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: Paul Woods
	Title: President & CEO
	Organization: London Health Sciences Centre
	Email: Paul.Woods@lhsc.on.ca
	Phone: 519-685-8462
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Nancy DoolKontio
	Title: Director Corporate Planning
	Organization: London Health Sciences Centre
	Email: Nancy.DoolKontio@lhsc.on.ca
	Phone: 519-685-8500 Ext. 34794

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

Attributed Population

Alignment between Western Ontario Health's proposed service area and our attributed population is extremely high. Western Ontario Health (WOH) is committed to being accountable for the primary and secondary health needs of our full attributed population (514,024 people) at maturity, with only a few minor considerations. This has not deviated significantly from the service area outlined in our readiness assessment, which was built on the same population attribution methodology used by the Ministry of Health.

Upon review of the data on our attributed population, our stakeholders have noted that the attribution approach may not include local residents who are unattached to primary care. Western Ontario Health will seek opportunities to identify these unattached individuals, include them in our population served, and support their ongoing primary and secondary care needs. The data also demonstrated that some of our attributed population includes Ontario residents from regions geographically removed from Middlesex County (eg. Toronto, Kitchener/Waterloo, Chatham-Kent). Western Ontario Health will work with the Ministry to better understand the needs of these individuals and decide if WOH is the right OHT for them.

Challenges

The data provided to WOH by the Ministry of Health aligns well with our understanding of local need. Eight of the top 10 most costly Health Profile Groups (HPGs) in our attributed population include significant comorbidities and hospital care represents our largest expense on these patients. Western Ontario Health is committed to establishing an integrated healthcare system with patients and their caregivers at the center of everything we do. We are committed to building a local healthcare system with primary care, care coordination/navigation, and patient self-management as the foundation (Appended in Supporting Documents 1.1 Key

Principles). Fortunately our attributed population is among the most loyal in the province. Among our 3 most costly Health Profile Groups, 89% of General Practice fees, 84% of specialist fees, and 91% of acute inpatient expenses were paid to physicians included in our Ontario Health Team. In addition, 93% of patients received their hospital care at one of our Ontario Health Team Network. In primary care, none of our local Patient Enrollment Models included patients who were aligned with a different Network (a finding we understand to be unique to our OHT).

Several performance indicators within our attributed population offer opportunity for improvement. Wait times for first home care service and avoidable ED visits both rose between April 2016 and March 2017, which aligns with observed increases in 30-day readmission rates, hospitalizations for ambulatory care sensitive conditions, and hallway bed days. We believe that these challenges exist largely as a product of our need to better integrate and coordinate access to primary care and community-based services, which is anticipated to improve outcomes, experiences, and overall system costs. On a more positive note, during this same period, a nearly 10% increase in patients able to make same or next day appointments with primary care was observed; a trend we will work to continue.

A few inconsistencies in the data provided to us have been identified during the full application process. First, the Health Condition data appears to be under-representing the true population-level prevalence of many conditions. This is likely a result of the use of hospital administrative data to generate the CIHI Population Health Grouper, which misses patients cared for outside of hospital, or living in the community with undiagnosed symptoms. This issue was raised with the Ministry and we have committed to working together to improve data collection going forward.

Also, it is well recognized that census data provided under-estimates the size of Indigenous populations in general, which is also apparent in our region. Fortunately, the Southwest Ontario Aboriginal Health Access Centre has just recently completed a census in the London area that suggests our Indigenous population is between 17-22k people (approximately double the census estimate). As support for our Indigenous population is a high priority for WOH, we will use these higher estimates when considering resource implications for supporting their needs.

Opportunities
We are confident in our abilities to improve the health and wellbeing of our local population. Our team has been built on the principles of Population Health Management with a focus on the quadruple aim of better patient outcomes, patient and caregiver experiences, care provider experiences, and lower overall cost. With this in mind, we have several local strengths from which to draw.

Our team has extensive experience in population health management, system design and coordinated care. Local projects like the Connecting Care to Home Integrated Funding Model, Best Care for COPD, Telehomecare, HealthLinks , the Community Support Services Central Intake and integrated care for frail seniors have brought

together numerous organizations with shared accountability for better care. These programs will be leveraged in Year 1 with an eye to expansion to our entire attributed population at maturity.

Western Ontario Health also includes extensive population health expertise through partnerships with our community and Western University. So far, the Schulich School of Medicine and Dentistry, Ivey Business School, and Department of Geography have provided support. A Population Health Coalition has been formed to bring patient representatives together with experts in a variety of areas including health equity, health economics, Indigenous and Francophone health, and social determinants of health. Coalition members have no affiliation to health providers, so they can offer unbiased suggestions for improved population health management. This Coalition has been instrumental in supporting selection of our Year 1 population and will be expanded to continue support for Western Ontario Health at maturity.

Finally, our region has made significant advancements in digital health, which will play a key role in our ability to support sustained care relationships with our population. These digital tools will be discussed in more detail later in our application, but include a commitment to finding a population health management tool (or applications with similar functionality) that will help to integrate local data, provide real-time data monitoring, and offer prescriptive analytics to help guide population health management at point of care.

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

Our Year 1 Population

As the result of an in-depth population selection process, our agreed upon Year 1 priority population is:

Adults with a primary diagnosis of advanced Chronic Obstructive Pulmonary Disease and/or Congestive Heart Failure, who are in need of system-level care coordination or navigation; with special emphasis on patients who are at risk of institutionalization.

In Year 1, our partners will develop a targeted recruitment process to establish sustained care relationships with between 2000-3000 people in our attributed population. The following criteria will be used to establish the screening tool that will be used for this purpose:

Adult – our population health working group has recommended that we not place any age restriction on inclusion beyond being 18 or older, but understands that this population will primarily consist of older adults and seniors.

Advanced COPD – defined using the Global Initiative for Chronic Obstructive Lung Disease (GOLD) system, categories C and D.

Advanced CHF – defined using the European Society of Cardiology Criteria categories C & D

In need of system-level care coordination or navigation – A needs-identification tool will be used as a screen for patients who meet the criteria of adult with advanced COPD and/or CHF. This tool will build on the concept used by CSS central intake (and the inter-RAI suite) and will document patient and caregiver needs. Patients will be eligible if one or more cross-system care need is identified.

At risk for institutionalization – An emphasis will be placed on identifying patients who are at imminent risk of institutionalization (Emergency Department, Hospital, or Long-Term Care). Screening tools will be built to support identification of at risk patients using predictive models available in the peer-reviewed scientific literature. Opportunities for patient/caregiver self-report will also be included.

Our Process

The Western Ontario Health Team did not suggest a Year1 population in our readiness assessment. Instead, our stakeholders agreed to a process by which we would work together to select a priority population. Our ultimate goal is to extend this process of priority population identification in an iterative manner until sustained care relationships have been established with our entire attributed population.

Our process for population selection is based in the principles of change management, population health management, and value-based healthcare. A population suggestion tool was developed (1.2 WOH Population Suggestion Form appended in Supporting Documents) that offered partner organizations and their staff the opportunity to suggest a priority population, outline their rationale, and discuss what impact could be made relative to the quadruple aim.

A scoring tool was developed for use by our Population Health Coalition to assess the relative strength of the proposals.

In August of 2019, the population suggestion tool was circulated to Western Ontario Health signing partners. Seven suggestions were received; six of which related to adults with chronic conditions. The Population Health Coalition reviewed all suggestions and felt that there was sufficient overlap in these six suggestions to return to the submitting partners and seek opportunities for collaboration. On August 23rd, a meeting was convened between the leads of all 6 population suggestion groups related to older adults with chronic disease, which included representatives from primary care, community support services, home and community care, EMS, and hospitals. This group agreed with pursuing a shared proposal, which was endorsed by our OHT coordinating council on August 29th.

Population Description
A population-based model developed by Ivey's International Centre for Health Innovation suggests that in our attributed population, approximately 34,900 people are living with COPD. Proportional analysis suggests that 6,397 of these would be living with advanced COPD (Gold C + D). Our Health Condition Grouper data report 6,389 total patients in our attributed population with a diagnosis of COPD. One potential explanation for this disparity in estimates is that the administrative (data primarily collected in hospital) may not capture patients with less advanced COPD and misses patients who are being cared for in the community. We hope to begin to address this issue in our Year 1 work.

The Canadian Chronic Disease Surveillance System (CCDSS) estimates a 3.37% age-standardized prevalence of Heart Failure in Ontario among people 40+ in 2015. Applied to our attributed population, this leads to an estimated 8,880 people living with Heart Failure. Our CIHI Health Condition Grouper data report Heart Failure prevalence as 4,836 within our attributed population.

Information on patient needs related to system coordination and navigation is sparse. However, given that we have restricted our Year 1 population to people with advanced COPD and/or CHF, it is anticipated that 100% will require some system-level care coordination. A key element of our Year 1 work will be to better understand the care coordination needs of these populations and preferred method for addressing them. Options made available to patients and their caregivers may include access to a dedicated care coordinator, care-coordination services, and/or self-management tools.

It is recognized that the Year 1 population may have additional co-morbidities that will require engaging with other sectors to ensure their care needs are addressed (such as mental health and addictions).

Finally, patients at risk for institutionalization will be captured as an area of focus, but not a restriction. Three types of risk will be captured: risk for ED visits, hospital admission, and transfer to long-term care. Targeted recruitment approaches will be established with our partners upstream from each of these institutions (eg. primary

care, EMS, and home care for ED visits, ED departments for hospitalizations, and hospitals for long-term care). Standardized tools such as the Katz ADL and Lawton IADL scores will also be built into patient screening tools for use by all of our clinical partners, but partners will also be encouraged to work with patients and caregivers to self-declare risk.

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

Equity Considerations

The geography covered by Western Ontario Health is home to a diverse population that makes for a vibrant community, but also contributes to a variety of equity considerations that include issues of access to services, equitable delivery of appropriate care in keeping with their diverse needs and histories, and tracking and measurement of equity-sensitive indicators.

As stated in our self-assessment, noteworthy concerns that have been identified in our region include high rates of non-participation in the labour market, limited access to affordable housing, disproportionately high rates of injection drug use, >25,000 patients without a primary care provider, >22,000 individuals living with 4+ chronic conditions, and over 20% of the population identified as experiencing a mental Illness.

Census data significantly underestimates our local Indigenous population. The

[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.

Western Ontario Health geographic region is home to a growing urban Indigenous population and eleven southwestern Ontario First Nations communities. Southwest Ontario Aboriginal Health Access Centre research (2018) found that, among >20,000 Indigenous adults living in London, 51% reported one or more chronic condition and 28% experienced multi-morbidity. Seven percent had a diagnosis of COPD, 6% heart disease, and 17% high blood pressure. Poverty is a determinant of health and access to care that severely affects this population with 90% living below the low-income cut off, and 22% precariously housed or homeless. Only 65% report connection to a primary care provider. Beyond access, equity considerations involve the need for care that is culturally safe and appropriate, includes Indigenous governance, is in alliance with Indigenous care providers, and acknowledges the histories and legal rights that have shaped these populations' experiences.

Delivering culturally and linguistically safe and appropriate services to Francophone Ontarians is another important equity consideration. In 2016, Middlesex County was home to an estimated 6,940 Francophone people; with most living in London. The Francophone population in Middlesex is older than the general population, and includes a substantial number of people under the age of 25. A survey of local Francophones found that over 10% reported that they or someone in their extended family had a diagnosis of Chronic Bronchitis or COPD, and nearly 30% had Heart Failure. Monitoring of health status and the degree and quality of delivery of French language health services (FLHS) will be an emphasis of Western Ontario Health.

Middlesex is also home to a large number of non-English speaking residents and visible minorities. Middlesex County welcomes large numbers of newcomers each year and in the 2016 Census, 20.3% of the population in Middlesex County was immigrants and 1.4% of the population reported no knowledge of English or French. Next to English, other commonly spoken languages include Arabic, Spanish, and Chinese. In addition, 17% of Middlesex County residents identified as a visible minority.

Within our attributed population of 514,024 people, 14% are noted as living in rural communities. Our rural care partners have expressed concerns about access to services that include (but are not limited to) primary care, housing support, and psycho-geriatric services. Transportation challenges to and from these services has also been explicitly noted as an issue that needs to be addressed. Due to these challenges, Middlesex Hospital Alliance has been experiencing extended lengths of stay among patients who cannot be discharged. A large proportion of these people are older adults with multi-morbidity. Access to specialty services will directly impact the target rural population as primary care may not have the direct relationships with specialists as in urban areas; leaving rural individuals solely dependent on their primary care physician and local ED. In addition, broader resource availability in rural Middlesex may be lacking. Rural populations and primary care

providers may also not use technology as readily, which becomes a barrier with access to and proficiency in the use of digital technology.

Poverty continues to be a challenge in the London area. In the 2016 census, 11.8% of residents aged 18-64 and 2.4% of residents >64 were living below the Low-Income Cut-Off, After Tax. According to research from the London Poverty Research Centre, between 2001 and 2013, the use of social assistance, Ontario Works, and Ontario Disability Support in London have all increased at a higher rate than provincial averages. This is particularly important given research that has identified increased rates of COPD in individuals with low socio-economic status as a result of differences in health behaviors, sociopolitical factors, and social and structural environmental exposures.

Our Strategy

In Year 1, we will employ a purposeful recruitment strategy to actively identify and engage our diverse population. This recruitment strategy will include routine monitoring of prospectively collected data on residence (or lack of), language spoken, income, gender, and self-identification as indigenous or visible minority. Locally available data will be used to ensure that recruitment includes individuals from urban and rural communities as well as high and low-income neighbourhoods.

Western Ontario Health recognizes that beyond access, equity considerations include the delivery of appropriate care that meets the distinct needs and histories of all Ontarians; and, the effective tracking and measurement of equity-sensitive indicators through the care process. These considerations will be operationalized differently, according to the contextual and intersecting needs of these populations. Working with the Alliance for Healthier Communities on equity-sensitive and -specific indicators and metrics will also ensure that we assess the impact of identifying and providing care to these groups.

Many of Western Ontario Health's partners have experience providing services to traditionally under-served and/or marginalized populations. As examples, the London Intercommunity Health Centre works closely with homeless or precariously housed individuals and with people who use drugs, while the Middlesex Hospital Alliance services the secondary care needs of much of our rural population Recruitment, intervention, and assessment processes will be developed with our partners to ensure that strategies are established in a way that is successful and sensitive to their context. Strategies like Active Offer (where staff greet patients in English and French simultaneously), and translation services will be incorporated as appropriate. The Population Health Coalition will support development and monitoring of these processes to ensure alignment with established best practices.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

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

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

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

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

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

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

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

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

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

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

Max word count: 500

Implementation of the Ontario Health Team model began by engaging all interested organizations and providers accountable for the primary and secondary care needs of all residents of our geographic region. An open invitation was offered to local healthcare providers to collaborate and participate in the development and implementation of a local Ontario Health Team (OHT). The initial partners who endorsed the OHT self-assessment are members of several groups: primary care, home care, community support services, patient families & caregivers, emergency health services, hospitals, and long term care.

[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

Interested partners who were unable to endorse the OHT self-assessment in May 2019 are ensured that there will be many opportunities to become involved in the development of Western Ontario Health (WOH) as we continue on this journey. Future collaborative partner organizations and individuals for Year 1 and into maturity include: secondary care (includes specialist services), Indigenous representatives, Francophone representatives, health promotion and disease prevention, rehabilitation and complex care, palliative care, mental health and addictions, residential care and short term transitional care (retirement homes), laboratory and diagnostic services, and midwifery services.

We feel that our Year 1 team is well positioned to begin work to integrate and improve care for the first patient population. Membership covers a broad range of health services providers who are currently connected to the Year 1 patient population.

One challenge for Year 1 is the engagement of more primary care providers, including physicians, beyond those already participating. There is an opportunity to enlist the support of the Partnering for Quality program to continue building necessary relationships within primary care.

Scaling improvements beyond Year 1 will require support from many health services providers who have not yet been involved. The WOH Coordinating Council will continue to reach out to the broader community of providers with timely communication and organized learning sessions to develop a shared understanding, and offer opportunities to become involved in the evolution of our OHT.

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 partners of Western Ontario health have worked together previously on improvement initiatives and program development to advance integrated care delivery.

Here are examples of this work:

The Community Support Services (CSS) Network is integrating the intake, assessment, and registration of services for 23 individual CSS providers, utilizing a Quadruple Aim Approach with shared metrics around patient experience and provider experience, representing a 46% efficiency improvement and ensuring that individuals are connected to all of the services available to support them to live independently.

Connecting Care to Home (CC2H) is an integrated, multi-disciplinary team approach across care settings (hospital, community care and primary care), developed to support patients living with chronic conditions. The CC2H program has integrated shared leadership that includes hospitals, primary care, home and community care, home care providers, specialty physicians, and supporting technologies. The patient and care team are enabled by an eShift performance dashboard developed to provide ongoing access to outcome measures of patient experience, patient care success, and staff achievement. The objectives are: improved patient outcomes, improved patient experience/confidence to self-manage, reduced hospital length-of-stay, reduced avoidable emergency department/readmissions, and reduced overall system cost. The program is in the third iteration with key results as follows: Hospital length-of-stay has declined 39.4%, 30 day readmission has declined 51.3% and the total cost per patient to the healthcare system has declined 35.6% for COPD subject population (as of March 31, 2019).

The South West Primary Care Alliance is a network of primary care physicians where opportunities for improvement and learning are facilitated. Through the Partnering For Quality Digital Coalition, acute care specialists and primary care providers are beginning to work together to streamline/reduce the volume of referral forms in order to improve patient experience (reduce delays in referrals being accepted by ensuring the right info gets to the right spot the first time, leading the way for a more integrated centralized referral process). The Digital Coalition has streamlined the creation and dissemination of custom forms used to access testing, enabling patient referrals at tertiary care centers therefore improving timeliness of patient care.

The Partnering for Quality (PFQ), Practice Facilitation Program's Digital Coalition, is an active partnership of information technology champions. These folks work with our PFQ team to coordinate the creation and spread of digital tools that they need throughout their practices. By bringing these champions together, we enable them to share their time, expertise, and experience towards collective quality improvement (QI) gains rather than siloed efforts. Our role is to coordinate these efforts, allowing the collective to create the capacity to broaden QI efforts which is not possible in a siloed environment. Through the implementation of Experience Based Design (ebdth) in the region, a cross-sector Community of Practice has been launched (spring 2019) in order to build capacity within the region to support organizations with their own implementation of EBD (within their walls) but also, to support OHT development. This pool of resources will be able to help support capturing, understanding patient experience across sectors, identify areas for improvement and partner with patients in the co-design of system change. Membership includes individuals from Mental Health & Addictions, LTC, Primary Care and Community Support Service Agencies. The PFQ PF Program has offered cross-sector EBD training in order to build system wide knowledge to 478 participants between 2013 – 2019.

St. Joseph's Health Care London, together with a regional steering committee, has been leading the development of a South West Frail Senior Strategy (the Strategy). The goals of the Strategy are to create an integrated system of care for older adults living with frailty; streamlining and improving equitable access to geriatric care by leveraging the combined resources and efforts of the disparate initiatives, programs and services currently focused on this population.

The South West LHIN Medical Imaging Integrated Care Project is a regional team comprised of radiologists, clinical leaders, family physicians and the South West LHIN that developed regional checklists for knee and spine outpatient referrals. The checklists were based on the Choosing Wisely Canada recommendations with the goal of optimizing MRI services in the region. Additionally, the project resulted in the standardization of 26 Regional Imaging Protocols.

Participation House Support Services (PHSS) in partnership has created an integrated healthcare service collaboration serving adults living with long-term mechanical ventilation across the South West region (2.4 Participation House Support Services – Chronic Mechanical Vent appended in Supporting Documents).

This program has enabled people to return home from hospital and live in the community. This program has resulted in:

- Collaborative coordination of transition planning and ongoing care
- Enhanced region-wide Home & Community services – RRT and NP services available to home and community based persons dependent on LTMV
- LHSC's inter-professional LTMV Outpatient Clinic for healthcare continuity: respirologists, respiratory therapists, speech language pathologists, nutritionists, palliative care

PHSS, with support of Hospital partners and LHIN - Home Care has:

- expanded the number of LTMV beds and persons served within the community
- expanded access to Day Care / Day Respite on week days
- introduced Scheduled Overnight Respite care
- introduced Emergency Overnight Respite care

The Middlesex London Paramedic Service (MLPS) has extensive experience with collaborating with health professionals from a variety of disciplines following a robust process of performance improvement to improve health outcomes in a wide variety of patients.

One specific example within primary care - MLPS has participated in a program of remote patient monitoring of patients with chronic diseases such as diabetes, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) using novel technologies that allow key patient data points and vital signs to be monitored by experienced paramedic practitioners. Key performance indicators were tracked as part of the quality review and the results showed a 26% reduction in both 911 calls and emergency department (ED) transports and a 32% reduction in hospital admissions. (Broham et al., Community Paramedicine Remote Patient Monitoring: Benefits Evaluation. 2018)

A second example - In acute cardiac care, MLPS has collaborated with the interventional cardiologists at London Health Sciences Centre (LHSC) and developed a program where select acute myocardial infarction patients are identified using pre-hospital electrocardiograms (ECG) which are then transmitted directly to the cardiologists for review. The patients are transported directly to the interventional cardiology catheterization suite at LHSC bypassing the ED to receive percutaneous coronary interventions (PCI). Programs such as these result in a reduction in mortality from 8.9% to 1.9% in the paramedic primary PCI group. (Am J Cardiol. 2006 Nov 15;98(10):1329-33).

Through the Southwest Hospice Palliative Care Steering Committee, London Health Sciences Centre, St. Joseph's Health Care London, Home and Community Care, St. Joseph's Hospice, SW LHIN, South West Aboriginal Health Access Centre and community hospitals work together to coordinate the needs of patients who require palliative care services

The Postnatal Wellness Clinic was developed to connect all infants delivered at LHSC and their families with a primary care provider to ensure timely follow up care, support, and connection to community supports. This program was developed in collaboration with primary care, acute care, public health unit and Western University. There are more than 5700 infants delivered at the LHSC OB unit per year, and a subset of those infants and their families do not have a primary care provider. These families have been linked to primary care provider for follow up and support. In 2017, there were >800 ED visits by infants in the first 31 days of life
The program objectives are:

- To connect all infants delivered at LHSC and their families with a primary care provider
- To provide access to evidence based, trauma and violence informed care to infants and their families 24/7 during the first 2 months of life, that does not involve a trip to the ED
- To improve rates of breastfeeding at 3 and 6 months
- To connect families with community resources to help them thrive
- To minimize the ACE scores of the next generation of children born and raised in London-Middlesex

In Western Ontario Health (WOH), there are long standing relationships between Hospitals and LHIN-Home & Community Care, Community Support Service Agencies and Mental Health & Addiction agencies. The relationship between primary care and other sectors have grown over the past 10 years through involvement in various improvement initiatives. As WOH develops, it will need to continue to grow these partnerships and will invest in building trusting relationships with shared accountability for the delivery of integrated care to our attributed population (2.4 London Middlesex Community Support Service - Matrix of Services, appended in Supporting Documents).

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

Alignment between Western Ontario Health's proposed service area and our attributed population is extremely high. Western Ontario Health (WOH) is committed to being accountable for the primary and secondary health needs of our full attributed population (514,024 people) at maturity. Fortunately our attributed population is among the most loyal in the province. Among our 3 most costly Health Profile Groups, 89% of General Practice fees, 84% of specialist fees, and 91% of acute inpatient expenses were paid to physicians included in our Ontario Health Team. In addition, 93% of patients received their hospital care at one of our Ontario Health Team Networks. In primary care, none of our local Patient Enrollment Models included patients who were aligned with a different Network (a finding we understand to be unique to our OHT).

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	*Describe what services they provide*	*Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in*

organization		*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

Western Ontario Health is committed to providing integrated care to 100% of our Year 1 population, which is why we have chosen to cap our enrolment at 2000-3000 patients during this period. In Year 1, partners in WOH will pro-actively identify patients who fit with our defined patient population using a standardized screening tool. Eligible patients will undergo a needs assessment (which will draw upon pre-existing data wherever possible) and creation of a plan for their health. Through this process, WOH will be committing to establish a sustained care relationship with this individual that meets their care coordination and system navigation needs. Our intention is to ensure that from the patient and/or caregiver's perspective, the services they receive in Year 1 (and beyond) are seamlessly connected. If during Year 1 capacity allows for us to extend this integrated care beyond the first 3,000 such patients we will extend enrollment. However, our partners are aware of the need to monitor our ability to effectively meet the integrated care needs of our patients and not over-commit during the early stages of WOH development.

To achieve our commitment to providing integrated care, WOH signing partners are committed to providing integrated access to care that is within their current offerings. In instances where service needs are identified during their needs assessment that fall outside the scope of services provided by signing partners, the patient's care coordinator will actively seek to connect patients and caregivers to appropriate services outside of our signing partners. Services identified during this exploration process will be documented for future reference and potential inclusion in WOH. In instances where no service is currently available to meet and identified care need, this will also be documented for future consideration.

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

Planning for Year 2 has not yet been done as planning for Year 1 is still in process. In early discussions we have noted future collaborative partners and will continue to engage these organizations and individuals.

Our focus in Year 1 will be adults with a primary diagnosis of advanced Chronic Obstructive Pulmonary Disease and/or Congestive Heart Failure, who are in need of system-level care coordination or navigation; with special emphasis on patients who are at risk of institutionalization.

It is recognized that the Year 1 population may have additional co-morbidities that will require engaging with additional sectors to ensure their care needs are addressed, for example: Mental Health & Addictions and community based Palliative Care.

Patients at risk of institutionalization will benefit from strong engagement and planning with Long Term Care, residential care, short-term transitional care, retirement homes, and supported housing.

Recruitment of a patient engagement specialist is underway and the role of this person will be to ensure active involvement of patients, families & caregivers, which includes representation from Indigenous, Francophone, non-English and other minority groups.

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

All primary care providers in our network are not yet involved at this point.

Physicians and other primary care providers who are passionate about the necessity for change and improvement in the delivery of health services have come forward, endorsed the OHT self-assessment, and are members of the Coordinating Council overseeing implementation and co-design. Primary care has been actively involved in identifying the Year 1 patient target population as members of the Population Health working group. The Digital Health working group has physician membership.

Western Ontario Health is in the initiation and planning phase of identifying future changes and deciding upon starting structures that will enable people collaboration and process changes. There is still much work to come in order to investigate early prototypes and solutions and identify the paths forward.

In order to create an opportunity for physicians to join as equal partners there is recruitment underway for a primary care transitional lead to join the Coordinating Council secretariat and represent the “voice” of primary care. This individual will take the lead at engaging clinicians and expanding primary care partnerships in order to care for our patient population at maturity.

There is an opportunity to enlist the support of the Partnering for Quality program to continue building necessary relationships within primary care.

Primary care members who have been part of setting up Family Health Teams have invaluable knowledge and governance experience that should be incorporated into shared learning, decisions, and continuous improvement.

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

This OHT full application was developed using a participatory process that started with involvement by all organizations and individuals who endorsed the OHT self-assessment submitted in May 2019. When contacted in July to build upon the information in the self-assessment and submit the full application, signing members were invited to participate, make decisions, and gather information.

From mid-July until the end of August a timeline of tasks to be accomplished was created, a Coordinating Council with representatives for each of the signing sectors and patient advisors was created, and a secretariat with members to help organize, lead teams, and inform decisions was started. The Coordinating Council has two co-chairs: one patient advisor and one health services provider. The director of the secretariat is the contact for the OHT central program evaluation and has the responsibility to oversee the application submission on October 9. Sector representation was suggested at a June meeting with the broader community of OHT stakeholders in this region in reply to a question about the best way to begin to organize. The Coordinating Council terms of reference describes a process to bring more health services providers into the OHT design as we progress. The current members are well positioned to plan changes for the Year 1 patient target population and it is understood that the scope in the beginning will be scaled up to provide for increasingly more of our attributed population overtime. This will require engagement with all health services providers and the community as Western Ontario Health moves through Year 1 and towards maturity.

From mid-July until the end of August four additional work groups were formed: a population health work group; a digital health work group; a home and community care work group; and a communications work group. Leaders of these work groups are members of the secretariat who also attended the Coordinating Council meetings as non-voting members. The overall OHT solution structure (2.10 OHT Solution Structure appended in Supporting Documents) was created to allow timely sharing of information and decision-making. Coordinating Council sector representatives have the responsibility to share information, gather feedback, and represent their peers during decision voting.

The Population Health work group enlisted partners to identify the Year 1 target population. This collaborative process is described in detail in Section 1 of this application. A presentation of the process and recommended Year 1 target population was given at the first Coordinating Council meeting in late August 2019. At that meeting, the voting representatives for each sector and patient advisory group decided by consensus vote to proceed with the Population Health work group's recommendation. (2.10 Consensus tool appended in Supporting Documents).

The Communications work group has created a communications plan that addresses the needs of the OHT teams and broader community of stakeholders. They have also created a toolkit that includes key messages, a presentation, and a briefing note for individuals and boards of organizations to use when deciding whether to endorse the OHT full application prior to the October 9th submission. A communications specialist is being recruited as a member of the secretariat in anticipation of the need to expand the current communications plan to include a broader range of people as we progress.

The Digital Health work group assessed the current digital health capabilities and is assessing capacity to meet the minimum readiness requirements and Year 1 expectations. To be noted, at the time of writing, the Year 1 target population has only been known for a few weeks. Planning discussions will be continuing as we move forward.

In September at the second meeting of the Coordinating Council, it was decided that the responses to the OHT full application would be developed at the request of the secretariat director by work groups created from the signing members. Mid-September, the written responses as completed to date were circulated to the Coordinating Council members and 44 requests for additions and changes were received back. At the end of September, a final copy of the full application is available for endorsement by signature of the members. Coordinating Council representatives have the responsibility to circulate the information to individuals or member organizations' boards and to collect endorsement signatures.

One of the risks identified is the tight timeline to respond to the OHT full application and that there has not been a chance to engage as fully with stakeholders as we

would wish. We acknowledge that there are essential steps that need to be taken prior to completing the implementation plans in order to consult more fully with: patients, families, and caregivers; the local community which includes Francophone and Indigenous communities; and primary care providers, both urban and rural. We are currently recruiting a patient engagement lead and a clinical engagement lead to join the secretariat and provide the necessary leadership to close these gaps.

Western Ontario Health is committed to co-designing change initiatives with the direct involvement and feedback of those impacted. Membership on all teams and at all levels will include patients, families & caregivers, primary care, and health service providers.

We look forward to discussing our progress with you in more detail at a scheduled "post – OHT full application" site visit.

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

Western Ontario Health is committed to the Quadruple Aim of improving population health, patient and caregiver experiences, care-provider experiences, and financial accountability. As has been demonstrated in numerous regions around the world, high-functioning health systems that best achieve the Quadruple Aim are built around a strong primary care sector. Therefore, of the indicators noted above, the following will be of greatest focus for WOH:

- Total health care expenditure
- Patient-Reported Experience Measures
- Provider-Reported Experience Measures
- Patient-Reported Outcome Measures
- Timely access to primary care

In alignment with the principles of value-based healthcare and the growing literature around the benefits of a population health management approach, we feel that an emphasis on these indicators will results in concomitant improvements in the other indicators listed. Data collection strategies will be strengthened for each and system-level reporting and shared accountability will be established.

In our Year 1 population, we know that the nearly 6,400 people with advanced COPD and 8,880 people with CHF represent a diverse and complex group of patients. While it is difficult for us to identify in detail the specific challenges facing this population until they are prospectively screened, we anticipate that they will all require some form of care coordination and or system navigation. We also know that these coordination needs will extend far beyond traditional medical services. For example, a recent survey of our local Indigenous population identified that 7% of the approximately 20k Indigenous adults in London have been diagnosed with COPD and 6% with heart disease. We also know that nearly a third of this population reported living with 2 or

more chronic conditions and 90% live below the Low-Income Cut Off. During Year 1, we will proactively be seeking to identify some of these individuals, work with them to develop an individual care plan, and then supporting integration of services that may include primary care, care coordination, specialist services, Indigenous traditional healing, and housing support. Even more, Western Ontario Health will be accountable for ensuring that this care plan is carried out and will periodically re-connect with these individuals to monitor their outcomes and experiences with the system. It is through sustained care relationships like these that the greatest opportunity exists for Western Ontario Health to improve care.

As noted previously, data on our attributed population suggest that our most costly sub-populations are heavily weighted towards patients with significant comorbidity (8 of the top 10 health conditions included this caveat). These complex patients are felt to be significant contributors to the fact that wait times for first home care service, avoidable ED visits, 30-day readmission rates, hospitalizations for ambulatory care sensitive conditions, and hallway bed days all rose between 2016 and 2018 in our population. These comorbid patients are the ones most at risk of being lost in our current system as their complex needs often mean that they require multiple services and care from a wide variety of providers (many of whom are not well connected). The confusion this causes in navigating the system is what often leads to poor experiences, poor outcomes, and the associated high costs.

Despite general consensus across the province (and around the globe) on the importance of the Quadruple Aim, relevant indicators are very poorly collected. The Ministry has noted above that indicators related to patient-reported outcomes and patient and provider experience are in development. Western Ontario Health is committed to collecting these measures within our Year 1 population. It is our contention that this collection should be undertaken prospectively and proactively (not only at point of care). This will be built into the OHT out-reach processes and will ensure that we remain connected with patients who do not access the health care system. This collection will be established within our Year 1 population with an eye to sustainable collection among our full attributed population at maturity. Fortunately, WOH's partners are leaders in collection of this information. Our team has committed to working closely with the Ministry to share findings from our local collection of PROMs and PREMS in our cancer, hip and knee, and stroke populations. We will ensure that all processes we establish align with the Ministry plans for provincial roll-out.

In Year 1, all patients who are prospectively enrolled in Western Ontario Health will be administered a brief measure of self-reported health and quality of life (such as the Euro-QoL 5D) and a measure of patient experience (such as the WatLX). Signing providers will also be asked to complete baseline measures of experience with the health system in managing complex patients with COPD and/or CHF. These baseline measurements will allow for monitoring of change over time and will lay the foundation for future health system improvement. In the short term, we hope that this will help us identify and better support patients noting poor health and/or quality of life. The data will also allow us to track system performance in improving the Quadruple Aim. At

maturity, WOH will use this data to inform prescriptive analytics that proactively identify patients at risk for poor outcomes (to inform out-reach services) and offer data-informed recommendations for optimal care. Information like this will allow the patient, their caregiver, and care providers the opportunity to weigh treatment and service options and make more informed decisions about their health. Research suggests that access to this type of information can help to decrease system-wide healthcare spending and improve efficiency by ensuring that patients get access to the most cost-effective services to meet their needs.

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

Western Ontario Health, above all else, will seek to promote simplicity in everything we do. Our patients and their caregivers should have all of their information available to them in a simple and easy to use manner, should know what to expect and what is expected of them, and should know what to do if something goes wrong. Our care providers should also know how to access their patients' shared health record (including their health plan) and how to connect them to the services they need. Finally, everyone working in our local system should understand the principles of population health management, health equity, and the Quadruple Aim. As such, we should have shared system goals that are simple to present and easy to understand; and that are rooted in the Quadruple Aim. Our care providers should have a clear line of site into how their daily activities contribute to improving those system goals.

In our current health care system, we consistently hear from our patients that they are pleased with the care they receive, once they get access. Our greatest challenge is in getting patients to and between these services. Western Ontario Health is committed to the concept of population health management and accountability for the outcomes of all of the people we serve. This will require a significant shift away from the siloed care we provide today, and towards a truly integrated system. At the heart of this change will be a shared digital health record and active care management.

These two elements together will be the focus of how we redesign care and change practice in our OHT.

Data collection is not a significant issue in Ontario's healthcare system, however, integration of data is. While there are some key data points that we don't routinely collect (eg. patient-reported outcome measures and patient-reported experience measures), our care providers are comfortable with data collection. Our challenge is data integration. A key pillar of the change management plan for Western Ontario Health will be integration of information into a central data repository and creation of a shared (and accessible) patient record. To this end, we are actively seeking to identify and connect potential solutions (such as Cerner's HealtheIntent) that can help us to connect primary care EMRs with CHRIS, EMS, and hospital records to support patient management in clinic (see Appendix B for more detail). We have committed to the principle of human-centred design, which means that we are working with our patients to understand what data they want access to, in what format, and when. We are equally working with our providers to understand what information they need (and in what format) to improve clinical decision making. Western Ontario Health will not settle for patchwork solutions that don't connect. We are driving towards creation of a central record that spans all of the care providers who are part of our patient's care team and communicates seamlessly.

The principles we are striving for in this data collection will be real-time access to information and standardized formatting. A key element of this will be creation of an individualized care plan for each patient in partnership with their primary care provider. Once available, this information will be the foundation of each patient's care coordination and should never need to be re-created; only adjusted as appropriate. The data in this plan will also lay the foundation for system accountability. If a care plan denotes the need for imaging within 24hrs, then the system (and those working within it) should be accountable for coordinating imaging within 24hrs. Likewise, if a patient is to see their primary care physician twice a year, then we should be able to document if they have seen their primary care provider 2 times each year and actively support patients and providers to ensure this happens. Patients should have access to this plan at all times and should know what to expect from the system and what is expected of them. If they can manage their appointments, then they should have the right self-management tools made available to them. If more active care coordination is necessary, then that should be made available too.

Finally, the data that comes from this central repository will be actively mined and analyzed to inform better patient care and system performance. Once a complete data set is available in a central location, prescriptive statistical analyses (and ultimately Machine Learning) approaches can be used to identify associations between patient characteristics (including social determinants of health), and successful interventions. This learning can be imbedded directly into clinical software to provide patients and clinicians real-time recommendations to optimize their outcomes. While this will never entirely remove the need for clinical expertise, it can be a powerful tool for informing clinical best-practices and improving care. Data can

also be used to identify variation in outcomes and drive quality improvement. The combination of clinical and socio-demographic information (for instance) in combination with measures of outcome, experience, and cost can allow for identification of areas of excellence in the quadruple aim and opportunities for improvement at the system, organization, and even provider level. In a spirit of collaboration, this information can be used to help our providers learn from one another and to inspire a vision for better care.

The second arm of how we intend to transform care is through the provision of active care management; however, the two are perfectly intertwined. Proper care management cannot be achieved without access to appropriate data and without infrastructure to support care management the data will not be used to its full potential.

Our vision is to support the primary and secondary care needs of our entire attributed population (514,024 people). Not all of these people will require active care management. However, in our Year 1 population it is anticipated that a high proportion will. Many of our current providers already provide care coordination. However, there are opportunities for improvement in the care coordination model being used. For example, current care coordinators do not have access to the complete care record they require to effectively manage care for their patients and, second, in some instances the care coordinators have been responsible for caseloads that exceed the best-practice target. Established care management programs in successful Accountable Care Organizations and health systems around the world have targeted 60-100 patient caseloads when managing patients with complex chronic disease. This allows the care coordinators to work directly with primary care and be pro-active in connecting with patients, providing health promotion activities, and being available to respond to crises when they arise. The result is fewer ED visits and hospital admissions, while supporting patients and their caregivers to remain in the community longer. Western Ontario Health will support refinement of these roles within our Year 1 population and evaluate performance in terms of patient outcomes and experiences, as well as system costs.

By providing improved system navigation and care coordination, we anticipate that patients will feel more connected and better supported, which will translate into better experiences with the healthcare system and better outcomes. The capture of this information will be embedded within the care plan and we will be able to actively monitor this over time. We also anticipate that with these resources in place, our providers will spend less time searching for information and trying to navigate the system for their patients. We expect that this will contribute to improved provider experiences (which will also be measured), decreased costs, and better access to care (as providers can see more patients). It is our hope that in the primary care sector, these efficiencies can help us work with primary care providers to improve timely access to their services.

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

As noted previously, care management (including the concepts of care coordination and

navigation), is a key component of Western Ontario Health's plan to transform care. Our partners have expressed the importance of care coordination as a process, not necessarily a role. Every effort will be made to enable care coordination processes where possible by leveraging technological processes and automated notifications. However, we also need to ensure our care coordination roles reflect services that meet the needs of our population. There are several partners who currently employ care coordinators, but no one single partner has all the information or the capacity to properly support patients across the entire system. As Western Ontario Health evolves, we will leverage and realign these resources to support our attributed population and the health system, reflecting leading practices.

In Western Ontario Health, Primary Care will be at the heart of care coordination. Patients will be connected to a primary care provider (Doctor or Nurse Practitioner), who will work with the care coordinator (and care-coordination processes) to maintain their care plan. Care plans may be developed by the patient (and their caregiver) in concert with a care coordinator, primary care provider, or specialist as is appropriate. However, all information will be shared across providers and the coordination function will fall to the primary care provider and care manager working together.
Evidence from our local COPD Best Care program has demonstrated that patient outcomes are improved and system costs reduced when primary care doctors are given supports to manage care in the community. In the case of advanced CHF, international evidence suggests that patients achieve the best outcomes (fewer readmissions and/or deaths) when seen by a specialist and also their primary care physician. In Year 1, we will work within these populations to better connect patients to the services that are right for them and to ensure appropriate sharing of information across all providers.

Care coordinators will be responsible for ensuring that care plans have been co-created by the patient and team member and will monitor for adherence and variance. In instances where needs are not met, the care coordinator will document the service required and reason for it not being provided. This will help to provide a layer of accountability in the system and offer information that can be used for future capacity planning. Care coordinators will also be responsible for regular out-reach contacts with patients and collection of experience and outcome measures. In combination, this information will allow us to monitor the success of our program in Year 1 and guide planning for Years 2 and beyond.

As Western Ontario Health expands beyond Year 1, the care coordination levels for non-complicated patients managing chronic disease will be refined with a caseload estimate of 60-100 for complex patients. Western Ontario Health has committed to prospective enrolment of 2,000-3,000 patients with COPD and/or CHF who are in need of care coordination & system navigation. While many of these patients will fit into non-complicated risk categories, we have also committed to proactively including marginalized and diverse patients. Therefore, it is anticipated that in Year 1 the case load of our care coordinators may vary between 60-100 patients. Actual number of available care coordinators will need to be determined based on primary care and patient connections. Several of our organizations including LHIN-H&CC employ care

coordinators at this time and it is anticipated our partners will need to share and realign these resources to ensure that this care is available at the intensity necessary to ensure best-practice care.

Western Ontario Health has an existing integrated care management program for adults who are medically fragile and require intensely complex 24/7 care. This program provides a foundation to extend the provision of seamless ongoing 24/7 care to a broader range of people in our attributed population that would benefit from seamless integration of acute care, primary care and specialized 24/7 community services.

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

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

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

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

Max word count: 1000

As with care coordination, our partners have stressed that system navigation is a function and not necessarily a person. Our region is home to many excellent system navigation tools including the SouthWest Healthline and Connex Ontario. These programs will be leveraged to support patients in system navigation, but also to help our care providers (such as primary care physicians and care coordinators) with simple and easy to use strategies to connect with the resources their patients need.
In the spirit of human-centred design, patients, their caregivers and care coordinators will be engaged in design exercises to understand their information needs when navigating the system. From the patient and caregiver's perspective, self-navigation tools will be identified and laid out for them to help simplify the process. Information gathered during these sessions will be used to inform our local information providers (like the Healthline) to improve their services.

Likewise, primary care providers and care coordinators will be engaged in design sessions to understand their information needs. Existing repositories will be used wherever possible and, where they aren't available, centralized resource lists will be

created. This will be done purposefully in conjunction with the information gathered during the patient and caregiver needs assessment. As we collect information on the demand for services such as housing, legal support, and food, we will actively seek to compile inventory lists with contact information for these services and ensure they are added to the central repository. Western Ontario Health will also work with our care coordinators to establish relationships with these services that may help to facilitate improved navigation. Extensive work has already been completed in this region related to Mental Health and Addictions services that can be leveraged as an example.

We will work with our patients, caregivers, coordinators, and care providers to understand their ability to navigate the system over time. This will be formally tracked to assess changes over time.

There are several models of system navigation that currently exist in the region of Western Ontario Health including but not limited to Home Care, Community Support services, Mental Health & Addiction services, out patients services and in-patient services.

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

Care transitions are currently challenging in the health system and frequently reported as an experience full of uncertainty, lack of communication, and missed steps. Currently patients and caregivers report challenges with transitions including but not limited to hospital to home or ambulatory care, follow up appointments, follow up diagnostic testing, and primary care to specialty care. Most comments are related to communication gaps: lack of awareness of the care plan; timeliness of the discharge plan; uncertainty of referral to specialist; unsure of information shared between specialists; and uncertainty as to follow up processes. In the community setting, similar concerns are experienced about communication - poor or limited communication among providers– for example, visiting providers arrive at the home unaware of the specific technique to provide a transfer for that patient's unique needs; communication can be poor and not timely from one visiting worker to another within the same agency as well from member of the community team to another regarding the care plan. Patients/caregivers often repeat their story and their needs, then re-

educate workers how to provide the care – all of which is an exhausting and frustrating experience that results in lack of trust and confidence with healthcare providers and the health system.

Foundational to our model are the principles of patient and caregiver co-design, self-management, and sustained care relationships. The focus in Year 1 on a self-management approach will ensure health professionals in all settings have health literacy skills to communicate with patients/caregivers using evidenced based methods that ensure understanding. This approach also equips caregivers with effective skills to prepare for medical appointments, understand and manage their chronic conditions and daily living. The South West Self-Management Program has proven results within the South West for the past 10 years and we will build on the work of this team to support our target populations and providers, and to expand the program to meet the diverse needs of marginalized and other diverse populations. Building on a model that ensures 24/7 access to the care team and using technology to support patients and caregivers, including secure connections and virtual access, will enable patients, caregivers and health services to access care plans in real time and view changes as they occur.

Using the learning from models such Connecting Care to Home, Telehomecare and other virtual technology, the model of care developed will use consistent team members, and ensure 24/7 responsiveness to patient/caregiver concerns, provide coaching and education and provide real time intervention as flags are identified (i.e. increased heart rate, etc.). This enables providers to interact with patients when needed and de-escalate the event, preventing an emergency room visit – for example, a nurse calling a patient after noticing a spike in heart rate and assisting with breathing techniques, providing reassurance, and from a patient perspective knowing that someone cares. A series of learning modules and coaching support will form a component of the model. This ensures that patients are educated about their condition using a structured, evidenced-based approach. This fosters the relationship of the patient with the care provider. Patients experiencing this method of education have relayed that there was so much they did not know about their condition, such as proper use of inhalers or what an exacerbation was. This increased knowledge results in increased confidence, and a sense that they are prepared, and directly impacts on less use of ER and inappropriate transport by EMS to hospital.

Role expectations and role clarity within the team will be a focus of Year 1. Early in the model's development providers and patient/caregivers will use an experience-based design methodology to better understand the patient journey. This process will help to understand critical elements that need to be embedded within roles, and critical process such as "Always events". Together with patients and families, we will explore effective communication methods with a focus on clarity and timely sharing support by enabling technology.

As mentioned in the previous sections, a specific focus of the care coordination will be the hand-offs between sectors – ensuring patients/caregivers are prepared and

confident as the transition occurs. The care coordinator will provide the liaison and connections with the patient/caregivers and the care team.

Western Ontario Health is committed to improving care transitions which will be a primary focus of our system transformation and aligned with the responses to the previous questions. Through our emphasis on seamless transfer of digital health information to all providers and the patients/caregivers, we hope that patients will leave every interaction with the healthcare system with clarity around what is next, when that will happen, and what is expected of them. Through an established relationship with a care coordinator, patients and their caregivers should also feel comforted in the fact that they know who to contact if they have questions or concerns, and that they have the support in place to make sure that the transition goes smoothly. While there is a lot of work required behind the scenes to ensure the appropriate flow of information and resources are in place to facilitate this, our objective will be for patients to experience a seamless transition.

Currently there is a Geriatric Ambulatory Access Team who coordinates access to services. This team is exploring the use of virtual tools to enable their work. The team works with the Centralized CSS access team to assist in transitions and care coordination. In addition, through a co-design process, family caregivers have informed the coordinated discharge process ensuring the needed supports and connections for complex patients are made at discharge.

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

On average, people with chronic disease spend approximately 12 hours a year with a health care provider and are left to self-manage the rest of the time. Self-management will be an area of prime focus for Western Ontario Health, and will be incorporated into all aspects of care as appropriate. This will be achieved in part by emphasizing the need for self-management throughout our system and ensuring that patient needs are identified and documented in their care plan. This documentation will include specification of activities that fall to the patient to provide clarity for everyone involved.

Plans should also include documentation of education and/or self-training needs to ensure that these are well understood by all and have been completed. In accordance with this information, self-management resources including apps, websites, print materials and others resources will be sought to support people with their self-care needs. In instances where further support is required, connection with the South West Self Management program will be sought (3.5.1 Self Management and Health Literacy Program Overview appended in Supporting Documents).

Effective and evidenced-based self-management support includes targeting behavior change in both the patient/caregiver and the healthcare provider. This two pronged approach is what the South West Self Management program utilizes.

The South West Self Management program is a local resource that supports people and their caregivers living with chronic conditions through free community workshops that provide resources and teach practical skills. These evidence-based programs increase motivation and self-confidence in making healthy lifestyle changes.

Effective self-management also includes supporting behavior change in health professionals as well. The program supports any healthcare provider in the South West by providing a variety of workshops and coaching opportunities based on their needs and interests and all the free educational opportunities focus on how to improve the patient experience and communication flow. This program will be leveraged in Year 1 to support our population, and will lay the foundation for extending self-management approaches more broadly within Western Ontario Health.

The South West Self Management (SWSM) program has demonstrated marked

success in our region. Assessment of the Patient Activation Measure demonstrated an average increase from 57.9 at baseline to 62.8 by program end, which is significant given that a single point increase in score correlates with a 2% decrease in hospitalization and 2% increase in medication adherence.

The SWSM program that currently exists has all the following programs available:

Patients and Caregivers (self-referral or HSP referral):
- Living a Healthy Life with chronic conditions
- Getting the Most from your Health Care Appointment
- Powerful Tools for Caregivers

For Health Care Providers:
- Health Literacy
- Empathy Effect-Countering Bias to Improve Health Outcomes
- Choices and Changes-Motivating Healthy Behaviors
- Treating Patients with CARE- Connect, Appreciate, Respond and Empower
- Brief Action Planning
-

All these programs are currently in place and we have capacity to accept more referrals.

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

Currently, within our attributed population, there is a high need for support for our informal caregivers. Evidence suggests that close to 98% of individuals living with multiple chronic conditions receive support from informal caregivers. For example, the Alzheimer's Society (one of our signing partners) currently services just over 2800 clients each year; greater than 60% of those clients are caregivers seeking support. Our OHT believes that support for the informal caregiver is crucial and have steps in place to address this complex issue through a variety of different approaches. Open and transparent communication and inclusive care planning are very important. We will leverage caregiver support groups that already exist in our community (i.e. support groups for caregivers facing dementia, brain injury, bereavement, etc.) and connect caregivers to needed supports as much as possible.

To ensure caregivers have time for self-care, we have well established respite programs ranging from day programs, overnight programs, social recreation programs, in home support, and friendly visiting programs. A very successful approach in our area has been coordinated intake for Community Support Services.

Through this service, anyone in our population can call and have support to navigate the health system, access services, and seek coordination of care. Other services, such as Behavioural Supports Ontario (BSO), will continue to be available to clients. These services are helpful to ensure the caregivers have appropriate access to the services they need. Additionally, we plan to highlight available education and support services to help caregivers develop skills. Current examples include the Alzheimer Society which offers foundational dementia knowledge and skills education though the First Link Learning Series and more intensive skills development through the Enhancing Care program utilizing problem-solving therapy and simulated patients and VON chronic disease education programs. We will leverage these and other existing programs. The South West Self Management program also recognizes the importance of the caregiver role and how their health needs have to be addressed. SWSM currently offers the following free programs that support this;

- Powerful Tools For Caregivers
- Getting the Most from your Healthcare Appointment
- Living a Healthy Life with Chronic conditions.

Through a grant from the Change Foundation, there is collaborative work underway focused on implementing a care framework that improves the engagement of patients, residents and caregivers in the delivery of care.

Underpinning all of these strategies is our commitment to involving patients and caregivers in the planning of our OHT from the beginning. We believe that understanding the needs of our caregivers and providing the supports to address these needs will empower the caregivers to be able to perform the tasks of an informal caregiver thus strengthening the impact to the outcome of both our Year 1 population, and beyond.

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

Western Ontario Health is committed to the principle of developing sustained care relationships with our patients and their caregivers. In order to support this goal, a Population Coordination working group will be struck in Year 1 to oversee the identification and tracking of our Year 1 patients. As noted previously, our recruitment strategy will take a multi-pronged approach whereby patients are identified in various settings including Primary Care, EMS, Community Support Services, Home and Community Care, and Hospitals. Recruitment will be targeted to ensure we capture a diverse group of patients from marginalized communities, diverse geography (including rural residents), and different languages. Although we will be focusing on patients with advanced COPD and/or CHF, we will also seek to identify patients with a variety of co-morbid conditions and other care needs. The recruitment process will be monitored by the working group with insight from the Population Health Coalition to ensure equity and diversity in the patients identified.

Primary care and care coordination/navigation are at the heart of the vision for Western Ontario Health and will, therefore, be integral in tracking and developing a sustained care relationship with the Year 1 population. A system will be designed in consultation with patient, caregivers and providers that will help identify the best way to manage the care relationship and ensure appropriate components of the system are engaged to provide best care when needed. A central data reporting system with a longitudinal patient record will be created to support care transitions, tracking, and reporting. This longitudinal patient record will be built to incorporate Primary Care data from existing EMRs and pooled with information on service provision from other data sources such as EMS, Community and Home Care services, and Specialist care (in hospital and otherwise). The system will be designed to have bi-directional data entry and communication to ensure that information is captured and transferred in a way that supports the clinical practice of all care providers, while also making information available to the patient and their caregiver. These systems do not yet exist, but will represent the core work of the Digital Health Working group in Year 1, which is exploring opportunities to leverage and extend existing solutions, and other opportunities to meet these system-wide needs.

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 Western Ontario Health geographic region is home to a growing urban Indigenous population and eleven southwestern Ontario First Nations communities. In the London area alone, we know that there are an estimated 20,000+ Indigenous adults who live, work, and/or access health and social services in the city. Western Ontario Health is committed to the principles of Truth and Reconciliation and supports Indigenous Health in Indigenous Hands.

We recognize that the Indigenous people of our region face unique health challenges and barriers to accessing appropriate and timely health and social services. For this reason, Western Ontario Health understands the need to work with our Indigenous partners to co-develop health systems that meet local Indigenous population needs. Although the Western Ontario Health team has started to develop formal relationships, our team recognizes that strong and meaningful relationships with our local Indigenous populations and Indigenous partner organizations will take time. Many of the organizations on our team already have pre-existing relationships in place and as WOH evolves, we will continue to engage and build upon these relationships in support of Indigenous Health in Indigenous Hands. As examples, London Middlesex is home to an Indigenous Palliative care team that is well supported by local family physicians. It is through these partnerships that we will be best able to address COPD and heart failure in the Indigenous population.

As noted previously, local research has suggested that within our local adult Indigenous population there is a reported 7% and 6% diagnosis of COPD and Heart Failure respectively. Many of these people access the services of our partner organizations including EMS, Hospital, and Primary Care. In Year 1 – through our

Indigenous partners and other WOH team organizations – we will seek to prospectively identify a minimum of 100 Indigenous people who have been diagnosed with COPD and/or heart failure. This sample size, in alignment with the estimated population size of 20,000 would allow for a 5% representation within our total of 2,000 to 3,000 enrollees. As with all of our needs assessments, health plans will be established with these patients and their caregivers and will include information on accessing culturally safe medical and social services, as well as traditional Indigenous healing needs. Outcomes and experiences will be monitored over time to ensure equity.

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

Recognizing the barriers the Francophone population may face when accessing services, in Year 1, WOH will actively seek Francophone individuals who meet the inclusion criteria of a primary diagnosis of COPD and/or CHF and are in need of care coordination and/or navigation. To achieve this goal, partner organizations must include a mechanism to identify Francophone individuals during recruitment. Regular monitoring will be undertaken to ensure that a reasonable proportion of French-speaking people are included. Given that the Francophone population of Middlesex County is estimated at 1.8% by the SW LHIN, a minimum target of 40 Francophone patients will be sought in Year 1.

Work performed in the SW LHIN has emphasized the concept of Active Offer when considering Francophone health care needs. The ability to do this for all partners is limited by the number of individuals/staff who are competent in the French language. As much as possible, this work will be expanded within Western Ontario Health care partners to support our identification of Francophone individuals. Once identified, French-language care coordination and navigation services will be made available via connection to existing local resources such as the Regional Francophone Community Health and Social Services Hub. The Hub is a partnership between local providers who support services, referrals or direct service offering across a number of areas including system navigation. The London Intercommunity Health Centre (a WOH

signing partner) is an identified agency under the FLSA and an active participant in the Hub.

WOH commits to the principle of health equity, which means accountability for creating and improving positive health system experiences for our Francophone residents, just as it will for all of the people we support. Achieving this objective will mean that the individualized health plans established for our Francophone residents reflect their language needs and actively seek to meet them. This, of course, includes ensuring that the assessment tools themselves are made available in French, as are the care coordination, navigation, and self-management tools. Health outcome and experience measures will be developed to capture Francophone patients' experience and also be administered in French and monitored over time to ensure that equitable experiences and outcomes are being achieved.

WOH will actively work with the French Language Health Planning Entity and the local French Language Services Coordinator to engage the Francophone community, to design, adapt, implement and evaluate services to meet the needs of the Francophone population. WOH will align with the French Language Services Plan that all partner organizations will adhere to. 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, easily accessible, and equivalent to the quality of services offered in English. The French Language Services Plan includes elements to increase access to services in French such as training for staff on Active Offer and cultural and linguistic sensitivity training as developed by the ESC and South West LHINs (available online in January 2020).

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

Members of our team are currently engaged in work that seeks to address the healthcare needs of marginalized and vulnerable populations. Many of our primary care physicians and Nurse Practitioners, within our partnered FHTs as well as our partnered CHC and NPLC, have a strong and evidence-based approach to be able to address the 'hard-to-reach' populations within our community. We will have access to the expertise of these clinicians, as well as the support from community care providers to ensure we are reaching these patients within our program.

The London Intercommunity Health Centre (LIHC, a local CHC) has a mandate to provide services to marginalized populations that include the homeless, non-English speaking communities, and those unattached to primary care. They have been successfully providing these services for over 30 years through programs such as the Health Outreach- Support for people experiencing homelessness. Health Zone NPLC, is an IHP model of service within community housing and a family crisis support centre with a mandate to serve woman, children and families experiencing barriers to health services.

Other providers who are involved with the OHT, but not directly with our Year 1 population (example Dr. Brenna Velker) support comprehensive care for vulnerable populations (eg: high-risk pregnant mothers).

We also have buy-in and support from our local EMS. Middlesex-London EMS has been running a compressive Community Para-medicine program for over a year and can, through the current data collection process, help locate vulnerable patients who may be at a high risk of institutionalization and who may not have regular access to a family physician.

Perhaps most exciting for our OHT is that the connection among these providers is already up and running. These are a few of the many programs in which we are running that effectively are able to reach out to vulnerable and marginalized populations that exist within our community.

While we have set specific criteria for our Year 1 population and access targets for these patients, we do not plan to exclude patients who might stand to benefit from the services being offered. As an OHT, we will collectively support individual providers working within our OHT to refer patients who do not fit all criteria but for whom our services would be beneficial to their care. Providers will be encouraged to consider patients who do not have a primary diagnosis of COPD or CHF, but require care coordination and navigation and to complete a needs assessment. Western Ontario Health will support provision of care to those patients to the best of our abilities but, at minimum, the collection of this needs information will support population expansion in Years 2 and beyond.

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

We plan to take a variety of approaches to involve patients, families and caregivers in the care redesign. We have already begun our engagement with patients, families and caregivers through engagement of two patient and family advisors on our Coordinating Council as a co-chair and member. We are also actively recruiting more patients and caregivers to be a part of our planning. We will make sure that the information we share and disseminate includes language appropriate to enable greater patient understanding; this will also support our aim to ensure we are effectively communicating with 'hard to reach' populations and populations who may be vulnerable or traditionally unengaged or marginalized.

We acknowledge the importance of addressing any power imbalances that are present. To address this, we will have multiple patients and caregivers during any OHT planning activity to ensure that the patients feel represented and comfortable. We will avoid having only one or two patients at a table and by having multiple representatives we can invite them to participate in varying capacities and roles.

We will empower patients, families and caregivers to take part in their care rather than simply consult; we acknowledge the unique needs and knowledge of our patients.

In our region, we have rich resources supported through Partnering for Quality and the Patient Experience Team at the South West LHIN. Partnering For Quality has established a community of practice for Experienced Based Co-Design to support ongoing learning and application of the practices. This group will help us determine experienced-focused activities to explore patients' needs and expectations. Addressing these will greatly improve the patient experience.

We will ensure that our partners and collaborators are aware of our patient-engagement goals, strategies, and resources, to ensure everyone has an understanding of patient engagement principles. We will create a reference manual for our OHT which will highlight existing resources around patients and use the HQO patient engagement framework to guide our approach.

It is important to make feedback continuous and to adapt care as needed. Patient, family and caregiver understanding and input into their care are main objectives of the health team approach and it is crucial that we base our success from these outcomes.

4. How will your team work together?

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

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

Max word count: 500

Our team is fully committed to the Ministry's vision for OHTs. As health and social service providers there are opportunities to better serve our community by offering a comprehensive and coordinated continuum of care and 24/7 access to supports including coordination of care and system navigation. There is a strong commitment to a performance culture that is rooted in the Quadruple Aim, to achieve better patient and population health outcomes; better patient, family and caregiver experience; better experience for care teams who provide health and social care; and better value.

Western Ontario Health (WOH) believes in operating within a clear accountability framework, supported by a fully integrated funding envelope. This provides a compelling opportunity to be more responsive in an objective, transparent, and evidence informed way, shifting funding to members of the team who can deliver the greatest improvements in health outcomes at the best possible value.

As an integrated team, there is a deep responsibility to identify service gaps from a patient, family, and caregiver perspective and to shift resources and approaches to care to meet local needs. WOH believes strongly in equity, and will commit to reducing unnecessary and avoidable differences in health outcomes that are unfair and unjust.

There is a history of consultation related to strategic planning; however, this needs to be enhanced to create a collaborative strategic plan that builds on the strengths and contributions of each team member. The degree of alignment of organizational goals and values is high, even in advance of the OHT model, although not explicitly attended to. Values are aligned and focus on meeting the needs of individuals and their family caregivers.

WOH will engage in strategic planning that will set a common direction, and help foster alignment of individual organizational goals with the overall goals of the OHT. This will require each organization to develop internal governance processes that

foster alignment with the priorities of the OHT while also delivering on their unique vision, mission, and mandate.

In the process of values alignment the team members will be respectful of the ethical framework in place at St. Joseph's relative to Catholic Health Care. There is more commonality than difference in the importance of compassionate, inclusive, and respectful care of each individual person in the imperative to have an empowering workplace and good financial stewardship.

Operating practices vary significantly by sector and the harmonization of these would be part of the process to integrate a care model around patients' journeys.

There are many collaborative relationships that focus on the continuity of care of the people. A few examples include:

- LHSC, St. Joseph's, Home Care and Hospice have regular meetings to coordinate the care needs of people in need of palliative care.
- St. Joseph's together with multiple regional and local partners have developed a care model for frail seniors, which is in the process of implementation.
- Through a grant from the Change Foundation there is collaborative work focused implementing a care framework that improves engagement of patient, residents and family caregivers.

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

Western Ontario Health (WOH) recognizes that governance will evolve as the team matures, and that 'end-state' governance could take different forms. The potential end-state models that were identified within the Rapid Improvement Support and Exchange (RISE) resource on collaborative governance are worthy of exploration by the team. WOH believes this exploration must be a journey that the team takes together over time, and we are committed to developing a thoughtful process that will allow us to achieve an end-state model that best suits the needs of the team and those we serve and reflects our collective values.

In the meantime, WOH will be governed by a transitional structure (refer to 4.2 Western Ontario Health Solution Structure (diagram) appended in Supporting Documents) called the Coordinating Council which has been developed using sectorial based representation. Terms of reference have been adopted by the team members. There is a process to bring new members onto the team. The Coordinating Council is being supported by a secretariat, funded by members of the team or provided through "in kind" support. The secretariat consists of secretariat director, administrative assistant, population health lead, clinical engagement lead, digital health strategist, ethicist, quality & performance lead and communications specialist. Support has been committed until the end of the fiscal year. Consideration will need to be given as to the funding needed to create an ongoing supportive structure for the team.

The Coordinating Council is co-chaired by a family caregiver, and a health service provider who is the executive director of one of the Family Health Teams. Each sector has a process to ensure their representatives are speaking on behalf of participating members of the sector.

If the full application is accepted, a working group will be established to explore a more formal "governance" structure for the team and what a timeline for transition would be. This would include input from volunteer boards of the members in addition to patient and provider representatives. As the governance model is developed it will be essential to ensure it reflects the needs and values of our community including being

respectful of the Catholic Health Governance requirements of St. Joseph's while developing a collaborative governance model.

Patient and family caregivers have been included in broader community sessions and are engaged in the Coordinating Council. With the identification of the Year 1 population, patients, families, and caregivers will be involved in co-design of integrated care models. There is experience in patient/caregiver and provider co-design in the region.

There are several examples where experienced based co-design has been utilized in the past including: the redesign of the care of the frail elderly; the design of the caregiver support models funded by the Change Foundation; Ontario Renal Network Partnerships; and MyDoctorsVisit. Also, several organizations have developed strategic plans through co-design sessions with patients, staff, leaders, physicians, researchers, board members and community partners.

Specialist physician leaders have been informed of the development of the OHT through Medical Advisory Committees at the hospitals. Geriatricians, Geriatric Specialists, Respiratory Physicians and Cardiologists have been fully involved in the development of care process for older adults with chronic disease on which the year one population focus will be built.

A critical success factor in both the short and long-term will be ensuring that the wisdom, skills and experiences of direct health service providers, and patients, families and caregivers, are well represented in our governance model. To achieve this goal, our OHT must develop opportunities to compensate clinical leadership, which would achieve equity with our administrative leaders. We must also ensure equity for our patient, family and caregiver colleagues, recognizing that there are monetary and non-monetary barriers to full and meaningful participation, which must be addressed by the OHT.

In the immediate term, while we rely upon a collaborative governance approach, each sector will develop clear and transparent processes to ensure engagement and buy-in. In primary care, this will involve the continued development of a strong primary care sector, with the goal of ensuring alignment across the sector regardless of the payment model.

We will also develop a mechanism for 'community stewards' to articulate the needs of the community, to ensure that the directors of community-governed organizations and other key stakeholders (patients, caregivers, community representatives) can hold our OHT accountable to meeting the needs of our community.

We will rely upon working groups' structure to support collaboration and implementation of specific initiatives. The current working group structure is aligned to the full application and includes the coordinating council, the secretariat, population health, home & community care, digital health and communications. As WOH moves beyond

the submission of the full application, the work groups will be aligned to the Year 1 deliverables and the implementation plan.

After October 9, the operational components necessary to meet the Year 1 deliverables (for instance quality, measurement and performance management) will be identified to ensure alignment with progressions towards the long term/maturity state vision for WOH.

Operational infrastructure and resources will be identified and costs evaluated. Sources for these resources and funding will be identified. Committed human resources related to management of performance of the OHT against targets and deliverables will be necessary and funding for these resources is yet to be determined.

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

Sharing patient information across members of the health care team (including the patient) is a foundational component to the work in Year 1 creation of a full Digital Health plan for Western Ontario Health. While provider teams in this region have very advanced electronic systems for serving patients, those systems are best of breed systems for their stakeholder group (ie. hospital vs homecare vs primary care). There are a few systems that share some information between systems. Some exceptions include Clinical Connect or the CHRIS system. Most of the sharing is either view only information or limited data sharing for certain functions. Almost all of the current data sharing is not actionable for care needs of the patients in another stakeholders' system. This results in the current reality that we have "windows" into other systems

but not the ability on scale to ingest information into systems for the purpose of transacting care for patients or being proactive to support a person's health needs. Having actionable information is the basic functionality to start an eco-system of health services.

There are two aspects to the sharing of patient information within the team. Both aspects require action to meet the future health needs of the full population within the Western Ontario Health region.

i)Security and Privacy
The health provider organizations in this region have experience in shared security and shared privacy solutions that are robust and scale up to the provincial level of operations. Examples include:

- Clinical Connect that is available to over 40,000 users in Southwestern Ontario sharing both home care and acute care hospital information with primary care and other health care providers.
- A shared hospital information system across eleven hospital organizations
- eNotification services to multiple members of the health care system
- Waitlist and Surgical Referral solutions within the region
- Provincial ENITS imaging solution for over 100 hospitals across the province

In all of these examples there are appropriate data sharing agreements and advancing levels of cyber security functionality that are coordinated at a regional/provincial level for discrete functions for pockets of providers. There will be a need for a coordinated cyber security service offering that will be mandatory for all health providers in the region to protect the Western Ontario Health patients and ensure continuity of health services. Equally, there will be a standard network data sharing agreement that all providers will be signatories to for the purpose of creating a circle of care to eliminate barriers for sharing of information across the eco-system of health.

ii)Health Integration Systems
One of the net new investments that will be required for the Digital Health strategy (a Year 1 deliverable) will be for a technology solution that integrates core solutions for the purpose of transaction care (not solutions that allow for view access to information). There are North American standards for how health integration exchange (HIE) solutions communicate and function. Ideally, this technology solution would be something we could share with other OHTs in our collective pursuit of effective solutions to transact care for patients and point of care population health tools. The foundation of a point of care population health system is a health integration solution. These systems are the opportunity to support new workflows required to be an enabler of the desired sustained care relationship for patients in this region.

Key next steps

The requirement for governance and architecture for Digital Health will result in key principles associated with the collection/use/disclosure of information. The other opportunity is to leverage the academic and research activities of this region to advance the health of residents with leading edge health practices. This will drive privacy and security tactics. Key steps will include:

- Define the meaning digital transaction of care for patients (as opposed to data sharing) with the stakeholders (including patients/caregivers)
- Creation of a data flow. map of the current and future state
- A cyber security assessment from the current service provider
- Creation of a privacy team to pool existing human resources with privacy expertise to create a region wide team
- Creation of a risk/mitigation registry associated with current and future planned data sharing
- Integration of this work into the Digital Health Plan per appendix B

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

At present none of the Western Ontario Health (WOH) partners indicate any persistent challenges with performance or compliance issues. However, WOH does believe that by working together the performance of the collective has the potential to be enhanced.

Organizing as an integrated system of care will allow for improved identification of population health needs and responses to gaps in service. It will also allow for consistent, standardized, effective, and efficient service provision. With shared learning through a 'learning health system' approach, clients and health and social care providers will set meaningful targets, and organizations and providers will work together using their unique knowledge, skills, and experience to resolve challenges and tackle problems.

We will establish meaningful benchmarks that measure progress towards improving individual and population health. Benchmarks will include the adoption of patient-reported outcomes measures (PROMs) in addition to patient-reported experience measures (PREMs) and medical measures of health. Measurement must also be focused on an equity lens, and outcomes need to be compared against socio-economic data in order to identify and address health inequities within our attributed population.

WOH will leverage a learning collaborative approach, which are small, diverse groups formed to tackle particular challenges, bringing people together from multiple organizations, disciplines and sectors. Solutions will be implemented within a plan-do-study-act (PDSA) cycle to evaluate the impact of each change and make iterative improvements.

With so many solo practice physicians within the WOH area, a burning platform linking care delivery and improving practitioner experience is crucial. There are

limited incentives for solo practice physicians to join. Offering support to primary care, such as practice facilitation through Partnering For Quality (PFQ) is one possible approach to encourage engagement. PFQ can support quality improvement learning as primary care providers come onboard.

Data integrity and performance reporting in primary care is ongoing improvement work for primary care practices. Standardization of data aligned with meaningful decision support tools would support primary care to engage more effectively in a population health management approach. The introduction of dashboards that captures data at a practice 'team' level, community level, and regional level would be beneficial. At present there is limited ability to access and leverage primary care data at a partnership or system level.

Within primary care, WOH envisions a sector that is well integrated with the community sector, which ensures that people have access to care that meets their needs across the social determinants of health, including social prescribing, which will become a standard approach. We also envision a sector that has a single quality improvement plan and a common strategic plan that is fully aligned with the overall direction of the OHT.

Within the hospitals and community support organizations there is strong governance, financial record, and compliance with contractual performance obligations for HSAA, LSAA and all MSAA's and all legislation.

Accountability agreements will need to be developed to support WOH partners and will be aligned to the Year 1 population.

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

WOH partners have experience with quality improvement, performance improvement & reporting, and continuous learning. The partners have this experience as part of their organizational and sector requirements and reporting aligned through Health Quality Ontario. Many organizations have quality committees reporting to their governance. Organizations collect and report data through standardized tools, tracking to performance indicators, outlined in quality plans or QIPs. In addition, most organizations have a focus on patient experience and utilize patient engagement strategies, including surveys and patient relations approaches, to drive improvements. Many of the organizations, including Home Care, Community Support Services and some practices within Primary Care have quality improvement and performance plans in place.

The partners have experience working together on quality improvement projects and in collaborative learning. Here are examples of organization specific and system level quality improvement and performance improvement and continuous learning activities:

The South West Primary Care Alliance is a network of primary care physicians where opportunities for improvement and learning are facilitated. Their Digital Coalition has streamlined the creation and dissemination of custom forms used to access testing and enable patient referrals at tertiary care centers, therefore, improving timeliness of patient care.

The Partnering for Quality (PFQ) program has supported broad quality improvement learning across sectors since 2012 with a strong focus on Primary Care. PFQ has supported various learning sessions in the South West covering a variety of sectors including Primary Care, Mental Health & Addictions, Community Support Services, Long Term Care and Hospitals (5.2.1 PFQ Practice Facilitation Brochure appended in Supporting Documents).

Over the past 5 years, PFQ has hosted formal learning sessions with the following

participation:

- over 400 participants in QI 101/QIP learning sessions
- over 300 participants in EMR learning sessions
- over 450 participants in Experience Based Co-Design (EBCD) learning sessions

In our region approximately 33 primary care physicians are using the OMD – iC4 dashboard. This is early in its adoption within Primary Care.

Dashboards are a foundational concept for supporting the population health approach and are used within a variety of partners including acute care and community care. A goal for WOH will be to consider a shared dashboard across the team and further exploration will be required to develop this tool.

Leaders across St. Joseph's have experience in quality and performance improvement at a local and regional level. Using data supported, evidenced based, expert informed processes leaders have led a regional approach to vision care and imaging (CT and MRI) for the South West LHIN. St. Joseph's has been a full participant in the stroke care realignment in the region, provided leadership for the Frail Seniors strategy across the region, championed and facilitated a new pathway for Indigenous mental wellness with an integrated evaluation framework from the start. The Caregiver Change initiative was developed with multiple sectors, co-designed by patients and part of continuous improvement. The Cardiac Rehabilitation, CHF program and the Pulmonary Rehabilitation program developed has been done through evidence based, data driven, co-design approaches supported by strong clinical researchers. These are current examples of improvement.

Decision Support provides quality data for programs and this is used as a basis for continual improvement. The QIP has included a systematic approach to target setting, achievement and monitoring.

London Health Sciences Centre is committed to continuous improvement and learning as illustrated through the Continuous Improvement in Care (CIC) initiative which is foundational to the organization. This initiative supports ongoing learning and application of improvement methodology to identify, implement and monitor improvement opportunities. The CIC initiative is the next step of LHSC's journey to develop a culture of continuous improvement.
In addition, London Health Science Centre has a balanced scorecard (BSC) to coordinate and align Quality and Performance improvement efforts across the organization and in alignment with the QIP process. This plan outlines the quality and safety goals for the year, including targets, process methods, and key success factors.

One Number Protocol - The Regional One Number Protocol project in partnership with hospitals and clinicians across the South West LHIN was created to govern appropriate and timely access to beds and transfers between hospitals in the South

West LHIN.

Thames Valley Family Health Team Data Sharing - In 2019, LHSC entered into a cross-sectorial data sharing partnership with the Thames Valley Family Health Team (TVFHT) to address 'Effective Transitions' as an important system quality issue.

Transitional Care Project (TCP) - The Transitional Care Project (TCP) was a collaboration of provincial TCP program teams, LHSC, St. Joseph's, South West LHIN, and CMHA Middlesex. The purpose of the project was to identify ways to improve Alternate Level of Care (ALC) rates and reduce the percentage of ALC days for mental health patients.

The Community Support Services Network has integrated the intake, assessment, and registration of services for 23 individual CSS providers, utilizing a Quadruple Aim Approach with shared metrics around patient experience and provider experience, representing a 46% efficiency improvement and ensuring that individuals are connected to all of the services available to support them to live independently. Through our partnerships within Connecting Care to Home, an integrated team is providing high quality care informed by key metrics using the Quadruple Aim approach. The patient and care team are enabled by an eShift performance dashboard developed to provide ongoing access to outcome measures of patient experience, patient care success, and staff achievement.

The Postnatal Wellness Clinic was developed to connect all infants delivered at LHSC and their families with a primary care provider to ensure timely follow up care, support and connection to community supports. This program was developed in collaboration with primary care, acute care, public health unit and Western University. There have been more than 5700 infants supported with less than 800 visits to the ED in the first 30 days of life.

At present, the hospitals and home care have the most capacity with data analytical teams available. Primary Care practices have been supported over the past few years with increasing their use of data to inform practice and to drive improvements. System partners will work together to develop a collective approach to data management.

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 partners of WOH recognize that success depends on our ability to meaningfully engage with and co-design solutions to healthcare challenges that patients, families and caregivers face today.

There are strong practices across our OHT members for engaging patients, family and caregivers to change practice and redesign care. We will convene a working group of our members, patient advisors, caregivers and community members along with external experts such as the Change Foundation, to develop a robust method of engaging patients, family and caregivers as full partners at all levels of the OHT, from strategy down to direct service delivery.

St. Joseph's has used a co-design approach to advance care with experience in COPD, Cardiac Rehabilitation, Chronic Pain, Palliative Care, Mental Health, Rehabilitation, Care of the Elderly and Surgical Care. Patients are engaged in development of policies, design of care facilities, way finding, and communication tools. This is achieved through 7 patient and family councils in each of the key care areas of the organization. Each care area uses standardized patient experience measures which are used to improve care. For example: in the Specialized Mental Health Hospital patients expressed concerns that there were not enough meaningful activities. This was used to re-develop the services. The ratings by patient/families were improved in the next survey and the councils provided a letter of appreciation for the changes.

London InterCommunity Health Centre has extensive experience with client co-design, and engaging clients in Quality Working Groups to develop new programs and re-design current services. They conduct annual client experience surveys, and annual EQUIP survey, which measures how well they are delivering equity-oriented care.

WOH will ensure inclusion and engagement of Francophones on committees. We will collaborate with the ESC / South West French Language Health Planning Entity and

the South west LHIN French Language Service planner, who have unique expertise and knowledge about the Francophone population, to seek input on how to offer services and programs that meets their needs and reflect their values, cultures and experience. The Entity and the SW LHIN FLS planner have planned and organized many community engagement events and focus groups with the Francophone population in our region to help inform planning, strategies, and reports.

LHSC has a strong background in experience based design (EBD) and design thinking. They have a dedicated patient experience team that includes 220 patient advisors. In 2018/2019, patients and families were engaged in over 181 initiatives. Work that has been developed or improved through EBD includes program development, policy definition and refinement, performance metrics, strategic plan development and patient relations process.

The Community Support Service network has engaged patients, families and caregivers in the design of support services including the central intake process. Our OHT needs to integrate the patient voice in all strategic plans going forward. EMR platforms that support client feedback will be integral to identifying needs and designing programs to improve health outcomes, as well as, ensuring an equitable voice is heard at the OHT table.

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

WOH will draw upon the strengths and experiences of OHT members to ensure strong engagement with the broader community. As with patient and family caregiver engagement, we will convene a working group of our member organizations to design formal and informal methods of engagement, to ensure that the OHT is highly responsive to the needs of our community.

One of the key recommendations of a study “Understanding Health Inequities and Access to Primary Care in the South West”, focused on ensuring that the right mix and distribution of health human resources exists throughout the region so that patients have access to timely and quality primary care. To support this, it was agreed that new primary care providers could benefit from supportive measures to enhance the utilization of currently available resources in the South West LHIN.

The Partnering for Quality program staff have been facilitating the orientation program for new clinicians to the community. Feedback collected shows that:

- On average 43% of participants knew very little to nothing about the

community resources presented (e.g. CMHA, Home and Community Care, thehealthline.ca) prior to the orientation session.

- 100% of participants stated that after attending the orientation they have more knowledge of services and resources to better provide care to patients
- 100% of participants agree or strongly agree that the orientation session was useful, interesting, convenient and relevant

London InterCommunity Health Centre is community governed and relies on community advisory groups to inform program development and prioritize service delivery. They engage with clients, caregivers, peers, and people with lived experience. They also have experience with co-design and experience-based design. Health Zone NPLC is community governed and has well established community partnerships for outreach and health education provision to women, children, and families who face barriers to health equity. Their model of care supports a holistic wrap-around approach to individual and family health.

London has limited clinically supported mental health housing. This has resulted in patients remaining in a specialized mental health hospital or being discharged to homelessness. Recognizing the gap, leadership at St. Joseph's engaged the city in 2018 to change the philosophy/approach regarding integrated housing. Advocacy with the LHIN led to funding for a not for profit housing provider to provide the clinical support needed. The first housing opened in July 2019.

There was a significant gap in care for children coming into adulthood with Cerebral Palsy, and Spina Bifida. Collaborative advocacy with families, the Thames Valley Children's Centre, and St. Joseph's resulted in the establishment of an inter-professional clinic to support this population.

The Infectious Disease program at St. Joseph's noted a significant increase in cases of HIV in London. They engaged public health and together with an outreach team from public health were able to bend the curve in the number of new cases.

St. Joseph's developed three community stroke outreach teams to serve all of the SWLHIN as direct care in the home. In addition, the team implemented aphasia groups to sustain speech capability based in senior centres.

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

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

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

Max word count: 500

The partners are able to demonstrate a strong track record of responsible financial management and fulfillment of their accountability agreements.

At present there are system pressures. The current needs of the population has put pressure on the health system to provide more care to patients within the available resources, which has influenced the development of integrated care models. The introduction of the integrated funding model for Connecting Care to Home (CC2H) has enabled partners to provide an integrated care delivery system supported by technology that resulted in improved patient experience, improved health outcomes, and effective use of resources.

From this experience, partners are committed to pursuing discussions on how best to establish further integrated or bundled care approaches that support funding aligned with the patient. The partners have expanded the integrated funding model to have an acute focus with CC2H and an ambulatory focus with BestCare COPD. In addition, there is responsibility for bundled funding for hip and knee interventions. These experiences will allow OHT partners to gain valuable insights into working together to better understand risk, and gain sharing practices, before committing to an integrated funding envelope and single fund holder. This will require ongoing commitment to responsible fiscal management and the agreement to reinvest shared savings generated through efficiencies back into improving patient care.

Many partners have health informatics and a robust data management system that will support the analysis of cost information and drivers. The partners have worked collaboratively to use these systems to understand and analyze population and cost drivers including for initiatives such as Health Links.

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

Western Ontario Health has made significant progress this summer, initiating the design of an Ontario Health Team (OHT) after the OHT self-assessment was submitted in May.

An OHT solution structure (6.1 Western Ontario Health Solution Structure appended in Supporting Documents) was put into place to enable the flow of information between a broader community of OHT stakeholders who are interested in this initiative and those who have committed to participate as early adopters. A Coordinating Council with supporting secretariat was formed to enable issue escalation, nimble decision-making, and allow systematic changes to progress. The Coordinating Council will operate as a steering committee for the Year 1 expectations set out for OHT candidates. As the OHT reaches maturity and a new integrated governance structure is in place, the Coordinating Council will dissolve and be replaced by the new governing body.

After receiving an invitation to submit an OHT full application in July, working groups were deployed and created a communications plan, assessed digital health capabilities, outlined a vision for a re-designed home and community care model, and selected a Year 1 patient target population for implementation.

The Population Health working group and Population Health Coalition collaborated with partners and, considering the quadruple aim and Year 1 expectations for early adopters, reached agreement for the target population to present to the coordinating council. At the first meeting of the Coordinating Council on August 29, 2019, the Year 1 target population decision was made by consensus vote.

The approach being taken to operationalize the care redesign priorities stated in section 3 is described below. Western Ontario Health is committed to a facilitative and participative style using experienced based design. We will collaborate and plan changes as an interdisciplinary team which includes patient, caregivers and families. Our change strategy consists of a number of phases: initiation, planning, implementation, sustaining and scaling the change. Suggested timing of each phase is an early estimate and will need verification as work planning progresses.

Initiation Phase: 3 months

In the first phase, the Coordinating Council will be tasked with visioning to create a clear and compelling vision of the preferred state and accompanying values and

principles. The vision should be tested by patient family and caregiver advisory groups and direct care providers to ensure clarity of purpose, the rationale for proceeding, and a solid case for change.

The secretariat will actively recruit a patient engagement lead to work with the Coordinating Council and partner organizations and individuals to recruit patients, families, and caregivers as members on committees and working groups. A patient and community engagement strategy will be formulated which includes community focus group activities. The communication plan will be revised to include the broader community within our geographic location and incorporate the vision and values created by the coordinating council. An ethics framework will be put into place to support decision-making.

The Population Health working group and Digital Health working groups will determine the health service providers who will lead the change initiatives for the Year 1 target population. They will meet to assess the change readiness of the participants, the capacity for change, and identify desirable outcomes and key performance indicators to measure success. They will begin communications with the front-line staff and physicians using the vision and values created by the Coordinating council. Appropriate membership of the working groups will be ensured to begin planning the detailed implementation at an operational level.

Operationalizing the Care Redesign Priorities Identified in Section 3 for the Year 1 Target Population:

Planning Phase: 2 months (0 – 62 days)

In the planning phase, the working groups will have a clear, shared understanding of the work to be completed and desired outcomes. Scope of the changes to be undertaken will be verified as well as associated risks and mitigation plans.

30 day milestone: Participative co-design sessions will be completed to: capture the patient and provider experience, understand desired improvements, review and evaluate system change prototypes. Change suggestions will be evaluated based on IHI's quadruple aim (population heath, patient experience, caregiver experience, and cost containment). Feasibility (can we do it?) and justification (business improvement) will be taken into consideration.

60 day milestone: The implementation plan will be completed by brainstorming with the leaders who have authority and responsibility for the changes. A detailed work breakdown structure for each work-stream of similar tasks will be developed. The implementation plan will include a schedule, scope of work, resources, definition of roles and responsibilities, a risk management plan, and a change management plan.

Implementation Phase: 6 months (62 – 246 days)

90 day milestone: Implementation of changes officially begins with a Kick-off meeting. Data for key performance measurements have been collected as a baseline prior to the implementation of changes.

120 day milestone: Education has been completed for health service providers to support the transition. Phased rollout of changes has begun.

180 day milestone: Changes have been rolled out throughout the partner organizations and with participating individuals. Continuous improvement cycle has begun and first improvement cycle planned. Key performance indicators measured at predetermined intervals to support the plan-do-study-act cycle.

Sustaining Phase: 4 months (247 – 365 days)

300 day milestone: Celebration of the integrated new state. Transition of the changes to operational leaders is completed to continue measurement of key performance indicators, sustain changes, and continually improve.

330 day milestone: Lessons learned captured and incorporated into plans for next phase to scale improvements and expand range and volume of providers.

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

A change management strategy will be used to support both the OHT design and transformation, and Year 1 implementation. The change framework will address three major aspects: People, Process, and Content.

The “People in Change” aspect is about how to optimally engage people and ensure broad commitment and capacity to change. People strategies are designed to contribute to people being ready, willing, and able to make the necessary changes.

The “Process of Change” is the roadmap to get from where we are today to where we need to be to achieve results from the change. The process sets the change up for success through the design of sound solutions, successful implementation, and ultimately, to the full realization of intended outcomes.

The “Content of the Change” refers to what existing structures need to change in order to achieve greater overall performance. These structures include systems processes,

business service delivery models, technology, cultural changes that focus on operating values, participative management and co-design, and reorienting focus from an inward "service push" to an outward- looking customer focus.

Prior to the implementation of changes for the Year 1 target population, we will create a clear and compelling vision of the preferred future state. System change leaders will come together – including physicians, patients, families and caregivers - to articulate the challenges that will be addressed. The underlying reason for change will be clarified as written principles that describe the value to be obtained and expected benefits. The change principles will be used to prioritize, plan objectives, and define measurable outcomes for change initiatives starting in Year 1.

To support the people side of change, the vision, change principles, values, and expected outcomes will be used to communicate the strategy and case for change across organizations and to health service providers who are accountable for the needs of the attributed population in our geographic region. The goal is to create a shared vision and commitment that reaches out from providers to the broader community at large. It will also provide a basis to expand our communication and engagement plan and support structures to address the needs of all levels of healthcare providers, including interdisciplinary staff and physicians. An ethics framework will be put into place based on the values and principles, to support leaders during shared decision-making, conflict resolution, and resource allocation.

Engaging key stakeholders and developing work groups for the change initiatives is important to successfully manage the process of change. This will be done deliberately to empower those directly involved in the change and build trust, relationships, and coalitions of supporters. The most effective operational leadership structures for clinical changes will be determined prior to implementation in order to promote, achieve, and sustain desired outcomes. Individuals will be empowered by their participation in co-designing and planning detailed implementation plans and higher-level roadmaps. Success of the leaders and health service providers will be supported by providing timely information, education, and structural changes as required.

The importance of leadership from all partners including patients, families, caregivers, and primary care is recognized and is part of the change strategy. A patient engagement framework will be developed which includes representation of patients, families and caregivers on all committees and work groups and an engagement plan for the broader community.

Primary care providers have been included in our OHT journey since the beginning. Many senior administrative roles are filled by physicians. Primary care has started to develop as a unified sector with a steering committee made up of administrative and clinical leaders. There are current plans to hire a Primary Care Engagement lead to grow engagement, coordinate the work to achieve sector priorities, and foster alignment with OHT development. There is also a plan to resource a Primary Care Clinical Lead to support sector development, and represent the voice of primary care providers.

During the planning phase, the change strategy will be translated into a pragmatic change management plan that is customized for each change initiative and the individuals who are involved in the transformation. The content of change will be addressed - as structural barriers and risks to achieving the desirable outcomes are identified - and modifications put in place as needed. Change is easily derailed if the details are overlooked and involving healthcare providers to co-design service changes with patients, families and caregivers gives people who have knowledge and experience a chance to collaborate and innovate. During the planning phase for the project, the timing of the changes will be scheduled, there will be a detailed assessment of costs and resources required, and those who have responsibility for the work and key deliverables will be described. Change management and sustainability will be a defined work-stream within the implementation plan in order to ensure that the necessary elements of staff learning, change readiness, communication, system process changes, and measurable performance metrics are delivered and sustained.

Year 1 will focus on a specific population within our geographic region with the goal to scale the improvements overtime as interested healthcare partners join in to care for our attributed population. The changes to care models will be aligned to the vision, values and principles articulated by our change leaders. In the beginning, the scope of change will be limited to allow time to refine and improve cross-sector pathways, and celebrate some wins along the way, before scaling up to expand the range and volume of providers who provide a full and coordinated continuum of care. As Western Ontario Health matures it is expected that the change strategy will evolve, building on lessons that are learned along the way through continuous improvement and lifelong collaborative learning.

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

There will be no detriment to care for those who are not part of the Year 1 populations. We will continue to provide “business as usual” services to the populations we already service. There are many initiatives already underway within and between organizations that will continue to advance, are aligned with the quadruple aim, and will be incorporated into WOH as it evolves over time. In addition we will find opportunities to leverage new relationships and learnings from our work with the Year 1 population to improve patient care. Many of the patients in our Year 1 target population are already being served. The opportunity is to create more efficient care, a better experience, and improved outcomes.

The improvement in outcomes in Year 1 priority populations will happen through the leveraging of technology, care coordination, and integrated care plans.

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

There is a level of effort that will be needed in order to coordinate the design and delivery of the Ontario Health Team and the implementation of Year 1 improvements. A barrier is funding necessary resources. Some roles that are necessary include:

- Quality Improvement expertise to "train" trainers in the OHT
- Decision Support
- Change Management
- Project Management
- Practice facilitation to support primary care members in shared data collection/analysis and patient centred improvement efforts i.e. currently provided by South West LHIN Partnering for Quality (PFQ)
- Patient and caregiver provider programs for self –management i.e. current provided by South West Self-Management (SWSM)
- Secretariat operational support

We have also identified a number of barriers related to legislation and regulations, human resources shortages, privacy legislation, physician funding, licensing, and IT structures.

In long term care, the environment is highly regulated which can make innovation and adoption of new models challenging.

The current market share model and the funding model for home care limit the ability to develop relationships and expertise in the care of unique populations. Lack of a provincial strategy for Home and Community Care makes it challenging for us to plan.

Human resources shortages, specifically related to personal support workers (PSW) s and nurses, have been indicated by Long Term Care and Community Support Services. Home and Community Care funding has been frozen for 10 years contributing to human resource challenges. This is a provincial challenge. The differential in salary rates and the remuneration models between sectors may limit the ability for teams to work together in a collaborative way. At a larger, regional level (e.g., OHT) this will need to be

reviewed and appropriate strategies developed to ensure delivery of care is not impeded by shortages or transitions.

It is unclear how the home care coordinators will be reassigned (or structured) in the post-LHIN environment. This does, however, provide an opportunity to leverage these resources more effectively in our OHT solution. As such, an OHT model provides an opportunity to develop a new model of care coordination from inpatient to outpatient to home-based care to best suit the clients/patients and their families.
There is a lack of resources at senior levels in order to support the development and implementation of the OHT framework and governance structures.

Privacy legislation may impede the ability to share information with all team members.

Virtual care is only funded for physicians if using OTN applications. The ability to use other virtual care modalities including phone consultations is limited by a lack of physician funding. Virtual visits are not funded, except for physicians through Telemedicine.

Rural transportation as a barrier and any OHT model must take into account that it must serve patients in both urban and rural settings. By implication, a proposed OHT model must consider issues/barriers such as transportation in its implementation model.

Inter-jurisdictional issues will need for be addressed. Moving from 14 LHINs to numerous OHTs across the province may create further levels of complexity related to health service providers located near the boundary of its geography, as it the case with our Southwest Middlesex area which has a hospital and a Family Health team located within 10 minutes of 3 adjacent counties (and eventual OHTs). Coordination of care will depend on how homogeneous (or not) the care coordination model evolves across the province.

Lack of funding for physician leadership involvement in the system redesign process is a barrier. There is no compensation for time when primary care does improvement work (i.e.: they need to close clinic to do QI work during early morning hours or after hours) or they do it on their lunch. In addition, physicians oftentimes have multiple responsibilities which extend beyond a clinical office practice, such as performing, emergency department, hospitalist, palliative care, and/or LTC medical director roles.

The community lab licensing and funding framework currently restricts the hospital-based laboratory medicine program from working with community clinical colleagues in delivering community-based and home-based diagnostic solutions to support care.

A significant barrier to decisions is the lack of appropriate digital and IT infrastructure and analytics to gather appropriate data. There is no "overarching "QUALITY IMPROVEMENT" dashboards. There is a lack of common data standards across primary care, and lack of a common business information reporting tool to pull data from the varied electronic health record platforms to provide a sector-snapshot of performance.

We do not have a population health management system.

From a hospital perspective, the LTC Act in terms of patient choices, Ontario Public Hospitals Act, and lag in the claims process.

Existing funding contracts (M-SAAs, etc.) and rules around use of funds could make it challenging to re-allocate resources across the OHT between now and when we have an integrated funding envelope.

There is new legislation for EMS which will change current transportation patterns.

Also of note is the value of volunteer hours and donations to resource and fund community support services. Note below example:
London Middlesex CSS – Community Contribution to Service Delivery and Health Care System

- *Based on 2016-17 Data reported by 85% of CSS providers
- Total Volunteer Hours: 128,183 hours valued at $1,922,749
- Donations and Fundraising Support: $2,481,104
- Total Value: $4,406,853
- For every $1 spent by the MOH, the community contributes an additional $0.15 to the operations of CSS Service Providers in the provision of CSS services.

Donors and volunteers are connected to a cause and an organization based on their personal affiliations – generally because that organization has made an impact and has touched their life in some way. Ongoing support of Foundations and current critical fundraising for all organizations is important. The money raised is often used to support specific services and/or to eliminate barriers such as co-payments for patients or families.

A risk as we look forward in the development of the OHT is the potential loss of identify for organizations through integration, and the subsequent loss of the volunteer and donor support which helps to fund the health care system.

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

Non-financial supports that our team would find helpful are information-based:

•Already developed templates and tools such as accountability agreement templates, and referral management tools
•Models that are successfully being used i.e. regional services, governance options
•Data and decision support to interpret it
•Collaborative learning platform
•Clinical Expertise to learn more about the priority populations i.e. clinical knowledge of how to best care for populations

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

It is the assumption that the regional services provided would continue and that the work being done provincially to address specialized services would inform the OHT model. The regional services provided within the geography of WOH serve multiple proposed OHT's in Southwestern Ontario and beyond.

In addition to our response to question 3.7.1., Biigajiiskaan: Indigenous Pathways to Mental Wellness aims to co-design and -deliver transformative mental health care to provide culturally-safe and accessible services to Indigenous urban and rural populations in the London-Middlesex region. Biigajiiskaan is grounded in culture as care; thus, combines traditional healing medicine and knowledge with current hospital-based mental health care and practices. Biigajiiskaan is a formal co-lead partnership between an Indigenous-based agency (Atlohsa Family Healing Services) and a hospital (St. Joseph's Health Care London), which will bridge and enhance services at the community and regional-hospital level. Importantly, Biigajiiskaan actualizes Indigenous-led and informed pathways by actively collaborating with Indigenous community members, Elders and Knowledge Keepers, and Indigenous agencies to catalyze innovative mental health systems re-design and delivery processes

The Southwest Regional Wound Care Program was developed by the LHIN in 2013/14. This initiative engaged Acute Care, LTC and Community Care representatives and has a mandate to promote evidence-based care practices and standardization of products across care sectors. Key metrics are measured and demonstrate very positive outcomes for patients and residents in our care and current efforts are in place to ensure that results will be sustained and further optimized through a transfer of program leadership as the LHIN role changes.

Lawson Health Research Institute is the research institute of St. Joseph's and LHSC. Researchers within Lawson partner with the clinical teams address challenging question for the system. Researchers have developed models for Supported Discharge models in mental health which have been adopted internationally. Smart homes are current a research focus to facilitate successful integration in the community. Social Innovation Labs engaging young people to find solutions to the challenges of youth mental health are in place. Researchers have shown the benefits of cardiac rehabilitation in the prevention of a second cardiac event. Lawson researchers are integrated into the clinical environments to enable collaboration.

In addition Southwestern Ontario has academic network called SWAHN (Southwestern Academic Health Network). Contributing partners include most hospitals in

Southwestern Ontario, St. Clair, Lambton and Fanshawe Colleges and Western, Windsor and Waterloo Universities. SWAHN facilitates interprofessional collaboration, networking, and knowledge-sharing opportunities across health-care related education, research, health service providers, and other stakeholders in Southwestern Ontario to identify gaps and to improve the health of individuals, families, communities, and systems. This Network can collaborate with OHT's across SW Ontario to assist in driving evidence based practice across a broader geography.

7. Membership Approval

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

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

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

Ontario Health Teams
Full Application Form

APPENDIX A: Home & Community Care

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

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

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

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

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

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

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

Max word count: 1500

Western Ontario Health is committed to improving and integrating the health system and the experience of patients, caregivers and health team members. Our patients will experience improvements that include sustained care relationships, an integrated

care team with shared accountability, and services and supports that are responsive. Our end state will include access to 24/7 system navigation & care coordination linked with primary care, as well as 24/7 access to front line care providers in a system funded to ensure stability of integrated care teams.

In the future when a patient describes Western Ontario Health, the person will say:

- I know that someone who understands me, my needs, and my context is looking out for me
- I am connected to a consistent primary care provider
- I feel that I am respected, included, and am being treated equitably
- I have an individualized plan for my health that I (and my caregiver) helped design
- I (and the people who care for me) have access to my health information including my individual plan
- I know what to expect and what is expected of me
- I know who to contact if I have a problem/question related to my health

One goal for Western Ontario Health is to support people to live in the community, as independently as possible connected to a responsive care team. Home and community care is a key element of our integrated care team approach that reflects the complexity and diversity of care needs of each individual.

Our integrated service delivery approach will focus on and reflect the diversity of needs of our attributed population. To do this effectively we will engage patients, families, community members, and health system partners to co-create a home and community care system that reflects their local needs and expectations. There are challenges in the health system, we need the collective to develop and support the solutions.

In this submission, Western Ontario Health will describe some opportunities for improvement but we acknowledge that this information has not been compiled through the co-design process that aligns with WOH core values. This co-design work will be completed post-October 9 and will involve detailed planning, ensuring consultation with stakeholders including patients, caregivers, Community Support Services, Home Care Service Providers, and LHIN leadership.

Key Elements that support the vision & direction of Western Ontario Health are described below:

Primary Care as the foundation to the Integrated Care Team

- Patient access and connection to a primary care provider is essential
- Integrate comprehensive care coordination & system navigation/intake into primary care practices with alignment of care coordinator to primary care and the patient and caregiver
- Co-design with patients, caregivers, primary care and health system partners

Team Based Care

- Patients and caregivers are members of the team
- Ensure team based care is available to all patients and caregivers
- Social prescribing practices by the care team are utilized thus seeing the patient as a whole person and not just addressing medical needs
- Clinical health and supportive care teams will be aligned to patients and connected to primary care practices through integration of existing home care, community support services and health disciplines available within team-based primary care models.
- Co-design the neighborhood care team concept to ensure patient focused, consistent care provision and effective and efficient care delivery with careful consideration of the precarious HHR resources and the commitment to minimize the impact on staff and patients.

Effective Access to Services and Supports

- Reduce barriers to access and coordinate access through clear partnerships to ensure no matter who a patient or caregiver calls, the person is directed back through a simple and defined access point
- Develop pathways facilitated by care coordinators and/or navigators so patients experience seamless transfers between agencies
- Use a centralized intake approach with distinct roles for system navigation that links to care coordination
- Access services by one number with live answer on a 24/7 basis
- Enable the access through technologies that enhance timely sharing of information and moves toward the concept of one record accessible by patients, caregivers and all team members
- Transform existing connections between hospitals, primary care, specialty and broader community care to ensure referrals systems are improved and consider service provider organizations working differently with hospitals and primary care, and ensure capacity to be responsive to our attributed population in the short and long term

System Navigation

- Define the functions of system navigation and distinguish from care coordination and integrate into the care journey from the patient's perspective
- Leverage enabling technologies and standardized tools to support these functions
- Support and equip patients and caregivers to self-manage the navigation function or role based on their preferences
- Ensure system navigation is holistic in its approach considering clinical health and the broader determinants of health.

Care Coordination

- Clearly define the functions of care coordination and the people who will provide this service with patient and caregiver direction
- Ensure care coordination is holistic in its approach considering clinical health and the broader determinants of health.
- Modernize the role of care coordination with various degrees of intervention – from referral management through an algorithm for patients with basic personal care needs to the highest system navigation/coordination involvement for very complex patient groups.
- Enhance care coordination with enabling technologies and standardized tools
- Explore and define care coordination intensity as it aligns to the diverse needs of our attributed population (514, 000+); this will not be a one size fits all approach
- Shifting away from transactional function that is based contract needs and towards this being based on patient outcomes and patient needs decided in conjunction with other health care team members.

Integrate Home Care and Community Support Services

- Develop a single community care, service and supports “sector” by integrating home care and community support services sectors with the focus of providing integrated community services that reflect the diverse needs of people who require ongoing community-based care.
- Overtime (with the least impact on front line provider HHR resources) create teams including Home Care Service providers and Community Support Services to allow front line workers to develop relationships and communication networks across providers.
- Establish team conferencing for the most complex patients to ensure communication with Primary care involvement and a seamless care team for the patient.
- Align funding and seek to eliminate co-payments for support services to ensure equitable access
- Use standardized tools including one technology enabled platform to manage intake, information, referrals, assessment, care planning and communications.

One Care Plan

- Commit to one care plan that has been developed in collaboration with patients and caregivers
- Care plan should encompass clinical health and the broader determinants of health
- Establish a process to monitor and revise the care plan with patient, as needs change and at regular intervals
- Evaluate effectiveness of the care plan as a team including patient experience and outcome measures
- Ensure the care plan is connected and supported by interprofessional teams with clinical expertise to support complex patients for both short term and long term

care needs. (i.e. from hospital into the community)
- Ensure this care plan is accessible by the team with varying levels of privacy clearance.

Leveraging Value of Standardized Tools
- Commitment to the use of common standardized tools (for example: assessment, care pathways, care plan & education) to enable consistency and sharing of information and to reduce duplication
- Common assessment tools will be identified through the review of existing tools and the development of shared understanding amongst partners and patients and caregivers

Modernize the approach to Home Care Service Delivery
- Revise the home care delivery model; moving away from market shared and contractual obligations by type of service
- Modernize the service provider contacts to ensure long term stability of the sector and minimize the impact of changes on current HHR shortages and patients.
- Develop bundled care, care pathways or baskets of service that are aligned with client need and determined by a standard set of evidence based tools, including single funding envelopes or outcome based funding models.
- Current home care system has a role in allocation of resources based on patient need and available funding; WOH will use the quadruple aim to guide our improvement approach understanding that we must provide care within available resources

Innovative Models of Care delivery
- Expand existing innovative models including Best Care COPD Program and concepts from Connecting Care to Home and Community Stroke Outreach Teams
- Expand virtual care through video or telephone technology
- Explore clinic visit options from community care with self- booking options based on identified parameters
- Expand roles for system partners including Community Paramedicine Program
- Leverage and further integrate supported living environments into community care options

Shared Accountability
- Develop shared performance metrics at the patient, providers and WOH level to measure patient experience, health outcomes and cost effectiveness

Shared Services
- Leverage existing technology, data and human resources infrastructure within

LHIN-Home Care and Home Care Providers to further integrate community services, including non-regulated/clinical supports such as information & referral specialists, team assistants, clinical supervisor, education specialists, safety specialists, etc., many of whom provide supportive roles to patients, caregivers and direct care teams

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

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

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

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

Max word count: 1000 The focus for year 1 will be adults with a primary diagnosis of advanced Chronic

Obstructive Pulmonary Disease and/or Congestive Heart Failure, who are in need of system-level care coordination or navigation; with special emphasis on patients who are at risk of institutionalization. Our aim is to prospectively enroll between 2000 and 3000 such patients with a goal to improve the Quadruple Aim.

We have identified the clinical level as being at the advanced stage of disease progression and persons living with additional complexities including broader determinants of health and diversity or equity.

Based on these descriptors we anticipate a large percentage of these individuals will require home care and community care supports. We anticipate some of the suggested 2000 will already be connected but realize there will be people who are not accessing these services and supports.

We will focus on ensuring all patients are connected to a primary care provider. This primary care provider will have direct support from a care coordinator and access to integrated community care teams that will provide services and supports that align to the care plan that has been co-created with the patients and caregivers. In addition, for complex care needs, there will be coordination with a specialized interprofessional team to ensure clinical excellence and evidence based care.

Part of our Year 1 deliverables will be to develop an integrated care team delivery model. This model will be developed in collaboration with patients, caregivers, health system partners and social service agencies using design thinking or experienced based co-design principles. We will explore other models that are in place locally, provincially, nationally, and internationally. We will look at the concept of Neighbourhood care teams to ensure that care is wrapped around the patient and caregiver and linked with primary care providers, supported by appropriate specialty care, and reflects a care delivery approach that meets both clinical and social needs and expectations of patients and caregivers.

The model of home and community care will need to be built by leveraging existing home care resources including care coordinators, home care providers, medical equipment and supplies. This will require the ability to access, align and locate resources differently than at present. We will also want to leverage innovative approaches to care delivery including but not limited to home visits, home monitoring, clinic visits, and virtual care visits.

Western Ontario Health will also need access to specialty care teams such as palliative care, wound specialists, respirology, placement services, EMS, community Paramedicine, telehomecare, etc. Further discussion and development will need to occur to align these supports and services. By utilizing a non-traditional approach to care teams, centred around the whole person’s clinical and social needs, it is expected to improve patient and caregiver experience, improve all aspects of health and well-being, and provide a system of support for providers to enable them to focus and excel in their areas of expertise.

The goal is to enhance the achievement of the Quadruple Aim for this population, their caregivers, and associated health teams by:

- Improving the health and quality of life of these patients through the provision of integrated health and supportive care services
- Providing better care through integrated care teams and care plans
- Providing more efficient delivery of needed care to this population
- Reducing stress on care providers and health teams through better management of care and reduction in urgent/emergent occurrences across this population

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
Max word count: 1000

As part of our Year 1 deliverables Western Ontario Health will develop an integrated care team delivery model and care coordination model that is linked to primary care. This model will be developed in collaboration with patients, caregivers, and health and social system partners using design thinking or experienced based co-design principles. We will explore existing models that are in place locally, provincially, nationally and internationally, to enhance our understanding of successful options.

However at the present time we anticipate that we will need to transition supports and services from South West LHIN - Home & Community Care and some additional programs and support functions housed at the LHIN for Year 1 and beyond.

It is important to understand that we have not completed detailed planning, analysis or discussions related to these proposed ideas. We would benefit from access to the following roles, programs and functions.

1) Care Coordinator & Care Coordination supports

In an integrated care delivery team, care coordination is a key element that focuses on patient needs and outcomes rather than a gatekeeper function. SWLHIN – H&CC employs the largest number of available resources. WOH envisions the need to transition care coordinators and care coordination supports to align with an integrated team concept. This will include direct linkage with primary care and front line providers. In addition, access and system navigation roles will need to align with the vision for a centralized intake model in collaboration with Community Support Services and Community Social Services sectors to ensure continuation of this existing service and to allow for scaling with the implementation of WOH.

2) Home Care Providers:

As Western Ontario Health develops its integrated care delivery model in Year 1, we recognize that we will require enhanced understanding of resource availability and contract management of Home Care providers. Similar to other OHTs, we understand that we have to create a new system while the current system continues to provide care under the current structures, policies and practices.

Our Year 1 population will need care from contracted Home Care providers for health

professional services, health disciples/allied health, personal support, medical equipment and supplies related to their needs and in alignment with our delivery model.

We will require a detailed planning process including Home Care Providers, Contract Management Support and quality monitoring at the South West LHIN to ensure access to these services and to ensure continued care for the remaining attributed population who will not receive WHO services in Year 1 but will in the years ahead.

3) Regional Support Programs

a. Placement Services

Western Ontario Health will need access to placement services, as needed for our Year 1 population. We will require the care coordinators who are supporting the patients and families to be educated on Placement legislation and trained to complete or support completion of the components done in primary care and in the community. We recommend that the actual placement functions remain within a centralized service, which is currently housed at the South West LHIN.

b. South West Self-Management (SWSM) Program

This will be an essential component of the integrated care team approach from Western Ontario Health and other OHTs in the south west region of the province. This program was developed from a provincial strategy and housed within LHIN regions in different organizations (previously South West CCAC). We are concerned that these supports for patients, caregivers, and health providers may not be identified as patient care delivery and our recommendation is to transition this essential function to retain its value to patient care. SWSM currently holds the licensing and associated funding that supports patient, caregivers and providers workshops across the region. SWSM has developed a strong peer leader group (volunteer) that deliver these programs hosted out in the communities across our region in locations accessible to patients and caregivers. This has been a centralized support program that has effectively impacted patients, caregivers, and health providers over the past 10 years and has achieved this through partnership agreements with health service providers. If this programming were to be eliminated, this support would be lost to our patients and caregivers, as no other organization would have the human or fiscal resources or knowledge base to replace these programs.

c. Partnering For Quality Program

This will be an essential component of supporting primary care in the integrated care team approach and digital strategy components for Western Ontario Health. Partnering For Quality (PFQ) has provided supports to primary care with system transformation including quality improvement, effective use of data to inform practice,

effective use of technology to improve client and provider experience. PFQ developed the Digital Coalition which has provided a coordinated approach for health system partners to engage with Primary Care on digital solutions in care delivery. PFQ has also supported the spread of the experience based co-design approach across multiple sectors in the LHIN (LTC, HCC, MH&A, PC) and continues to be an asset to support patient experience and partnership. We are concerned that these supports for primary care partners and system partners may be eliminated and we envision a continued role for this high-value function within WOH.

We require continued access and support from both SWSM and PFQ. At this time we do not have a detailed plan for transition. However, WOH is requesting that these two programs transition from the SWLHIN to be housed in another organization until the time that the province determines its longer term plan and/or an OHT becomes an entity. There is an ongoing dialogue amongst partners at present with interest to support this transition following the development of a detailed plan, with expectation that resources and personnel would remain intact.

4) Specialty Support programs – Need to discuss the roles & location of specialty programs and services such as Palliative Care, Wound Care and IV teams.

5) Access to Technology and Business Intelligence assets – SWLHIN – H&CC program has access to assets that would be beneficial to OHTs including but not limited to technologies & robust business intelligence team.

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

This section is written with input from Western Ontario Health stakeholders and in consultation with other OHT partners across the province. We understand that this response is for information only and will not be evaluated by the Ministry of Health. There are many long standing challenges that have been identified that have limited the advancement and effectiveness of home and community care. These have included legislative and regulatory frameworks, policies, practices, funding, contracts as well as misunderstandings and assumptions related to the complexities of home

care delivery.

Home Care Service Provider Contracts
The existing contracts have been in place too long (since 2009) and are based on market share commitments that are too rigid and often impede patient centered care. There are multiple layers to the current contractual service system which creates siloed and fragmented service delivery and adds a significant administrative burden and duplication. The current Provincial Contract Management Guidelines, released by Ministry of Health in 2012 restricted the CCACs ability to redesign the current delivery model. It is anticipated that the Connecting Care Act may provide an opportunity for renewed discussions.

Human Resources Shortages
There is an ongoing shortage of human resources in the home care sectors, including PSWs and nurses. The current demand for in home care far surpasses the supply of people. This has been an ongoing and growing concern for several years locally, provincially and nationally. Contributing factors include historical funding inequities between sectors, disparity in working conditions between sectors, challenges with transportation in rural communities requiring reliance on personal vehicles and home care volumes that change and impact availability of consistent work.

Labour Relations
Non-union and unionized agencies and organizations are concerned about what this will mean for partners who participate in OHTs.

Funding Issues
- Fee for service (by hour/visit) reimbursement (not only impacts negatively on our ability to recruit as noted above) but doesn't support teamwork and integration activities. It limits the participation of some team members in unfunded activities – e.g., care planning and review conferences.
- As well, along with various collective agreements, the lower pay in the home care sector restricts secondments across sectors that would benefit client care. For example, for some clients (such as children with medical complexities who go in and out of hospital frequently, it would be of benefit for continuity of care and for safety to have the same staff team follow them in and out of hospital.
- Service eligibility and funding allocation formulas at the individual client level, as well as overall investment in home and community support despite recent increases, are insufficient to support client choice to remain at home without great personal cost (for those with the financial means) and significant burden and stress on the part of caregivers often negatively impacting their own health and well-being.
- Co-payments within community support services (for specified programs, such as adult day programs, etc.) needs to be addressed as it presents a barrier to access for patients and caregivers.

Privacy Legislation
- Sharing information among the broader care team needs to be easier under

privacy legislation. Although one of the stated purposes of PHIPA was to facilitate health information sharing, health care partners are too cautious and/or apply different interpretations with respect to the 'circle of care'. The Personal Health Information Protection Act needs to be amended to explicitly define all service partners in an Ontario Health Team as part of the "circle of care" for clients of any member of that Ontario Health Team. PHIPA will still be a barrier to accessing care across OHT boundaries but that will have to be dealt with by consent.

- By the terms of the standard LHIN Home & Community Care contract, home care providers are "agents of the LHIN" for privacy purposes rather than Health Information Custodians. Not being a HIC prevents Home Care Agencies from participating in systems of shared health care records (e.g., Connecting Ontario, ClinicalConnect) that support integration efforts and causes excessive, non-value-add bureaucratic work (e.g., reporting every request for third-party or client review of records to the LHIN and waiting for LHIN approval before releasing a client record.)

- The Archives and Record-Keeping Act should allow home care providers to follow normal and appropriate record destruction schedules. In our region we were instructed over 2 years ago not to stop and await instruction from the LHIN which to date has not been forthcoming.

Technology
Each Home and Community Care provider has unique systems and processes for Patient Records Management and Health Records. Some providers have electronic health records, while others do not. A lack of data integration or unified health systems—both within Home and Community Care partners and with other sectors partners--for patient management and charting makes sharing of important information challenging and will erode both patient and provider experience in the Quadruple Aim.

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

At the current time virtual care adoption is limited to discrete projects and services, across multiple clinical service providers. These projects are in the evaluation and sustainability assessment phase. Our paradigm shift: virtual care incorporated into all workflows and considered as an option for care delivery whenever possible.
The goal is to improve residents/patients access to specialists, hospital services and primary care providers; as well as community services to address timeliness of care needs and best utilize time spent on direct patient care. Virtual care seeks to increase face to face contact for patients and their physician and care team to support them and their caregivers in their home or community setting whenever these could be delivered virtually.
Virtual care can enhance these key determinants.
- patient and caregiver experience
- identifying the most appropriate avenue for patient care
- ease of navigation/transition to different care settings/teams by all parties.

Our model will build upon existing provider systems, provincial assets and look to scale and expand virtual offerings in year one. Patient information will transition to and from the circle of care by utilizing provincially approved systems and networks capable of supporting virtual care needs. This includes:
- supply of information to other health care environments for clinical points of service,
- availability of patient population data for analysis and reporting

- tools and information patients and families need to work alongside their care providers in a meaningful way.

New workflows, technology integration and scheduling functionality are identified gaps. Through the year one population experience (ensuring 2-5% of patients have virtual services) the enterprise testing of current technologies will inform the collaborative strategy on virtual care for the broader WOH population.

Current Assets/Services

- Telehomecare is a chronic disease self-management and biometric monitoring program for patients with COPD and CHF conducted remotely by Nurses. The Program is servicing 400-500 patients per year and there are opportunities for scale and expansion to other patient models
- Primary Care clinicians are using a variety of eVisit solutions including REACTS, HealthMyself, Medeo
- The South West Self-Management program provides online resources for patients/caregivers that includes tools, online booking of consumer workshops, and access to provincial self-management online program (via Champlain LHIN)
- A project at St. Joseph's with OTN to deliver up to 10,000 virtual visits by June 2020 in specialty clinics that include Endocrinology, Geriatrics, Rehabilitation, and Mental Health

Older Adults COPD/CHF/Chronic Disease Year 1 Clinical Population

The patient journey over the next twelve months across the WOH will evolve to:

> build upon the CC2H project that demonstrated the value of both virtual access and care coordination for a pilot group of 70+patients (leveraging tools such as eShift and OTN virtual access services)

>utilize eServices and other assets to ensure we identify patients within our population across sectors and also provide a basic accountability framework to ensure timely service between sectors

>Virtual care needs will be identified by the year 1 clinical population (patients and their care team) and established off the base current technologies leveraged (OTN, Reacts, email, Skype, telephone)

> Innovations for home and self-monitoring will be explored through research projects currently underway (i.e. Dr. Licskai COPD project)

Aligned to the Digital Health Service Catalogue, and leveraging OTN, key actions for success include:

- A core project team(patients/caregivers and clinicians) with clear measures of success and defined population
- OHT stakeholder contributions to fund the project team
- Identification of the highest value impact to patients of the target group
- An implementation strategy over 12 months to see 160-400 minimum virtual visits serving 2,500 patients
- A sustainability and assessment phase for future implementations
- Appointments missed improved

Specifics strategies for the Year 1 Clinical Population include: in home monitoring/vivify, web site interaction, phone, text, OTN services, patient portal.
PI Metrics to be improved for year 1 clinical population include:
-Wait times for first home care service (from community and from hospital) decreased by 10%
-Avoidable ED visits decreased by 10% (EOO4C 1,685 patients; creates a minimum of 168 visits targeted)
-Time to access to primary care decreased by 10% (EOO4C 168 patients that have access to primary care via virtual services)
-30 Day Re-Admission 15% improvement - current re-admission rate is 16.3% (EOO4C 253 patients)

Government Support and Services
i) Creation of a service that allocates a menu of services from OTN to the OHTs in support of virtual care
ii) Confirm the provincial role of thehealthline.ca to support the creation of a community services dataset into the OTN primary care service delivery, in support of an enhanced referral/navigation strategy

Next Steps Toward System Wide Sustained Care Relationship
i) Evaluation Criteria to Measure Success – The providers will collaboratively establish metrics related to patient experience, reduced wait times and improving efficiency through workflow redesign related to the year one population
ii) Work with OTN and other key vendor partners to create an integrated eVisit/eConsult/eReferral solution; and explore funding/operating cost sources
iii) Creation of a local strategy that supports the use of virtual care platforms to enable home and community care with patient care givers and community service agencies. The focus would be on patient autonomy and standardized best practice clinical approach across the continuum
iv) eReferral currently supports LTC and Acute Care for HomeCare services, with similar functionality and infrastructure needed for all services, including Primary Care and Community Services through a common eServices solution set

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

Patients/Caregivers Digital Access – aligned to Section B 2.5 (below)
Patients have come to expect a digital experience because we live in a digital consumer economy, and healthcare is no different. The engagement of digital tools can make a world of difference to health outcomes. The entire area of the WOH is directly connected to the Canada Health Infoway funded South West Regional Patient Portal. The MyChart patient portal is a partnership of Sunnybrook Health Sciences Centre (operator of MyChart patient portal), Hamilton Health Sciences Centre and London Health Sciences Centre/St. Joseph's Health Care London. The MyChart portal is used by over 165,000 patients and has a national and global presence. For the southwest region of Ontario, the unique strategy is the opportunity that all health providers feeding information into the federated Clinical Connect clinician viewing solution can have that same information available through a single architecture within the portal. This platform can be used to help patients navigate their care needs across a broad group of functions and providers.
Most importantly, patients are partners in the delivery of health care services, and access to the MyChart portal (as a first generation portal) will increase the success of that partnership.

Current Assets
There are two main patient engagement solutions being leveraged in this region. The MyChart portal noted above and PocketHealth. PocketHealth allows patients to access their medical imaging information. It is a subscription service that is being offered to patients. The solution allows patients to share their images with other health care providers (https://www.mypockethealth.com/)
The focused clinical population will have access in the first year to the MyChart portal. Key data sources include:

- HomeCare Chris information
- Ontario Lab Information System (OLIS) data
- Diagnostic Imaging Repository (DIR) reports
- Hospital Information System (HIS) data sets
- Access to Thehealthline.ca (relevant services/navigation - https://www.southwestthehealthline.ca.ca/)

This information is available geographically from clinical stakeholders between Hamilton to Windsor and St. Thomas to Owen Sound. This large number of stakeholders creates a patient portal that is regional and integrated with key clinical stakeholders. The clinical data in MyChart today includes:

- Allergy information
- Care Plans
- Laboratory test results
- Blood Bank information
- Medication management summaries
- Radiology reports

- ECG/Echo reports -Pathology reports

The largest gap is the enterprise integration of the primary care provider data that in turn would allow patients to access their primary care chart information in MyChart. In addition there is future functionality that is sought by patients and on the product road map for MyChart. Key future functions include:

-Self Registration to MyChart	- Primary Care EMR Integration	- Mobile platform
-QR code registration	-Device/wearable integration	-appointment scheduling
-App library	-virtual visits	-social health network
-shopping for services	-eRX refills	-personal health strategies

Senior COPD/CHF Year 1 Clinical Population

One of the significant opportunities is to allow for patients to self-register for services and self-schedule. In the future, the online booking functionality for medical imaging and access to members of the care team should be through a collaborative effort with multiple OHTs, leveraging a standardized eServices tool set.

Another opportunity is to collaborate with PocketHealth to understand the value of patients utilizing their imaging information to inform them of their health status and actions they can take to support their health needs.

Key Measures

- Improving baseline patient experience and the ability to be able to navigate the health system will be the primary measure of success
- Of the 2000-3000 patients in the year one clinical target group, the portal will be supported for 100% of this population with an expected adoption of rate of 20% or up to 600 patients
- A defined strategy for accessing patient apps will be part of the year one work (possible collaboration with CANET)

Government Support and Services

i) A policy to confirm MyChart as the patient facing front door and access sign-in for all digital tools that contain PHI for all services associated with the Ministry of Health, Community Service, Mental Health and Long Term Care

ii) Direction from the MOH for the MyChart solution to inform other consolidations/standardizations within the Playbook; app access for patients to allow for self-monitoring and self-assessment

iii) A strategy and support for all “211” type services to be coordinated with the Thehealthline.ca, with a focus on navigation for access to health services

iv) Advance CHRIS – Ministry integration to allow immediate validation of health cards across Ontario which is utilized by partners.

v) Support Ontario MD in aligning future EMR vendor specifications to integrate with MyChart

Next Steps toward System Wide Sustained Care Relationship
Key actions to overcome barriers and ensure that a minimum of 10-15% of 2000-3000 patients of the year one clinical population have access to MyChart:

- Month 1-2 – build the project team (including patients/families) and project plan, through the patient rostering process, create mechanisms to reach out to patients; focus on patients/families leading the local design/process changes
- Months 3-4 –explore the opportunity of the three predominant primary care systems to be integrated into the MyChart solutions and the navigation tools from the Thehealthline.ca that are locally relevant for patients in the clinical population for year 1
- Months 5-6 – early adopter patients will start to utilize the MyChart portal; community based registration onto MyChart will improve utilization; creation of a risk/mitigation strategy to ensure successful outcomes
- Months 7-8 – a full implementation plan, and sustainability plan will be developed
- Months 9-10 – implementation for the full clinical population will be executed, with a goal to have 10-15% of the population using the MyChart portal
- Months 11-12 – evaluation and scenario planning for future clinical populations

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

Providers and Digital Tools – aligned to Section 2. 5 (see below)
In order to achieve complete information sharing, we will be expanding access to all digital sources of health information for both the HCP as well as the patient. Contribution to the electronic record by both the HCP as well as the patient will help create a single source of truth. Each patient will be contributing to a common shared database helping build a knowledge base of population health for our OHT. Future plans include the use of an established population health tool that would help create a live dashboard of virtually real time data which could be used to inform the treatment plans for our OHT population. The foundation for this work will be through shared exploration, in the creation of a digital health plan

based on patient/human design principles.
Accessing specialist opinions is a dis-organized and complicated workflow for primary care providers. Our OHT will endeavor to simplify appropriate specialist access by delivering a common eReferral process to a centralized triage recipient. The triage process will be used to determine appropriate eService (phone, text, eConsult or virtual visit) as well as FTF scheduling for each referral received.

Current Assets
Our region has already successfully deployed eNotifications to facilitate interdisciplinary communications between community and hospital based care providers. Expansion of these notifications to other care providers such as EMS, primary care providers and community pharmacies will reduce the gaps in care currently experienced by our patients. The efforts already underway with EMS will use eNotifications to support near real-time alerting and tracking of our patient's identity, location as well as health status. These alerts will simultaneously alert all involved care providers of the changes in health status as they occur. Published coordinated care plans will be used to support clinician decision making on an individualized basis. Location services will assist in identifying geographical trends such as clusters of opioid overdoses. Receipt of these details by Public Health will allow for early intervention in a proactive fashion to potentially avert future overdoses and possible deaths. This can translate into risk identification for those at risk of institutionalization.
Care co-ordination is not limited to health interventions but also includes basic necessities of life. As our population ages, the demand for supportive housing options increases. Last year more than 375,000 new applications were received for the 629 existing long term care (LTC) homes in the province. Each applicant can select up to 5 housing options. In addition these LTC facilities also received over 22,000 requests for respite of short term convalescent beds. Housing needs often change significantly at times of transitions in care (e.g. stroke at home) resulting in extended hospitalizations. Coordinating access to available housing options across the province can expedite these timely transitions back to the community and reduce the overall time spent in alternative levels of care (ALC).
Clinical Connect has been developed with the intent to deliver a federated view of the patient journey via a single electronic view. This application brings together patient data from disparate systems including the hospital information system (HIS), Client Health and Related Information System (CHRIS), OLIS, DHDR, DHIR, etc. Adding the primary care EMR data set to the existing Clinical Connect view would provide data that should improve the timeliness of care delivery as well as potentially reduce the need for duplicate investigations. A seamless contextual access to the federated data set within Clinical Connect will ensure that providers are viewing a single source of truth representing a near real time account of our patient's journey.

The Health Report Manager (HRM) is now established as the provincial communication bridge from hospitals to primary

care. Expanded use of the HRM (i.e. EMS eNotification, etc.) or implementation of a unified eReferral/triage program will reduce the administrative time required to schedule and confirm encounters in the hospitals as well as in the community.
eServices Solutions – Implementation for Senior COPD/CHF Year 1 Clinical Population
For our Year 1 population we will look to leverage the current provider tool used by the certified primary care respiratory and cardiac educators in our region. Support for the development of patient facing apps which could add valuable clinical information for decision support. Dr. Chris Licskai has established an expanding clinical program which supports the primary care provision of care for this complex patient population at an estimated cost of only $500/year/patient. A recent Ivey Business School assessment suggests that this approach to our COPD population could result in ongoing cost avoidance.
eServices Solutions – Implementation
Purpose: Working with the MOH directions around eServices, the WOH will provide an innovative approach to consolidate eReferral, eConsult and eVisit solutions. These tools will allow clinicians to function more seamlessly as a team for patients.
Outcome: Patients/Families, Primary Care, and Specialists get access to a set of tools that support navigation within the health care system.
Status: Exploring the opportunity to build off the WW SCA program to advance the provincial goal for a fully integrated cross continuum eServices solution
The Digital Coalition (DC) as an active partnership of information technology/information management champions, are positioned to ensure eServices are focused on both practice and access. The regional focus of the DC will enable inter-OHT alignment. The regional Partnering for Quality team coordinates the creation and spread of digital tools that primary care teams require in their practices.

Government Support and Services
i) Request policy that the MOH supports Ontario MD to an open data sharing strategy (at a practice level - not only a provincial/regional/team level). This would allow OHTs to support the ongoing monitoring of current assets deployment/reach.
ii) Consider how Ontario MD might have stronger accountability agreements with EMR Vendors to ensure vendors meet requirements.

Next Steps toward System Wide Sustained Care Relationship
1. Working with both government and local stakeholders to establish open data sharing agreements/common cyber security strategy

2. Using existing dashboards in primary care EMR systems to inform the needs of the year 1 clinical population

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

Through the implementation of digital health tools, the stakeholders across the WOH are committed to the Quadruple AIM principles from IHI. Current examples of quality and performance enabled by digital health tools include:

i) Clinical Connect & Access to DHDR information - digital access to dispense events for medications including all controlled drugs in the province regardless of the funder

ii) Hospital Information System & Medication Safety - The three WOH hospital organizations implemented physician order entry and bar code scanning medication administration in 2014. The result was a reduction of over 100 adverse medication events per month for hospital patients.

iii) Emergency Neuro Image Transfer System (ENITS) – The LHSC/St. Joseph's ENITS serves the entire province with information sharing technology that connects emergency department clinicians with the scarce neuroradiology professionals in Ontario. The technology allows patient presenting with stroke symptoms to have their CT interpreted very quickly by a Neuroradiologist in one of 6 centres in Ontario. The information back to the ED clinical team supports the treatment decision for patients. The result is that patients get the right care faster and the province avoids millions of dollars of unnecessary patient transfer costs per year.

iv) EMS eNotification - notification to community stakeholders when patients access hospital based care (pharmacists, primary care providers, home care etc.)

v) Wound Care – website and digital tools (dressing-selection tool, e-learning, Diabetic Foot Ulcer screener and service provider selection tool) to support integrated, standardized, evidence-informed skin and wound care. http://swrwoundcareprogram.ca

vi) Primary Care - The PFQ program Practice Facilitators support primary care to extract data from their EMR allowing for local practice quality improvement initiatives.

With other provincial agencies, (i.e. HQO, CCO, etc), there will be full WOH engagement in the following actions:

- Building a structure for the team members currently responsible for quality and performance across the WOH stakeholders to create a vision and set of goals centered on the clinical population for year one

- Development of a plan to address key clinical / operational issues of the year one clinical population through broad stakeholder/patient consultation focusing on workflow and human factors
- Creation of a quality/performance team for each issue aligned to digital health resources from the service delivery stakeholders/existing vendors to support the delivery of the plan objectives
- Learn from the year one examples to imbed quality/performance as the lead drivers for all digital health structures/operations, informing the full year two WHO digital health plan
- Secure the required human resources for year one stabilization and year two operations

Engaging patients beyond just the transaction of care delivery, to inform the creation of the system design is critically important to help reduce readmissions and derive better outcomes which are vital to the health system.

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

In collaboration with patients/caregivers and providers, the following will be accomplished in year one:
The current state of digital health within the WOH is strong within individual clinical stakeholder groups (primary care, home care, hospitals, etc.). The sustained care model for residents of WOH will require the integration of systems and new tools to ensure the patient care experience and health outcome improvements as envisioned by the Ministry of Health are achieved. Aligned with this overall vision, there is a need to ensure that patients/caregivers and providers are fully engaged to create a WOH digital plan (aligned to section 3.2/3.6).

A key first step will be to formalize a Digital Health Working group (DHWG). The DHWG will support the creation of cross-sectorial (including patients/caregivers) representative teams to build three distinct sections of a digital health plan.
i) Patient Facing (patient engagement apps, portals, self-management, online bookings, etc.)
ii) Primary Care/Provider eServices (primary care EHR, point of care decision support, eReferral, eConsult, EMR dashboards, virtual visits, etc.)
iii) Enterprise Solutions (applications, infrastructure, point of care population health solutions, integration functions, cyber security, privacy, training/support service, data strategy, etc.)

There will be dedicated focus to establish short term and long term strategies across each of these streams. The focus will be on ensuring that patients/care givers, primary care providers and other members of the health care team are guiding the steps required to develop digital tools to enable an eco-system of care that is coordinated across the full continuum. This will be a collaborative effort to explore together the immediate opportunities balanced with the future system design architecture. There will be consideration of the guidance from the Ministry of Health Digital Playbook and potential collaboration with other OHTs. The DHWG will serve under the WOH Governing Council.
The foundation of the planning and collaboration will be centered around mapping the patient journey through active examples of patients utilizing the health system. These patient/human factors will be reviewed and examined for gaps and opportunities. This mapping will define the priorities and focus for both short and long term prioritized opportunities in the collaborative efforts to create enabling digital health capabilities, for the best sustained care relationship conceivable for the residents of this region.

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.

Name:	Glen Kearns
Title & Organization:	Integrated Vice President, Diagnostic Services and Chief Information Officer, London Health Sciences Centre and St. Joseph's Health Care London
Email:	Glen.Kearns@sjhc.london.on.ca
Phone:	519-636-4842