net annual savings to the healthcare system of $775,000, after factoring in the resources to support the virtual ward. In summary, this virtual-care approach helps reduce hallway medicine, reduces the cost of delivering healthcare and improves the patient/family/caregiver experience.

Another example of scaling virtual solutions in Y1 will be the incremental adoption of CHRIS eReferral to Health Service Providers through CHRIS Health Partner Gateway (HPG). This functionality enables referrals to be sent electronically between HSPs. Information such as assessments and other ancillary documents are sent electronically, while allowing the HSP sending the referral to see whether the recipient HSP has accepted or declined the referral. Decision support data such as reporting on the number of eReferrals sent to community partners to support integrated care, as well as an ability to report on wait times (referral sent to referral actioned off of HPG) can be collected.

It should be noted a convergence plan for an eReferral solution with eConsult should be further considered in alignment with provincial planning in Y1.

eConsult expansion will continue in the coming year within the existing ESC LHIN with a target of 1,536 eConsults to be completed and a goal to increase the number of primary care physicians and specialists accessing the solution. The ability to access this valuable solution will provide enhanced, timely virtual care for Y1 population.

Finally, Telehomecare enhancements will now include virtual visits with patients through OTN – CKOHT will be within one of only two regions in the province piloting this model with OTN/Vivfy. Y1 planning includes providing access to primary care providers or specialists to view patient records.

The CKOHT will leverage experience gained through cSWO and TSSO, documented further in Section 2.4, to implement qualitative and quantitative methods (e.g., surveys, interviews, focus groups, and metrics) to measure the impact of virtual care digital health technologies on clinical and organizational outcomes. Section 2.4 provides an example of how the eShift

solution has resulted in significant improvements in the quality and efficiency of healthcare delivery, expected to be replicated within the CKOHT.

Through continued clinical and health system planning and prioritization locally and coupled with benefits evaluation of virtual care solutions, new tools may be identified to further improve digital maturity and provider and patient/family/caregiver experiences.

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

Current State and Year 1 Approach and Plan

An initial assessment of capabilities in place today (See Section B1 and Appendix 9) suggests CKOHT may have little or limited existing digital capabilities to provide patients with access to their health information. As such, a target of 10 to 15% of year 1 (Y1) patients may be of moderate to high difficulty.

The CKOHT's approach to planning in Y1 will leverage current work underway through Home and Community Care and the work that has taken place under both cSWO and the SW Regional Digital Health Program Management Office (TransForm Shared Service Organization) to further develop and align digital health and virtual care needs with regional and provincial strategies.

As part of the Y1 gap analysis, available solutions will be evaluated to determine their support of legislative requirements. This would include assessing their compliance with the Accessibility for Ontarians with Disabilities Act (AODA) and their ability to support healthcare for Francophone patients of the CKOHT. In addition to evaluating solutions, processes may need to be reviewed to ensure patient demographics such as preferred language are noted in patient files to facilitate health equity planning within digital health solutions.

CoHealth, a patient relationship platform distributed to patients and caregivers at any point along their care journey, is implemented at CKHA to provide access to discharge instructions. CoHealth may offer an early opportunity to provide patients with at least some digital access (e.g., use of CoHealth to make discharge summaries available for COPD/CHF

patients).This opportunity will be explored further during implementation planning and will also consider whether CoHealth has multilingual capabilities to provide a patient relationship solution for Francophone patients, families and caregivers.
Digital access through CoHealth currently supports the following areas:
• Digital content publisher
• Real-time patient reported data and feedback analytics
• Support directory
• Care management tools
• Discharge summaries

Opportunity for Exploration
MyChart is an existing regional asset which may provide an opportunity where patients can create and manage their own personal health information based on clinical and personal information. MyChart has adoption in the South West Ontario region but not within the CKOHT today. In year 1, the CKOHT will begin planning for a patient portal solution to serve its target population, early or accelerated integration options with tools such as MyChart, will be evaluated.

Another Y1 activity will be the launch of the eShift patient portal which will provide the patient/family/caregiver access to their record at home for the eShift service delivery models of care currently functioning in the CKOHT (palliative, orthopaedic, stroke, COPD and CHF populations) as well as the “virtual ward” once developed.

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
The CKOHT is in a high-state of readiness to leverage existing digital health tools and assets to share patient information securely and digitally across providers in year 1 (Y1) and beyond.

Digital Sharing Capabilities and Preparedness
There will be a concerted plan and effort to evolve information access capabilities and adoption across all CKOHT partners. At present, as detailed in section 4.3.1, 64% (9/14) of the CKOHT partners access electronic health records viewable through ClinicalConnect™. Plans are underway to provide access to the remaining 3 partners. A focus to deploy

provincial repositories is underway, with the understanding that additional provincial data is required for consumption including primary care and immunization records. As well, provincial policy issues must be addressed to enable all healthcare providers to access provincial assets.

Standardized Data State and Net Steps
Several business intelligence (BI) tools exist today across the CKOHT partners, e.g., Business Intelligence Reporting Tool (BIRT), Community Intelligence Reporting Tool (CIRT), Cancer Care Ontario SAR Report and Integrated Decision Support (IDS). In Y1 the CKOHT will collectively identify metrics and present BI data in a standardized way across the OHT to inform decisions and improvements in practice.

Service Design and Change Management Efforts
Successful access and adoption of digital health tools to facilitate information sharing across CKOHT teams will be contingent upon supporting programs and services, including ONE ID deployment, privacy and security assessment completion, and education and training, which are currently provisioned through the cSWO Program, with TransForm Shared Service Organization (TSSO) as the local delivery partner in the Erie St. Clair LHIN since 2014. See Section 2.4 below for examples of how digital health information has supported integrated care in the primary care sector at Thamesview Family Health Team (FHT) and Chatham-Kent Community Health Centre (CHC).

Data Contributors Status and Next Steps
Data contributions from all health service providers (long-term care, community care, primary care, etc.) as part of Ontario's Electronic Health Record (EHR) requires further planning. Current contributors include acute and community care, along with specific provincial repositories, resulting in a limited scope of contributing organizations and patient data accessible at this time. Data contribution solutions will need to be investigated in year 1. In the meantime, current patient information sharing practices will continue.

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
The CKOHT partners currently use digital health tools and information to drive both quality and performance improvement.

Quality Improvement Initiatives – Current Status and Processes Implemented

Digital health asset expansion programs should be viewed as quality improvement (QI) initiatives rather than IT initiatives alone. TransForm Shared Services Organization (TSSO), a partner with the cSWO Program, has an established EHR QI and evaluation strategy in place, with trained and experienced evaluators already working with CKOHT partners. The cSWO evaluation strategy includes qualitative and quantitative methods (e.g., surveys, interviews, focus groups, and metrics) to measure the impact of digital health technologies on clinical and organizational outcomes. The cSWO team is also a member of the Provincial Centre for Digital Health Evaluation (CDHE) at Women's College Hospital, leading large-scale evaluations to inform provincial digital health direction (e.g., MyChart Patient Portal Evaluation in SWO).

Digital health tools have already been found to drive QI and performance improvement within some of the CKOHT partners. For example, the Thamesview Family Health Team (FHT) has leveraged Health Report Manager/eNotification for more timely follow-ups and referrals. Furthermore, at the CK Community Health Centre (CHC) the use of ClinicalConnect was found to increase seven-day follow up after discharge from hospital, and greater availability of imaging reports as it supported a more informed discussion and care planning during follow-up visits. The Tilbury District FHT has found access to ClinicalConnect supports transitions from hospital to home through more comprehensive medication reconciliation after patient discharge from hospital. Finally, the Chatham-Kent Mental Health and Addictions Program uses ClinicalConnect to help complete pre-assessments prior to meeting with a psychiatrist, reducing anxiety and stress for patients while better determining the patient's clinical, social, and community support needs.

Another example would be the end-to-end digital medical supply system established to support Home and Community (H&CC) patients and leverage automated supply ordering from providers. This QI initiative has seen a savings of over $1 million the first year, has fully automated the supply chain, and introduced standardization of supplies between acute and H&CC. This success could be leveraged to others within the CKOHT to support quality, efficiencies, enhance the patient experience while demonstrating a significant value for money model.

Future Analysis Considerations and Approach
Other digital health tools such as the eShift solution by SensoryTech have also demonstrated quality and efficiency improvements. Results of the Connecting Care to Home program in the South West LHIN, which used the eShift solution, demonstrated a 59% decrease in hospital length of stay, a 13% reduction in 30-day readmissions and a 48% overall reduction of total cost of care. Additional digital health solutions will be reviewed during Year 1 to determine how they can improve overall quality of care for the CKOHT target population.

The cSWO analysis and research team, including the TSSO delivery partner, may be leveraged to evaluate how a broader set of digital health tools are enabling clinical and organizational performance improvements.

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

The CKOHT has some additional digital health plans that were not captured in the previous sections. These include:

Population Health

Chatham-Kent Health Alliance (CKHA) and other hospitals in the Erie St. Clair LHIN are implementing a Cerner Electronic Health Record (EHR) solution in 2020.

The Chatham-Kent, Western, North York and possibly other OHTs support working with the Ministry of Health on opportunities to standardize a population health management tool set. With Cerner's global leading point of care population health management tool set, that enables care transactions across non-Cerner Electronic Health Records platforms, the CKOHT suggests this solution be explored across OHTs and potentially as a provincial solution.

On October 18, 2019, the TransForm Shared Services Organization (TSSO) Board is hosting an information session on "Population Health Management and the Integrated Health System". OHT participants in Chatham-Kent, Windsor-Essex, as well as Health Service Providers in Sarnia-Lambton are invited. The intent is to provide a glimpse of the potential a population health solution could provide.

RDH Service Delivery Program

Ongoing success of digital health access and adoption in South Western Ontario (SWO) has been facilitated through a strong regional digital health presence, first through cSWO and more recently expanded to include the SWO Regional Digital Health (RDH) Program. While go-forward funding and structures are not yet confirmed by the Ministry, one key success factor of this application is having a continued RDH service delivery program in place beyond the end of the current fiscal year.

An RDH service delivery program with core digital health delivery capabilities including service design, change management and adoption, analysis and research, privacy and security, project/program/product management, and communications adds significant value to ensure clinicians make best use of digital health tools. Evidence in SWO shows a regional program can create a single window approach and basket of services through a transparent rigorous methodology for clinicians to improve adoption and build digital maturity. “In order to reap the benefits of these [digital health] investments, there must be adequate and sustained funding to proactively support the individual users and organizations in incorporating technologies into everyday practice.” (Source: White Paper - From Technology to Context, Why Change Management is Essential to eHealth Success, Dr. Julia Bickford, January 2019)

The Digital Health Playbook requires OHTs to use one of two provincial viewers, as the available data helps to support Ontario’s transformation towards integrated care delivery and health sector efficiency. In SWO, access to ClinicalConnect and provincial assets have been coordinated through cSWO. Patient-access tools such as MyChart are also required, and access within SWO is being supported regionally by Hamilton Health Sciences. These are two examples of the critical importance of a regional digital health presence to ensure widespread access and adoption of digital health solutions.

The CKOHT looks forward to working with the MOH to both help identify/remove any barriers, and effectively support digital health on a regional scale to ensure a strong RDH service delivery program continues for fiscal 2020-21 and beyond.

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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