Ontario Health Team: Full Application

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 an evaluation of the intake and assessment documentation submitted to date, your team has been invited to submit a Full Application, which will build on information your team has provided regarding its collective ability to meet the readiness criteria, as set out in '*Ontario Health Teams: Guidance for Health Care Providers and Organizations*' (Guidance Document). It is designed to provide a complete and comprehensive understanding of your team and its capabilities, including plans for how you propose to work toward implementation as a collective. This application also requires that your team demonstrate plans for encouraging comprehensive patient and community engagement as critical partners in population health, in alignment with the *Patient Declaration of Values for Ontario*.

OHT Implementation & COVID-19

The Full Application asks teams to speak to capacity and care planning in the context of the COVID-19 pandemic. The Ministry of Health (the Ministry) is aware that implementation planning is particularly challenging in light of the uncertain COVID-19 trajectory. It is our intention to have this Full Application assist with COVID planning, while at the same time move forward the OHT model. Work on the Full Application should not be done at the expense of local COVID preparedness. If the deadline cannot be met, please contact your Ministry representative to discuss other options for submission.

Please note that the application has been revised to reflect lessons learned from the previous intake and assessment process. It consists of five sections:

1. About your population
2. About your team
3. Leveraging lessons learned from COVID-19
4. Plans for transforming care
5. Implementation planning
6. Membership approval

Information to Support the Application Completion

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. This is the foundation of a population health model, as such (at maturity) Ontario Health Teams need be sufficiently sized to deliver the full continuum of care, enable effective performance measurement, and realize cost containment.

Identifying the population for which an Ontario Health Team is responsible requires residents to be attributed to groups of care providers. The methodology for attributing residents to these

groups is based on analytics conducted by the Institute for Clinical Evaluative Sciences (ICES). ICES has identified naturally-occurring "networks" of residents and providers in Ontario based on 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 Health Teams are not defined by their geography and the model is not a geographical one. 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 with potential provider partners. 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 either has been or will be provided information about your attributed population.

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 Teams. Teams are asked to indicate a contact person for evaluation purposes.

Submission and Approval Timelines

Please submit your completed Full Application to the ministry by September 18th, 2020. If the team is unable to meet this timeline due to capacity concerns associated with COVID Wave 2/Flu preparedness and response, future submission dates will be announced in the fall. Please note, teams that submit their Full Application on or before September 18th, 2020 will receive results of the Full Application review by October 19th, 2020 (pending any unanticipated delays associated with COVID-19 Wave 2).

Successful candidates will be considered "Approved" Ontario Health Teams. Unsuccessful candidates will be provided a summary of the evaluation and review process that outlines the rationale for why they were not selected and the components that require additional attention. Teams will work with the Ministry to determine the path to reach the Approved status.

[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.
- To access a central program of supports coordinated by the Ministry, including supports available to work toward completion of this application, 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 Full Application are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).
- The Ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The Ministry is bound by the *Freedom of Information and Protection of Privacy Act (*FIPPA) and information in applications submitted to the Ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the Ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Eric Hana
	Title: President and CEO
	Organization: Arnprior Regional Health
	Email: eric.hana@arnpriorhealth.ca
	Phone: 613-623-4844 ext 220
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Kelly Dumas
	Title: Executive Director
	Organization: Rural Ottawa South Support Services
	Email: kelly.dumas@rosss.ca
	Phone: 613-692-4697 ext 225

1. About Your Population

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

1.1. Who will you be accountable for at maturity?

Confirming that teams align with their respective attributed patient population is a critical component of the Ontario Health Team model. It ensures teams will care for a sufficiently-sized population to achieve economies of scale and therefore benefit from financial rewards associated with cost containment through greater integration and efficiencies across providers. It is also necessary for defining the specific population of patients a team is to be held clinically and fiscally accountable for at maturity, without which it would not be possible for teams to pursue population-based health care and expense monitoring and planning.

Based on the population health data provided to you, please describe how you intend to work toward caring for this population at maturity:

Maximum word count: 500

At maturity, our OHT is responsible for improving patient health outcomes for all people living within our various communities (1). Using the Quadruple Aim framework as a beacon of accountability, our health team is responsible for an attributed population of 331,822 people. This population accounts for people living in a variety of urban and rural communities attributed to the following three IC/ES networks: Queensway Carleton Hospital (N20), Kemptville District Hospital (N8) and Arnprior Regional Health Centre (N8). Most people attributed to this OHT reside in the western part of Ottawa (276,782), accounting for 83 percent of the population. North Grenville (18,000), Arnprior (7,389), McNab/Braeside (4,755) and several other smaller communities make up the remaining 17 percent. Despite the largely urban catchment area, our OHT commits to supporting the rural communities.

Key characteristics of our attributed population, such as average age (41 years), percentage of seniors 65+ (17 percent), percentage of minors (18 percent) and percentage of females (51 percent), are consistent with Ontario (2). A high proportion of our population, 73 percent, identify English as their mother tongue, eight percent identify French and 21 percent identify Other as their mother tongue (3). The minority populations across our catchment area include three percent identifying as Indigenous, two percent as recent immigrants, 23 percent as immigrants, and 22 percent as visible minorities. With this information we know language, diversity, equity and inclusion will be key considerations for our population health system planning.

[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.

A key challenge of our OHT will be our diverse geography. Although our attributed population is primarily urban, we also serve many smaller rural communities. To appropriately meet the needs of both geographical settings, we must be strategic and thoughtful in our approach. A significant advantage of this team is the existing partnerships and relationships among health system and community support services partners. We will continue to leverage old and new relationships that have emerged due to COVID as we forge ahead with reimaging our co-designed health system.

Our OHT partners will work collaboratively using a population-health management approach to serve the needs of our entire population. Using a person-centred approach, we plan to transform services actively with people to ensure our future health system includes a comprehensive array of services that best fit their needs and achieve important and appropriate goals for them. We believe that our focus must be on people seeking care from our organizations (in-reach) and those not yet accessing care (out-reach) to shift the whole population curve from unhealthy to healthy, e.g., receiving support from public health to outreach to those who are challenged from a social determinants of health perspective. Our system will have services that promote health, prevent disease and those that are key to helping people live well with their conditions at home for as long as possible. Our services will be rooted in evidence, connected and flexible. We will also focus on redesigning coordinated and straightforward care that is easy for people to navigate and access in their neighbourhoods or communities.

References
1. Waddell K, Reid R, Lavis J. RISE brief 6: Population-health management. McMaster Health Forum. Published online August 8, 2019:4.
2. IC/ES Data Package for Four Rivers OHT, January 2021.
3. Réseau des services de santé en français de l'Est de l'Ontario, based on 2016 census data and the inclusive definition of Francophones.

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.

Please 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 previously submitted documentation, please provide a brief explanation (for example, many teams have seen changes to their priority populations as a result of COVID-19).

Maximum word count: 500

In addition to managing our COVID response, vaccination roll-out and the ripple effects of a global pandemic, our OHT has selected two key priority populations of focus in year one:
1) people of all ages living with compromised mental health or addictions and
2) people living with complex chronic conditions.

Mental Health and Addictions

Partners unanimously agreed that we must begin our OHT journey with a focus on transforming the health system for people of all ages living with mental illness and addictions. We know that in Ontario, wait times are as long as two-and-a-half years for children and youth requiring mental health treatment (1). Of people aged 15 years or older who reported having a mental health care need in the past year, one-third shared that their needs were not fully met (2). We also know that approximately ten percent of the Ontario population uses substances problematically (3). There is a growing trend of harms and deaths related to opioid use among Ontarians aged 25 to 34, accounting for one in every eight deaths. IC/ES attribution data reveals that 23,969 people presented to our hospitals with Neurotic/Anxiety/Obsessive Compulsive Disorder (NAOCD) in 2017/18, ranking as the seventh top health condition in our region (4). We know the actual numbers of people living with mental illness and addictions are far greater than those seeking treatment.

We are committed to reimagining care and services to improve mental health and addictions services in our region. At the end of year one, partner agencies and lived experience partners will have worked together to integrate services and increase access and awareness of available and necessary mental health and addictions services to meet the needs and goals of people in our communities appropriately.

People Living with Complex Chronic Conditions

Canadians over 65 years of age consume roughly 44 percent of provincial healthcare budgets. A significant portion (17 percent) of our population are seniors (65+), which is an increase from 12 percent in 2011; this trend will continue as our population ages (4). Ageing is often associated with chronic conditions, leading to increased health care utilization, sub-optimal health outcomes and poor patient experiences. The rising costs of complex chronic illness for older adults are a burden to the health care system.

In year one, we commit to further analyzing our population health data to identify a specific priority population of focus for year two, with some early partner engagement and system design work to inform future planning and implementation. We recognize

that there are community, regional and provincial initiatives taking place to create a more effective and efficient mental health and addictions system. Our OHT recognizes that it will be important to ensure there is alignment with these various efforts (i.e. One Call-One Click, Access MHA, Regional Crisis Lines, etc.) so there is little duplication or competing solutions.

References
1. Canadian Mental Health Association. Wait times for youth mental health services in Ontario at all-time high. Published January 27, 2020. Accessed March 29, 2021. https://ontario.cmha.ca/news/wait-times-for-youth-mental-health-services-in-ontario-at-all-time-high/
2. Sunderland A, Findlay LC. Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey-Mental Health. Health Rep. 2013;24(9):3-9.
3. Gomes T, Mamdani MM, Dhalla IA, Cornish S, Paterson JM, Juurlink DN. The burden of premature opioid-related mortality. Wiley Online Library. Published July 7, 2014. Accessed March 29, 2021. https://onlinelibrary.wiley.com/doi/full/10.1111/add.12598
4. IC/ES Data Package for Four Rivers OHT, January 2021.

1.3. Are there specific equity considerations within your population?

Certain population groups (e.g., Indigenous peoples, Franco-Ontarians, newcomers, low income, racialized communities, other marginalized or vulnerable populations, etc.) may experience health inequities due to socio-demographic factors. This has become particularly apparent in the context of the COVID-19 pandemic response and proactive planning for ongoing population health supports in the coming weeks and months. Please describe whether there are any 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

Rurality

[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.

Our OHT encompasses a large geographical boundary that includes western Ottawa with a large rural segment, a small portion of western Champlain, North Grenville and some of Lanark County. Within these boundaries are urban areas (Ottawa), suburban areas (e.g. Stittsville), small towns (e.g. Kemptville) and rural communities (e.g. Kinburn). In rural areas there are many people who have very limited or no access to public transportation (1). There are others in rural areas who are either deferring or not obtaining the help they need due to transportation challenges. Rurality is included as an equity consideration given these individuals often need to travel longer distances to receive health care services, in addition to accessing their work and social connections (1). Poor to no access to virtual care services as a result of poor internet access and low quality in connection, creates additional barriers for those living in rural communities.

Immigrant/Minority

About 23 percent of our OHT population identifies as immigrant and 22 percent as a visible minority (1). For some of these people access to services may seem daunting due to transportation, language, cultural or racism barriers. In a recent study of Ottawa's African, Caribbean and Black (ACB) communities, it was identified that there are several significant barriers that prevent ACB individuals from accessing appropriate mental health services (2). This includes a lack of cultural competence within the mental health provider community. We also know in Ottawa, racialized populations (particularly those who identify as Black) are over-represented among people diagnosed with COVID-19.

Indigenous Peoples

Data has shown that Indigenous peoples experience broad health disparities. In a 2016 review on creating health equity for Indigenous people, it was reported that suicide rates are higher for both First Nation males and females aged 15-24 at 126 and 35 per 100,000, respectively, compared to non-Aboriginal males and females at 24 and five per 100,000, respectively (3). Rates are higher across all age categories compared to the non-Aboriginal population. Beyond this, Indigenous populations also experience a disproportionately higher burden of disparity related to workforce participation, low income, education and sub-standard living conditions which all contribute to higher burdens of illness, chronic disease and poor health outcomes. Those who identify as Indigenous range from two percent to six percent of the population across our OHT. Culturally specific and appropriate services are limited, and access is dependent on travel.

Of the Indigenous participants in a 2013 study of Ontarians with diverse gender identities, 44 percent identified as Two Spirit (4). In the previous year, 61 percent of participants reported at least one unmet health care need, 47 percent had experienced poverty, 34 percent were either under-housed or homeless, 67 percent reported having to move due to their identity, 73 percent had seriously considered suicide and 19 percent had seen an Aboriginal Elder for mental health support.

Individuals and Families with Low Income

There are a significant number of low-income households within our OHT, some areas being more affected than others. For instance, in Arnprior the child poverty level in 2016 was 24 percent (5). As a social determinant of health and equity concern, poverty

remains one of the strongest indicators of poor health outcomes. Low income populations will be given special consideration with regards to accessing services, transportation, access to virtual services and so on.

Francophone Population

Across the region served, the percentage of the population with French as their first language is eight percent, with a low of four percent in the McNab/Braeside area and a high of almost eight percent in the western part of Ottawa (6). Ottawa is the only French Language Services (FLS) designated city within our OHT, with very few designated FLS service providers among our partner organizations. This creates limited access to FLS within some parts of our OHT. Many Francophones choose to obtain services in French in other parts of Ottawa (i.e., east end) or agree to receive services in English. There is some indication that of the 21 percent of our population whose mother tongue is neither English nor French, many are immigrants whose preferred official language is French.

2SLGBTQIA+

Two Spirit, lesbian, gay, bisexual, trans, queer, intersex, asexual and other (2SLGBTQIA+) communities in Canada experience numerous health inequities. Each 2SLGBTQIA+ community experiences the inequities differently, but overall, these communities are more likely than cisgender, heterosexual Canadians to have mental health problems including suicidal thoughts and attempts related to their experience of minority stress. A June 2019 report stated lesbian and bisexual women are more likely than heterosexual women to suffer from chronic diseases such as arthritis (7). This report also shared that gay, bisexual and other men who have sex with men are at greater risk of being diagnosed with anal cancer or being infected with human immunodeficiency virus (HIV) than their heterosexual counterparts. Trans Ontarians experience significant barriers in the health system including erasure of their identities and invisibility in screening programs. Strategies such as building health provider knowledge and capacity and to increase accessibility of screening clinics for trans patients may help to reduce barriers to access and may increase awareness of the need for specific health services.

Intersectionality

Our OHT recognizes the need to consider the health needs of the above populations and all groups through the lens of intersectionality, defined by the Oxford Dictionary as, “the interconnected nature of social categorisations such as race, class, and gender, creating overlapping and interdependent systems of discrimination or disadvantage.”

References

1. DesMeules M, Pong R. How Healthy Are Rural Canadians?: An Assessment of Their Health Status and Health Determinants: A Component of the Initiative “Canada’s Rural Communities: Understanding Rural Health and Its Determinants.” Canadian Institute for Health Information; 2006.
2. Aden H, Oraka C, Russell K, et al. Mental Health of Ottawa’s Black Community. Published online 2020:86.
3. Richmond CAM, Cook C. Creating conditions for Canadian aboriginal health equity: the promise of healthy public policy | Public Health Reviews. Published 2016.

Accessed March 29, 2021. https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-016-0016-5
4. Scheim A, Jackson R, James L, Dopler T, Pyne J, Bauer G. Barriers to well-being for Aboriginal gender-diverse people: Results from the Trans PULSE Project in Ontario, Canada. Ethn Inequalities Health Soc Care. 2013;6:108-120. doi:10.1108/EIHSC-08-2013-0010
5. Arnprior's Ad Hoc Committee. The Path Forward on Poverty and Homelessness in the Greater Arnprior Area. Published online November 2020. https://gaccph.files.wordpress.com/2020/11/the-path-forward-on-poverty-and-homelessness-in-the-greater-arnprior-area-final-report.pdf
6. Le Réseau des services de santé en français de l'Est de l'Ontario using 2016 census data and the inclusive definition of Francophones
7. Casey B. The Health of LGBTQIA2 Communities in Canada. Published online June 2019:70.

2. About Your Team

In this section, you are asked to describe the composition of your team and what services you are able to provide.

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

At maturity, Ontario Health Teams will be expected to provide the full continuum of care to their defined patient populations. As such, teams are expected to have a breadth and variety of partnerships to ensure integration and care coordination across a range of sectors. A requirement for approval therefore includes **the formation of partnerships across primary care** (including inter-professional primary care and physicians), **both home and community care, and secondary care** (e.g. acute inpatient, ambulatory medical, and surgical services). In addition, to ensure continuity and knowledge exchange, teams should indicate whether they have built or are starting to build working relationships with their Local Health Integration Networks (LHINs) to support capacity-building and the transition of critical home and community care services.

Given the important work ahead in the Fall in preparation for cold and flu season and the potential for wave 2 of COVID-19, teams should look at efforts to engage with public health and congregate care settings including long-term care, and other providers that will allow teams to leverage partnerships that support regional responses and deliver the entire continuum of care for their patient populations.

As Ontario Health Teams will be held clinically and fiscally responsible for discrete patient populations, it is also required that overlap in partnerships between teams be limited. Wherever possible, physicians and health care organizations **should only be members of one Ontario Health Team**. Exceptions are expected for health care providers who practice in multiple regions and home and community care providers, specifically, home care service provider organizations and community support service agencies, provincial organizations with local delivery arms, and provincial and regional centers.

Keeping the above partnership stipulations in mind, **please complete sections 2.1.1 and**

2.1.2 in the Full Application supplementary template.

2.2. Confirming Partnership Requirements

If members of your team have signed on or otherwise made a commitment to work with other teams, **please identify the partners by completing section 2.2. in the Full Application supplementary template.**

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (i.e. meets exceptions identified previously e.g. specialized service provided such as mental health and additions services)*

2.3. How can your team leverage previous experiences collaborating to deliver integrated care?

Please describe how the members of your team have previously worked together to advance integrated care, shared accountability, value-based health care, or population health, including through a collaborative COVID-19 pandemic response if applicable (e.g., development of new and shared clinical pathways, resource and information sharing, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities, or participation in Health Links, Bundled Care, Rural Health Hubs).

Describe how existing partnerships and experiences working together can be leveraged to prepare for a potential second wave of the COVID-19 virus, and to deliver better-integrated care to your patient population more broadly within Year 1. In your response, please identify which members of your team have long-standing working relationships, and which relationships are more recent.

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Partners of our OHT have a well-established history of working well together.
Our OHT, an amalgamation of two existing networks (the former Three Rivers and North Rideau Health Alliance teams), have strong partnerships within and across both regions and have recently improved collaborative and integrative care delivery as a result of COVID-19. An initial response to COVID and the waves that have rippled through our community have forced service providers to work together and more collaboratively in many new ways. The levels of trust, cohesion and integration that have been built over this past year are noteworthy and position us well for reimagining care and serves within our OHT, using a population health systems lens. We see this level of integration as key to continuing on this journey towards delivering value-based health care together as one OHT.

Community Working Together

Community support agencies have come together to support our aging population to maintain their independence in the community. Our OHT community support partners have a long history of working together to meet the needs and goals of seniors and adults living with disabilities. This pre-existing collaboration allowed partners to mobilize quickly when the pandemic first hit, in March 2020, and will continue to support our frail elders as we manage through vaccination and reopening efforts, in our communities. For example, Rural Ottawa South Support Services (ROSSS), Ottawa West Community Support Services and The Old Forge, J.W Macintosh collaborated to provide urgent support to vulnerable seniors during the pandemic, with joint initiatives including:

• Food Security – a joint hamper delivery program was coordinated by OWCS where weekly hampers were delivered to vulnerable clients across a large part of our OHT serviced by these organizations;

• Social Isolation – ROSSS coordinated and distributed 100 tablets with enabled data to such clients and provided training and assistance to allow clients to access social programs offered by these agencies;

• Caregiver Support – agencies applied for joint funding to provide increased respite for caregivers during the pandemic; and

• Transportation - ROSSS and OWCS are working together on a joint initiative to provide free transportation to seniors in the Ottawa area.

Community support services are well connected in Ottawa and supported through the Champlain Community Support Service Network (CCSN).

ROSSS and Carefor Health & Community Services are also collaborating with Home and Community Care Support Services of Ontario Health East on a new pilot project called the High Intensity Support at Home (HISH) program. This is an innovative care model which provides intensive, supportive care in the community for patients and their caregivers who have complex care needs and require a high level of daily care to maintain their independence. The program targets patients waiting for long-term care (LTC) placement or those who require a similar level of care (e.g., have complex care needs, require a high level of daily care to stay at home, are in crisis but wish to remain at home) and aims to provide a more patient-centered, flexible care delivery model.

The Ottawa Community Action Plan is a strategy that aims to positively impact mental health while reducing harms from substance abuse, complementing OPH's strategic direction of MH and substance use.

Hospitals Working Together

Acute care hospitals within the our OHT have a strong history of collaboration to improve delivery of value-based care. For example, Queensway Carleton Hospital (QCH), Arnprior Regional Health (ARH) and Kemptville District Hospital (KDH) have worked collaboratively through combined procurement and logistics services, both as a group of hospitals and as members of Champlain Health Supply Services - a strategic sourcing organization that allows the hospitals to work together on procurement of products and/or services required by all. In place for over a decade, these arrangements and opportunities are being explored to expand such offerings to other organizational partners of the OHT. From a service delivery perspective, ARH and QCH are working together on arrangements for certain QCH surgeries to be performed at ARH to help address surgery backlogs as a result of the COVID shutdown. Moreover, QCH, as a bundle holder for orthopaedics, has experience collaborating with other bundle holders in the Champlain region to establish care pathways and have established service agreements with outpatient physiotherapy providers in hospitals and clinics throughout the region. Hospital partners also collaborate regularly with primary care to improve services, with natural partnerships forming in some areas based on their physician staffing model.

Breaking Down the Silos

Partnerships and collaborations across sectors also exist within our OHT. One key example includes the development of rural health hubs and Health Links, which brought care providers together to ensure more coordinated care for people living with complex needs by putting them at the centre of their care plan and experience. Some key elements of these models will help to inform our future work, with people engaged in the development of their own care plans and care experiences.

More recently, the Community Paramedic Long-Term Care (CPLTC) program has been implemented in collaboration with Ottawa Paramedic Services, QCH and other Ottawa hospitals. This program aims to provide services to individuals waiting for placement in LTC centers or those who are soon to be eligible for LTC to keep individuals stabilized in their illness trajectory and in their own homes for as long as possible. The CPLTC program does this through preventative and responsive care, such as home visits and remote patient monitoring, in collaboration with primary care and community services.

Members of our OHT will continue to partner to address the urgent and emergent needs of the population in addressing COVID-19, including supporting testing, assessments and vaccinations. Beyond this, there is a commitment to strengthen new and historical partnerships across sectors and networks to address the health and

wellbeing of our population and co-design the delivery of innovative, integrated care and services.

3.0. Leveraging Lessons Learned from COVID-19

3.1. Has your response to the COVID-19 pandemic expanded or changed the types of services that your team offers within your community? (this may include ED diversion services such as telemedicine or chronic disease management, in-home care, etc.)

3.2. Do you anticipate continuation of these services into the fall? If so, describe how partners in your proposed OHT will connect services and programs with each other to improve patient care

Max Word Count: 500

The COVID-19 pandemic has forced a rapid shift in the ways of doing business across all health care sectors. In response, our partners have implemented virtual technologies (e.g. secure video platforms, better phone systems, secure email services) and innovative in-person strategies to ensure continuity of service and address emergent needs.

Many programs have been launched or modified to address population health needs, while ensuring safety for users and providers. Some key programs to note include:

· Mental Health and Addictions services for Children and Youth (WAY – Wellness Access for Youth in North Grenville) adapted services by supporting clients over the phone and through virtual sessions, including in-person visits based on individual need;

· The Arnprior & District Family Health Team (ADFHT) is delivering a virtual cardiopulmonary rehab program. Clients appreciate the virtual aspect of the program and can participate from home, which is making a positive difference to their health and well-being;

· Home care providers have been able to integrate virtual care into their service offerings by incorporating video visits and telephone/mobile capability to conduct their scheduled visits;

· Community support service agencies have continued to support seniors and adults with disabilities with virtual social and exercise programs, adult day programs and supports for caregivers to combat caregiver burn out, as well as innovative care delivery models; and

· All family health organizations and teams have implemented virtual care.

In response to COVID-19 specifically, a Virtual Triage and Assessment Centre (VTAC) was created by many of our partners, including the ADFHT, Arnprior Regional Health, Renfrew County Paramedics, Renfrew County Public Health and many others. The VTAC ensures individuals in Renfrew County can be assessed without going to a physical location. This has helped limit the spread of COVID-19, improved remote monitoring capacity and increased access to care for our large geographic region, including unattached patients and those unable to access their primary care physician who would otherwise go to the emergency department. Moreover, QCH created the West COVID Care Clinic (WCCC) that offers both testing and assessments. It is estimated these clinics have been able to divert 20-30 percent of visits from the emergency department.

The pandemic has also led health care partners to work with other sectors in new ways to meet the needs of community residents. For example, the community paramedic services in Ottawa assisted Queensway Carleton Hospital with COVID testing in long-term care homes and supported the WCCC. Meanwhile, other healthcare providers stepped in to make regular calls to community paramedic clients to ensure they were supported and able to maintain independence at home.

Ultimately, the new partnerships formed, innovative service delivery solutions implemented, and provision of virtual care will have great utility for our OHT well beyond the end of the COVID pandemic. Going forward, these programs will continue as we address the impact of the pandemic on our communities. Opportunities to collaborate further will be identified to ensure existing programs are leveraged and services gaps addressed to meet our population's needs.

4.0. How will you transform care?

In this section, you are asked to propose what your team will do differently to achieve improvements in health outcomes for your patient population. This should include reflections on the lessons learned in response to the COVID-19 pandemic and how your team will deliver a coordinated response to COVID-19 in the future.

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experiences; provider experiences; and value. By working together as an integrated team over time, Ontario Health Teams will be expected to demonstrate improved performance on important health system measures, including but not limited to:

- Number of people in hallway health care beds
- Percentage of Ontarians who had a virtual health care encounter in the last 12 months
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions

- Percentage of Ontarians who digitally accessed their health information in the last 12 months
- 30-day inpatient readmission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Patient reported experience and outcome measures and provider experience measures (under development)
- ED physician initial assessment
- Median time to long-term care placement
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready
- Caregiver distress
- Time to inpatient bed
- Potentially avoidable emergency department visits for long-term care residents

Recognizing that measuring and achieving success on the above indicators will take time, and that teams will be focused on COVID-19 planning and response, the Ministry is interested in understanding how your team will measure and monitor its success regarding the delivery of a coordinated pandemic response, as well as improving population health outcomes, patient care, and integration among providers in the short-term.

4.1. Based on the population health data that has been or will be provided to you, please identify between 3 and 5 performance measures your team proposes to use to monitor and track success in Year 1. At least one indicator/metric should pertain specifically to your proposed priority patient population(s).

Please complete this table in the Full Application *supplementary template*

Performance Measures	Purpose/Rationale	Method of Collection/Calculation
1.		
2.		
3.		
4.		
5.		

4.2. How will your team provide virtual and digitally enabled 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 and other digital health solutions enable 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 from a distance. At maturity, teams are expected to be providing patients with a complete range of digital services. Please specify how virtual care will be provided to Indigenous populations, Francophones and other vulnerable populations in your Year 1 population and/or sub-group.

In the context of COVID-19, increasing the availability of digital health solutions, including virtual care, has been critical for maintaining the provision of essential health care services for patients, while respecting public health and safety guidelines to reduce transmission of the virus. Please describe how virtual care was implemented and used to support a response to COVID-19 and your plans to continue providing virtual care. Please also describe what digital health solutions and services are either currently in place or planned for imminent implementation to support equitable access to health care services for your patient population and what your plans are to ensure that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery. Please demonstrate how the proposed plans are aligned and consistent with the directions outlined in the Digital Health Playbook. Responses should reference digital health solutions that both predate COVID-19 (where applicable) and any that have arisen as a result of the pandemic response[4].

Max word count: 500

Our OHT partners have implemented many virtual care tools to support our populations. Partners, such as Phoenix Centre for Children and Families, provide designated French Language Service (FLS) virtually. Others, such as those contracted by Pikwakanagan, provide virtual Indigenous mental health and addictions services. Phone, text or video applications are used. Others, including primary care, use platforms such as EMR tools, Zoom, OTN, Doxy, MEDITECH Expanse, Aetonix and Novari.

In response to COVID-19, OHT partners pivoted with 70-80 percent of visits transitioning to virtual care. Primary care implemented online booking, virtual video, phone, and virtual triage. Acute care also implemented virtual care tools. Home care and community support services implemented virtual walk-in clinics, check-ins, remote patient monitoring, visits and symptom management, family meetings, social connections, education and brain stimulating activities. Virtual after-hours patient symptom management and supports were also added. All partners will continue to utilize these tools to enhance the service experience and will implement new tools where appropriate and available. With educational gaps in use of virtual care tools, training will be a future focus area.

Our OHT is well positioned to support equitable access to health care services for the target patient population. Many partners are leveraging shared platforms such as

[4] By completing this section the members of your team consent that the relevant delivery organizations (i.e., Ontario Health and OntarioMD), may support the Ministry of Health's (Ministry) validation of claims made in this section 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.

CareDove, where users may select a community service, determine the provider(s) of the service (such as AccessMHA; Counselling Connect), send a referral and book an initial appointment. Other systems such as CIMS, CHRIS and HPG are widely accessible and in use today. Primary care uses various EMRs. Despite this, digital health gaps exist such as an integrated patient portal spanning the continuum, improved access to CHRIS and Connecting Ontario across sectors and connecting siloed partner systems – there is work to be done.

Integrated care delivery will require data sharing and privacy agreements and will rely on leveraging existing secure systems. Two of our hospitals, Arnprior Regional Health and Queensway Carleton Hospital are part of the Champlain Association of Meditech Partners shared with four other hospitals using MEDITECH Expanse HIS, while Kemptville District Hospital is moving to EPIC. At this time patient information can be shared via ClinicalViewer or by providing secure access to systems. A clinical repository is being explored (i.e. SHIIP), with a future goal of bi-directional health information exchange. The expansion of existing digital health assets for eServices will address care delivery transitions and work to resolve current limitations.

Our partners are leveraging solutions that are outlined in the Digital Health Playbook. Acute care hospitals are contributing to and viewing in Connecting Ontario. eNotification for participants provides near-real time notification when patients present, are admitted to or are discharged from acute care or EMS. All home and community care data, including patient assessments, services and coordinated care plans (CHRIS) are available via ConnectingOntario. Primary care is linked via eConsult, eReferrals (Ocean/Novari), eNotifications, OLIS, HRM, and ClinicalViewer. Ocean eReferrals integrates into compatible primary care EMRs to facilitate bidirectional referral tracking and integrates to Acute Care via Novari eRequest and ATC and Waitlist management.

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Tim Pemberton
	Title: VP, Information Management, Clinical Support and Chief Information Officer and Chief Privacy Officer
	Organization: Queensway Carleton Hospital
	Email: tpemberton@qch.on.ca
	Phone: 613-721-2000 ext 2915

4.3. 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, racialized communities 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.

4.3.1. How will you work with Indigenous populations?

Describe how 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?

If there is a First Nations community in your proposed population base, what evidence have you provided that the community has endorsed this proposal? 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

Our OHT understands that healthcare for Indigenous peoples is complex. Historical legacies have changed the way healthcare is planned and delivered for this population, such as a reliance on a mix of federal and provincial government resources and infrastructure (1). We also understand that Indigenous peoples continue to experience ongoing forms of colonization and the intergenerational effects of the process of colonization as well as many forms of racism. These legacies translate to gaps in health care and in Indigenous peoples continuing to experience disparities in health outcomes as well as the social determinants of health. The need for culturally and linguistically appropriate health care and an appreciation of culture as a form of healing has never been more relevant in our history. We must

thoughtfully and meaningfully engage our Indigenous health organizations in reimagining a health system that meets the needs of the First Nations, Inuit and Métis peoples living within our attributed population.

In our OHT, those who identify as Indigenous range from two percent to six percent of the attributed population. Our OHT has members of the Algonquins of Pikwakanagan First Nation, Inuit and Métis within our geography. Currently, culturally specific and appropriate services are limited within our OHT, meaning that travel is required to access them. This information is reflective of the existing data from the Champlain LHIN.

Odawa Native Friendship Centre was a signatory partner of one of our two original OHTs in-development. When preparing this application, outreach was made to the Odawa Native Friendship Centre and the Wabano Centre for Aboriginal Health. Both organizations expressed a willingness to collaborate and work with us to enhance the engagement and experience of Indigenous peoples across our catchment area in the long-term. However, due to a ramping up of efforts to support the COVID-19 vaccination roll-out at the time of application preparation, they were unable to actively engage with us. Both organizations were focussed on supporting their communities that are at an increased risk of COVID-19 infection and its complications, in addition to working through some key leadership and staffing shortages. It is important to note that these are two Indigenous organizations within our region and that they serve most of the greater Ottawa area and surrounding rural communities. As a result of the pandemic, their resources are stretched extremely thin. Supporting reconciliation means recognizing and acknowledging that we must respect our Indigenous partners when they are unable to participate in broader engagement. We must appreciate their need to respond to a situation that has disproportionately impacted their client population.

We have many partners among our OHT who have been supporting Indigenous populations through their organizations. For example, SE Health has significant experience working collaboratively with First Nation communities across Canada and has worked locally with Wabano Centre for Aboriginal Health. SE brings a wealth of experience working with First Nations partners that our OHT will be able to leverage.

Ottawa Public Health (OPH) has strongly expressed its commitment to advancing Indigenous health equity through actions that promote reconciliation. The OPH Reconcili-ACTION Plan was designed to formally respond to the Truth and Reconciliation Commission of Canada's (TRC) health-related Calls to Action (2). The Plan is intended to be a living document that is guided by the United Nations Declaration on the Rights of Indigenous Peoples, while emphasizing the principles of truth and reconciliation and cultural safety - i.e., respect, relationship, reciprocity, and

reflection. The goal of the Plan is to develop systematic processes that enable individual and collective actions that promote reconciliation between Indigenous and non-Indigenous peoples.

Equity, cultural safety and an approach to reconciliation is a foundational commitment among our OHT partners. We have adopted Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework with a special focus on anti-Indigenous racism and will encourage our partners to educate themselves and their teams in indigenous history and cultural safety (e.g., mandated as part of Champlain MSAA requirements) (3). We will also work hard to build our collective knowledge and expertise in addressing racism and discrimination in order to reduce inequities in the health care system. By working closely with our Indigenous health partner organizations, we will build a health team culture that is focused on equity, inclusion, diversity and anti-racism to help contribute to better outcomes for patients, families and providers within the health care system. We are committed to supporting individuals for their participation as well as investing in cultural awareness education for non-Indigenous people participating in working groups to ensure there is no additional harm created as we continue to learn and respond to this population's health care needs.

Recognizing that First Nations, Inuit and Métis communities experience higher rates of chronic health conditions in addition to generally lower levels of social economic status, we acknowledge that more engagement with these communities in population health system planning is required as part of our OHT work. In addition to our current outreach to Odawa Native Friendship Centre and Wabano Aboriginal Health Centre, we plan to engage the Champlain Indigenous Health Circle Forum to improve our understanding of the needs of Indigenous peoples, work with Indigenous peoples to determine their priorities and develop culturally-appropriate programs and services with a strong emphasis on Indigenous cultural training. Throughout this process, we will continue to solicit participation as part of our organizational structure and within our lived experience partners.

References:

1. Mattison CA, Doxtater K, Lavis J. Ontario's Health System: Key Insights for Engaged Citizens, Professionals and Policymakers: Care for Indigenous Peoples.; 2016.
2. Ottawa Public Health, Reconcili-ACTION at Ottawa Public Health: Update. June 18, 2018 http://app05.ottawa.ca/sirepub/mtgviewer.aspx?meetid=7366&doctype=agenda&itemid=375729

3. Ontario Health. Equity, Inclusion, Diversity and Anti-Racism. Published January 22, 2021. Accessed March 30, 2021. https://www.ontariohealth.ca/equity-inclusion-diversity-and-anti-racism

4.3.2. How will you work with Francophone populations?

Does your team serve a designated area or are any of your team members designated under the *French Language Services Act* or identified to provide services in French?

Describe how the members of your team currently engage with the local Francophone community/populations, including the local French Language Health Planning Entity andor 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

Eight percent of the population within our OHT catchment area identifies as Francophone. Under the French Language Services Act (1986), part of the territory where our OHT will offer services is designated to offer French language services (City of Ottawa). Although the rest of the catchment area is not designated, the number of Francophones in our region is growing.

Evidence suggests that clients who receive services in their preferred language seem to follow instructions better, do not rely on hospital services as often and remain in better overall health (1). Often, they report a stronger sense of belonging to their community which also has a positive impact on their well-being. By offering services in a client's language of choice, providers are better able to understand their situation and offer services suited to their health needs. Not only does this improve the quality of services delivered, but it improves the experience of services received.

Among our 70 partner organizations, there are at least six organizations officially designated under the FLS Act. Le Réseau des services de santé en français de l'Est de l'Ontario (French-language planning entity) is currently involved with our OHT and will continue to provide data and recommendations to our partners. A partnership with La Maison de la francophonie is being explored.

By engaging Francophones in population health planning and offering services that are more inclusive, we will continue to eliminate barriers in access to services (i.e., language) and help build a more equitable, inclusive and healthier community. Francophone representation will be present at leadership and action team tables, including partners with lived experience.

Although there is limited data specific to Francophones within our year one priority populations, the demand for support in mental health and addictions and complex chronic conditions is increasing, as is true of the general population. Inconsistent access to FLS serves to increase the vulnerability and the risk of harm to Francophones.

To better respond to our Francophone community and their specific health needs, our OHT will collect further linguistic data and engage our lived experience partners. Where first language is neither French nor English, we will record which of Canada's official languages they are most comfortable using. Another important aspect for the OHT is to know where French language human resources are located amongst the health service providers to ease care navigation.

To inform this process:
• Each partner organization will obtain and record their patient population's linguistic identity;

• Partners will identify the staff within each organization who have capacity to deliver FLS and implement a process to direct Francophone patients to them;

• The OHT will eventually develop standardized and shared policies, processes and training to support FLS; and

• As service gaps are identified, we will explore the possibility of expanding service delivery to fill such gaps. Digital health platforms, tools and apps, where possible, will be offered and functional in French.

References
1. Sarah Bowen, Language Barriers in access to health care, Health Canada, Ottawa, 2001.

4.3.3. 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

When addressing the OHT priorities for year one, attention will be given to how to best support visible minorities, rural populations and trans and non-binary individuals.

According to census data, 22 percent of our population identifies as a visible minority with the largest percentage, 29 percent, being in western Ottawa. This includes new immigrants and diverse ethnocultural communities. Across our catchment area, 21 percent of people report having a mother tongue other than English or French, with the highest concentration of these groups (27 percent) also living in western Ottawa. Language is identified as a barrier to screening for various health care services, such as breast cancer, diabetes and other illnesses. Ensuring interpretation services for minority language services will be part of our planning. Other barriers include the cultural differences in help-seeking and the lack of culturally sensitive services or delivery modes available to some visible minority populations. We are commited to taking a health equity lens to planning services and will address these barriers in future planning.

A large portion of our geography is rural and with that comes barriers, such as long distances to travel to access health and community support services. Rural health needs can be supported with the use of remote monitoring technology. This technology leverages video calls and allows health care providers to address the needs of patients when they need it, preventing emergency department visits and hospital readmissions. However, the inconsistencies in rural bandwidth and connectivity remain significant barriers and challenges for the provision of virtual services. Poor to no access to virtual health services due to low quality and little choice in internet access creates an additional barrier in rural communities. There was a recent announcement of significant funds to improve rural connectivity in our geography and while this is a positive step, it will take time to implement and may still be cost prohibitive for some people.

Trans and non-binary persons are a marginalized group with unmet health needs which impacts their physical and mental health. Primary care is essential for general health care, hormone replacement and referrals for transition related surgery. Approximately 17 percent of trans Ontarians do not have a family physician (1). Meanwhile one in 200 Ontario adults identify as trans and many have expressed feeling unsafe when receiving care in rural communities (2). Training, mentorship and resources are available through Champlain Regional Planning Table for Trans, Non-binary, Two Spirit and Intersex Health and Rainbow Health Ontario (3). Some members of the OHT have existing partnerships with these organizations and will seek to build capacity by promoting local training and partnerships that should reduce the number of trans patients being denied local, sustainable primary care and decrease unnecessary visits to the Children's Hospital of Eastern Ontario (CHEO), central Ottawa community health centres and endocrinologists.

Our OHT intends to continue working collaboratively with regional partners who provide specialized services such as CHEO, the Royal and many others to further our work in service of our population.

References

1. Scheim AI, Zong X, Giblon R, Bauer GR. Disparities in access to family physicians among transgender people in Ontario, Canada. Int J Transgenderism. 2017;18(3):343-352. doi:10.1080/15532739.2017.1323069
2. TransPulse. Sex and Gender Diversity Among Transgender Persons in Ontario, Canada. Published April 24, 2014. Accessed March 29, 2021. https://transpulseproject.ca/research/sex-gender-diversity-among-transgender-persons-ontario-canada-results-respondent-driven-sampling-survey/
3. Sandbox Software. I am a Healthcare Provider. Rainbow Health Ontario. Accessed March 29, 2021. https://www.rainbowhealthontario.ca/healthcare-provider/

4.3.4. How will your team work with populations and settings identified as vulnerable for COVID-19 and influenza?

Describe how your team intends to deliver supports and coordinated care to communities and settings in which social distancing and other infection prevention and control practices are a challenge.

Max word count: 500

Our partners are connected to various regional planning tables and work collaboratively with local public health units to monitor and respond to the evolving impacts of COVID-19. Throughout this pandemic, public health has engaged with community partners like never before to understand the local geographic and socio-demographic realities of our population, proven to be effective in addressing the needs of those most vulnerable and impacted by COVID-19 (e.g., older adults, those living in congregate care settings, low income and/or racialized communities). OHT partners have worked together to understand who has been most impacted, their specific challenges and to provide community-specific supports to reduce such barriers. We have also joined forces to ensure consistent and ongoing communication among partner organizations, providers and local residents of rapidly evolving processes in testing, assessment and immunization, as well as key supportive resources.

In response to the pandemic, partner organizations shifted the way they offer programs and services to the broader public. Some organizations suspended face-to-face services and implemented enhanced Infection Prevention and Control (IPAC) protocols for PPE and physical distancing restrictions. Others prioritized service

delivery and shifted, where appropriate, to virtual care services provided via telephone, online and virtual programming. Many health care providers and non-essential back-office staff have been successfully working from home over the past year, with limited involvement with traditional face-to-face interactions within office settings.

People who live in congregate care settings, including shelters, long-term care homes, retirement homes, group homes and other residential care facilities, were most vulnerable across our province in the first and second waves of the COVID-19 pandemic. Locally, we approached this with specific strategies for prevention, early identification and risk mitigation as well as managing recovery. An effective strategy in the first and second waves, we've since included a broader set of stakeholders to strengthen connections at local and regional planning tables. Several partners participate in the Eastern Region Infection Prevention and Control Hub in support of congregate living settings in the region. Partners have also supported mass swabbing and immunization efforts in congregate settings as requested by Ontario Health and local health units.

Many partner organizations have risen to the challenge of responding to emerging needs for vulnerable populations, including community support services to address gaps in the social determinants of health, such as food security, education, transportation, isolation and addressing specific supply needs of vulnerable households. Beyond this, partners are actively working with other OHTs and public health partners to support high COVID-19 positivity clusters through targeted swabbing and vaccination clinics, personal protective equipment supply programs and enhanced education to help flatten the curve. It is important to note that efforts are also underway to address communication challenges and offer education and support in languages predominant in our communities.

The OHT will continue to deliver equitable care to address needs of vulnerable populations as we respond to the pandemic. Lessons learned will be gathered to ensure that the OHT can respond to similar crises in the future.

4.4. 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

Our OHT will refer to our patients, clients, residents, families and caregivers as lived experience partners. While founded on pillars of excellence and service, the delivery of health care is continually refined through lived experience partner engagement in the design,

implementation and evaluation of the system and its services. Thus far, lived experience partners have played an active role on the steering committee and action teams in addition to the writing of this application.

To ensure our OHT meaningfully engages and consults with all partners, we have adopted a philosophy of "nothing about me, without me." The Patient Declaration of Values for Ontario has been adopted as a framework to help us establish a culture that values lived experience partners at all levels. The Ontario Bill of Rights for long-term care residents will also guide our work in this important area. We will adopt a standard patient relations process for addressing lived experience partner input, feedback and complaints which will ensure that we continuously improve our services for all people.

The following frameworks will guide our work together: Ontario's Patient Declaration of Values, Quadruple Aim and our newly developed OHT values. Our values recognize a commitment to looking at the whole population, including those receiving services in primary care, home and community care, acute care, long-term care, retirement residences and other congregate care settings and are driven by principles of public health.

The following joint values guide our OHT:
- Patient-centric
- Collaboration
- Trust
- Accountability
- Respect (featuring equity, diversity and inclusion)
- Leadership
- Commitment to Excellence
- Sustainability

Central to our core values is person-centred care that invites lived experience partners to participate in system co-design, planning and change management as well as program development and improvement. For example:
- Existing services are leveraged and organized around patient needs;
- Capacity gaps are identified by reviewing and analyzing activities and processes;
- Connections between care settings and lived experience partners are actively engaged to support improvements in care;
- Data analysis, performance metrics, delivery and program innovations are shared to promote information exchange across regions; and
- Leadership and governance structures include lived experience partner representatives.

Our proposed approach is also rooted in evidence and leading practices, such as the Quality Standards of Youth and Family Engagement (March 2021), released recently by the Ontario Centre of Excellence for Child and Youth Mental Health.

Moving forward, lived experience partners will be engaged in many ways, including positions at leadership and governance tables, action teams and co-design workshops to help plan for system transformation. We have a number of existing networks of those with lived experience

(youth, addiction, caregivers, adults, seniors) that we plan to engage. Organizations such as the Renfrew County Youth Network, Parents Lifeline of Eastern Ontario (PLEO) and existing patient advisory committees, etc. will help us ensure system transformation improves the experience and service outcomes of our population.

As we expand our knowledge and understanding of population health, lived experience partners and relevant community groups will be right there with us. Building on existing practices, including patient and family advisory councils in acute care, resident and family councils in long-term care, committee and board membership, engagement of patients in strategic planning processes (e.g., ARH Declaration of Patient Values), acting as program advisors (e.g., SE Health and Carefor Health & Community Services), engagement in developing clinical pathways within organizations and involvement in new programs, we will expand our engagement of lived experience partners to all that we do, at all levels of our work together.

Proposed Engagement/Activities Framework
During year one, the OHT will engage with experts to explore engagement models and choose a model that best fits with our population health approach and attributed population. We plan to use the following resources to support this process:

I.Commitment to a patient engagement framework, guided by the Engagement Guiding Principles, Canadian Foundation for Healthcare Improvement:

a. Continual consultation with patients and care partners
b. Partnership model of engagement
c. Community engagement

II.Active Program Participation and Inclusion

a. Lived experience partners involved in all working groups (minimum of two per group)
b. Optimized engagement processes (technology, email access, admin supports, accessible schedules)
c. Monetary and non-monetary reimbursement/compensation to lived experience partners participating in OHT activities

Lived experience partner engagement activities and processes will include:

- Participation & Inclusion: confirmation that lived experience partners are represented as equal partners in the patient experience;
- Diversity: lived experience partners are representative of voices from vulnerable populations, including marginalized or minority groups (e.g., Indigenous, Francophone, LGBTQ2S+, racialized groups);
- Inventory of Resources: establish an inventory of current engagement practices to inform future process designs;
- Education & Learning: ensure lived experience partners have the tools and supports needed to be confident and valued OHT members;
- Healthy Literacy: improve the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions;

• Communication Strategy: communication supports/tools will be developed and shared broadly to inform and engage the public in our collective work (e.g., monthly newsletter, social media page);
• Access to Health Resources: maintain a database of key resources to support lived experience partners;
• Optimize Ways of Participating: ensure individuals can easily participate, including the use of technology (e.g., video participation, email access) and the provision of administrative supports to enable participation (e.g., scheduling supports);
• Enabling Participation: recognize the value of lived experience obtained through a variety of methods, such as focus groups, engagement using video, surveys and one-on-one interviews and postcards to gather feedback; and
• Evaluation: establish a lived experience partner council to ensure quality improvement and positive outcomes. Representatives of all sectors/geographies lived experience partners will be engaged in the design, implementation and evaluation of system improvement. There will be a minimum of one member who will serve on the OHT steering committee to represent their voices.

5.0. Implementation Planning

5.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3 (e.g. virtual care, population health equity etc.)? Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 4.1.

Note that the Ministry is aware that implementation planning will likely be affected by the trajectory of the COVID-19 pandemic, and applicants will not be penalized should the priorities identified within this section need to be adjusted in future as a result. In anticipation of this likelihood, responses should therefore be reflective of the current health sector context and include contingency planning for ongoing COVID-19 pandemic activities.

Max word count: 1000

Work to move our OHT towards maturity will continue immediately following the submission of this application. In addition to meeting year one targets as outlined in Ontario's OHT Guidance for Health Care Providers and Organizations document, this implementation plan describes how we will reimagine health care services for our year one priority populations as well as present a strategy and that will help us move towards maturity. A key element of this plan is a focus on managing the size and complexity of this transformational change, which has been incorporated into the strategic plan as outlined below. Plans for years 2-5 years, including the sequencing of additional priority populations will be informed by a strategic plan to be developed in year 1.

We acknowledge and commend our partners in their pursuit of collaborative efforts to manage COVID-19 related activities to maximize reach and utilization of resources. Where opportunities present themselves for new and/or innovative collaborations, we will endorse such initiatives. We also acknowledge that timelines may require adjustment related to delays while managing the COVID-19 response.

Strategy and Infrastructure Year 1

Leadership and Governance

• Collaborative Leadership Group (CLG): we are evolving our leadership structure to align with the Collaborative Decision-Making Arrangement (CDMA) process and requirements. Terms of reference will be developed. Anchor partners will be engaged and will go through a strategic planning process, including a focus on change management, to help shape our goals for year 1 and beyond. Representation will be inclusive of all health sectors and lived experience partners. This group will also monitor OHT progress of year one workplans and make links with our local OHTs to look for opportunities of alignment and consistency.

• Governance: a long-term governance structure and processes will be developed by the CLG, with active engagement from all partners

Infrastructure and Enabling Action Teams

• Management: an implementation lead with project coordination supports will be retained to operationalize the strategic plan and action team workplans that are developed for year 1 and beyond. Other workplan items will be included such as collecting inventories to inform a broader understanding of service offerings within our health team (e.g., service capacity to deliver services in French).

• Action Teams: key areas of work will be co-led by anchor partners. Co-leads will recruit relevant partners to support this work and together will build a work plan for each population of focus in year one. At a minimum, action teams will include mental health and addictions and complex chronic priority populations. Additional working groups or tables may be struck to support key areas of focus, such as equity, diversity and inclusion.

• Digital Health Strategy Committee: this committee will continue with a workplan that is feasible and consistent with the Digital Health Playbook.

• Communications Committee: change management will be a key component in moving this OHT and its stakeholders forward. Our communications committee will continue to share key messages via an updated OHT website and other commonly used communications channels.

• Data and Performance Committee: following the quadruple aim framework and our proposed metrics for year 1, this committee will lead the development of an evaluation framework. Teams will use a rapid cycle evaluation process to evaluate change initiatives and make rapid changes for learning and growth

Key Partner Engagement

• Lived Experience Partners: rather than develop a stand-alone committee of lived experience partners, we believe these partners must be a part of all activities of our evolving health team. Key roles will be defined within the CLG, action teams and committees. Recruitment and engagement of relevant lived experience partners will be a key focus in the coming months. We will continue to explore the need for a lived experience partner table, as part of our strategic planning.

• Primary Care Partners: with three family health teams, eight family health organizations and one fee-for-service clinic currently engaged, we are actively developing a primary care engagement committee that will inform our strategy for evolving health services in our region. Recruitment of other primary care practitioners is underway.

Priority Populations for Year 1

Mental Health & Addictions - all ages

Our goals for reimaging care for people of all ages living with compromised mental health or addictions include:

· A reimagined future state of integrated mental health and addictions services, co-designed with lived experience partners;

· Simplified and accessible integrated services with smooth transitions to different care environments when required; and

· Community based care facilitation and supports for navigating services across the system, connected to primary care.

Key activities we plan to implement in year one have been prioritized in the following timeline:

• 3 months: recruit health system and lived experience partners to the action team; develop a year one workplan for mental health and addictions (MH&A); identify and leverage existing collaborative initiatives among our OHT partners and local OHTs, including COVID-related virtual and drop-in services that have evolved over the past year; determine depth and breadth of MH&A needs and services in our region, including service volumes in primary care, community services and acute care (ED and inpatient units).

• 6 months: following multi-sector engagement and consultation, design a reimagined future state of MH&A services that will meet the needs of our community; maintain and leverage innovative virtual care and drop-in services that have evolved out of COVID response; identify key gaps and change initiatives for priority areas.

• 12 months: design change initiatives; begin implementation; utilize rapid cycle review process to identify areas to be adjusted and improved; track lessons learned and share with the broader OHT.

People with Complex Chronic Illness
Key activities we plan to implement in year one have been prioritized in the following timeline:

• 3 months: select an individual or team to lead this work.

• 6 months: conduct further data analysis of OHT partner data to help support a year two focus among those living with chronic complex illness; engage in stakeholder consultation to support a recommendation of focus for year two.

• 12 months: obtain full partner agreement on a recommendation for year two; develop a comprehensive workplan.

5.2. What non-financial resources or supports would your team find most helpful?

Please identify what centralized resources or supports your team would need to be successful in the coming year, if approved. This response is intended as information for the Ministry and is not evaluated.

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Since receiving an invitation from the Ministry to submit a full application, our OHT, including lived experience partners, clinicians and health partner organizations, have been collaborating to identify a structure and process for how to improve population health outcomes in our community. To ensure our readiness and ability to transform health care delivery, we believe the following non-financial resources and supports are essential.

Ontario Health facilitation and coaching support would be beneficial with an initial focus on the following areas:
• Assistance in developing a collaborative decision-making agreement;
• Understanding and selecting governance approaches and structures;
• Building and sustaining trusted partnerships among health sectors and community partners;

• Selecting decision making tools to satisfy the needs of a geographically dispersed health team.
• Population health management coaching;
• Understanding digital health options and strategies for improving communication and supporting integrated, seamless care coordination;
• Navigating the complexity of home and community care while home care reform is taking shape to optimize availability to our population; and

Data and Analytics
Data inclusive of the baseline attribution population data set has been received and reviewed by our team, which clarified the population health needs and service utilization patterns for our population. Further data to understand the social determinants of health that impact access to care given the broad geography of our OHT would be helpful. Having access to clinical data across sectors, with a focus on year one populations of mental health and addictions and seniors with complex chronic disease will be a critical enabler to improving service delivery.

Performance Measures
The selection of key performance measures will be important both to demonstrate impact and to enable benchmarking for improvement within our OHT and across the province. Facilitated sessions regarding the selection of performance metrics that represent system impact on population health (moving us beyond measurement of silos of care), measurement techniques and evaluation models provided by experts would be invaluable. We are also looking for access to resources and supports to help us create a shared dashboard to support reporting and monitoring of performance measures, sharing of results of quality improvement activities and to drive continuous learning. This would also support the accountability of partners for an improvement of health quality outcomes.

Engaging with Lived Experience Partners
We recognize the critical importance of working collaboratively with lived experience partners across our various communities to design solutions that will drive impact towards achieving population health. We would appreciate coaching and facilitation support as we create our model of patient partnership and engagement to truly amplify their voice and ensure an informed and iterative process of co-design.

Creating an Engaging Environment for Primary Care
We would appreciate support, direction and advice on primary care engagement and mechanisms to ensure primary care providers are active partners in our OHT. Education would be appreciated on how best to optimize the drivers of engagement across the different primary care models and how value can be established for this

group in the absence of a specific remuneration model in place to 'compensate' primary care providers for their involvement in the development of our OHT.

eHealth Center of Excellence
Improving access to services for people living with mental illness and addictions and better understanding the health needs of seniors with chronic illness will be the priority for our OHT in year one. The adoption and integration of digital health solutions will accelerate our capacity to provide evidence informed, integrated care for our priority populations. Information on digital solutions and enablers is required to understand the digital health landscape and inform decisions about virtual care, automated solutions, decision support tools, improved connections and eServices.

Access to Consultation, Direction, and Advice
Having access to evidence informed resources, such as resources developed by RISE (Rapid improvement Support and Exchange), shared by other OHTs or prepared by the MOH, has been invaluable. We would like this resource bank to continue to evolve as we move forward with a specific focus on the following areas:
• Identifying practices that optimize integration of our lived experience partners in co-design;
• Creating meaningful opportunities to engage people in health system transformation, including collaborative decision making;
• Learning from national and international integrative health systems that have progressed in achieving quadruple aim outcomes;
• Gaining insight on the integration of research and evaluation frameworks for rapid cycle change initiatives; and
• Effectively sharing our story with partners and the community at large, throughout this journey.
• Support with the creation of a meaningful CDMA that will both define roles and responsibilities of our membership but also fully engage our members in the work ahead

Staying Connected
Key leaders from our OHT have already begun to work collaboratively within our region and beyond through a network of informal OHT communities of practice which offer the opportunity to learn from and with peers, share insights, resources and minimize duplication of effort whenever possible. Ensuring that these communities of practice continue is important to us.

Other Non-Financial Resources
Collaborative efforts and joint sessions with various organizations (ex. OHA, etc) to ensure policy development for the maturity of OHT's represents opportunities

impacting all. This would also contribute to knowledge translation and reduce duplication and fragmentation across the province.

5.3. Have you identified any systemic barriers or facilitators for change?

Please 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.

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Our OHT has identified systemic barriers within four themes: strategy, structure, culture and skills.

Strategy
The OHT is evolving its strategy to achieve its goals and create the necessary flexibility to make timely adjustments for risk mitigation and change management. Starting with population health, we must shift our system lens from a focus on 'illness' to a focus on 'wellness,' where hospital is no longer the health care hub of the community. Focusing on health promotion and illness prevention, we envision people being supported by team-based primary health care hubs in the community, where they chose to live their lives, healthy and well for as long as possible. We envision quick and simple access to acute care and specialized services supported by a shared care plan.

A key strategy here is the continuous and full engagement of our lived experience partners. Engagement towards co-design is within our control but there are significant system barriers that are not, such as Ontario's home and community care modernization plan which aims to allow for greater flexibility to meet the needs of our patients and clients. Like many regions in the province, we face limitations in accessing home and community care for our targeted populations, such as in rural areas. Although we will work hard to reimagine a health care system that will allow for greater flexibility and continuity across the health care continuum, some services such as home and community care as well as mental health and addictions require coordinated, provincial systemic improvement.

Structure
Financial limitations are a key structural barrier that falls outside of our control. Two prime examples of this are: legislative barriers for paymasters to receive and distribute funds outside of existing perimeters and hospitals having the ability to retain surplus funds, whereas community agencies do not. There are also limitations that our current volume-based funding model supports, such as a one-size fits all approach to care provision with transactional activities rather than the goals- and needs-oriented approach to services that supports population health. Then there are the current accountability agreements, such as HSAA, MSSA, LSSA, etc., that fit with our current health care structure. While the OHT accountability framework is responsible for financial and performance management, today's structural limitations present challenges as we are expected to reimagine services and deliver innovative

care, while providing the same volumes and types of services expected of us today. We also struggle with pay inequity for providers across care sectors, most impacted is the home and community care sector. Recruiting and retaining talent is key for this sector if we want more people to stay healthy and well in their homes.

We do not currently have one shared electronic health record among partner organizations in the OHT. To address this challenge, we propose leveraging provincial digital health solutions for eServices and a common data repository, such as Shared Health Integrated Information Portal (SHIIP). These tools will help us get closer to a shared care plan and more timely access to services for people living in our communities.

Although we plan to leverage Ontario's Centre of Excellence for Mental Health and Addictions, to enable truly reimagined care pathways for people living with mental illness and addictions challenges, we support the development of a provincial strategy that would define and strengthen service delivery models across the province. A call to action from Ontario's leading mental health and addictions organizations, https://everythingisnotok.ca/ we too support a provincial strategy to reduce wait times, improve standards of care and improve performance metrics for this growing need.

Culture
The most important cultural barrier we face as an OHT today is the need for greater engagement of our lived experience partners in the co-design of a reimagined health care system. By engaging our diverse communities, we will begin to shift the yardstick from an "informed" level to an "empowered" level of engagement. With an understanding of our cultural make-up, we will work to build trust and engage representative members of our diverse community who have lived experience. With appropriate orientation and training, we will inform their knowledge and capacity towards a comfort with co-design. Given our commitment to equity, diversity and inclusion, we will work hard to address engagement barriers to create a trusted environment that is welcoming for all.

Communication will also present challenges for us beyond our OHT borders, particularly for those who belong to other OHTs and when accessing specialty services. Our commitment is to strengthen communications among our partners while working with our regional OHT partners to reduce such barriers.

Skills
Virtual care is here to stay; it offers greater access and efficiency in health care services and people love it. We must support the advancement of knowledge, skills and capacity among our population to use such tools and ensure accessibility and availability of broadband internet to participate. As we do this, we expect to see greater accessibility to services through provincial endeavors such as in a recent government announcement of a $300 million investment to support access to reliable cellular services in Eastern Ontario.

There is also a health human resources shortage in Ontario. We will require an OHT health human resources plan, starting with mental health and addictions professionals (i.e., mental health nurses) and home and community care providers. Plan features

will include current wage disparities across sectors, such as those influenced by centrally negotiated collective agreements and promoting a provincial plan for training to increase capacity.

Recommendations for the Ministry to consider in addressing key barriers:
- Modernize the provincial privacy policy to facilitate increased levels of data sharing between OHT partner organizations;
- Exploration of flexible funding models (i.e. bundled, population-based funding) that will allow OHTs to truly design population health services for improved outcomes, starting with streamlined accountability agreements;
- A provincial mental health and addictions wait times strategy that will establish standards of care, define consistent care pathways for improved system navigation and mandated performance reporting; and
- Incentivize specialty care providers by formally evaluating their services, with input from lived experience partners.

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.	