Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

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

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

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

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

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

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

Participation in Central Program Evaluation

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

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

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Additional Notes

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

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

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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: Barbara Collins
	Title: President & CEO
	Organization: Humber River Hospital
	Email: bcollins@hrh.ca
	Phone: (416) 242-1015
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Mehdi Somji
	Title: Director, Integrated Health Systems & Partnerships
	Organization: Humber River Hospital
	Email: msomji@hrh.ca
	Phone: (647) 407-2369

1. About Your Population

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

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

1.1. Who will you be accountable for at maturity?

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

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

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

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

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

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

Maximum word count: 1000

The North Western Toronto (NWT) Ontario Health Team (OHT) will be responsible for residents receiving care in the North and West regions of Toronto. There appears to be a high degree of alignment between the population and service area originally proposed during the Self-Assessment and the attributed population dataset provided by the Ministry. It was observed that the majority of Patient Enrollment Models (PEMs) associated with the NWT OHT fall within this region, and Central Local Health Integration Network (CLHIN) North York West (NYW) sub-region data was used as a proxy to supplement data provided by the Ministry. The assumption was made that residents reside near a PEM as the Forward Sortation Area (FSA) for the NWT OHT attributed population was not available; this assumption will be verified with data that will be provided by the Ministry.

Key opportunities for NWT in Year 1 and at Maturity include:

1. Chronic Conditions: NWT has a significant number of residents living with chronic conditions. 27.3% of the attributed population were categorized as having minor, moderate, or major chronic conditions, and accounted for 40% of total healthcare expenditures. Moreover, sub-region data demonstrated over 1 in 5 adults live with 2+ chronic conditions, and approximately 50% seniors with 4+ chronic conditions. A key focus for the NWT OHT is chronic disease management utilizing a Population Health Management (PHM) approach, with the goal to provide seamless care across the spectrum of services including wellness, prevention, and all aspects of clinical and supportive care. Additional information was provided in the supporting documents, tables 1 and 2.

2. Aging Population: the number of seniors attributed to the NWT OHT is between 17-18%. This population is rapidly growing and has an enormous impact on the healthcare system. In 2016, seniors accounted for 46% of total health sector expenditures across Ontario. A key consideration and focus for the NWT OHT is to

promote healthy aging. Specific information around this population was included in Section 1.3.

3. Health Equity, Diversity, Low-Income and Education: the NWT OHT has a unique patient population with a significant number of immigrants and visible minorities, along with low income and education. Key priorities include health equity, health literacy, access to care, health promotion and prevention. Specific health equity considerations and data has been included in Section 1.3.

4. Mental Health & Addictions: there is a high prevalence of Mental Health & Addictions (MH&A) across the NWT attributed population with approximately 10% of residents with MH&A condition(s), greater in seniors. NWT patient advisors have stressed this figure is under-reported due to cultural considerations unique to this community, as many patients do not seek care. MH&A is a key priority in Year 1, Year 2, and at Maturity. Additional information was provided in the supporting documents, table 3.

5. Data Collection & Analytics: the attributed population provided by the Ministry did not capture uninsured patients, community health centres, mental health and addiction services in the community, etc. Due to the unique nature of the population served by NWT partners, a key priority in Year 1 will be a comprehensive environmental scan and community health needs assessment, along with the establishment of an analytics strategy to continuously collect, monitor and analyze this information to thoroughly understand residents in this area, health status and determinants of health.

NWT OHT partners have experience in population health and have participated in LHIN sub-region planning and leveraged sub-region data to better understand community needs, and implemented interventions to respond to identified priorities. Our team has a number of partnerships that were developed to provide integrated care and services that have been identified in Section 2.4 of this submission, and is well positioned to deliver our PHM approach. Our team is well versed in the development, co-design, implementation and evaluation of evidence-based protocols including the implementation of Quality Based Procedures (QBPs), Bundled Care, and Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines (BPGs). NWT OHT is working towards becoming the first RNAO Best Practice Spotlight Organization (BPSO) OHT, and will implement/evaluate multiple BPGs over a three-year period; additional information has been included in the subsequent sections and supporting documents.

NWT OHT is uniquely positioned to leverage Humber River Hospital’s Command Centre, as the upcoming generation has been planned for community reach to reduce acute utilization by supporting health, wellness, real-time situational awareness in the community, virtual care, home monitoring, and communication. The Command Centre has the infrastructure to digitally enable and support our PHM approach. An illustration was provided in the supporting documents, figure 1.

The designation of OHT will allow for formalized partnerships and a NWT OHT PHM approach to provide coordinated and seamless care across the care continuum. Specifically, NWT OHT partners will employ risk stratification to segment patients into distinct groups of similar complexity and care needs, and implement standardized models of care for each group. An illustration and description of NWT risk stratification for the attributed population was included in the supporting documents, figure 2. This will be further enhanced through improved data collection in Year 1.

Traditional healthcare approaches typically employ a “one-size-fits-all” model where the same level of resources are offered to every patient, which is clinically ineffective and prohibitively expensive. This has often resulted in strategies targeted at complex and chronic patients as they contribute to the majority of healthcare costs. Long-term solutions focused on clients that are well or have minor conditions is essential, to keep them healthy and prevent their transition to chronic or complex. The NWT OHT will initially focus on the most severe patients and provide integrated care to this vulnerable and complex population improving efficiency in service delivery, seamless and accessible care, with the goal to prevent further decline in health status, and achieve outcomes identified in Quadruple Aim. In parallel, partners will also focus on health promotion and prevention, incrementally shifting the health system from reactive care (i.e. focus on illness) to proactive (i.e. focus on wellness), which in the long-term is projected to reduce healthcare utilization and costs.

1.2. Who will you focus on in Year 1?

Over time, Ontario Health Teams will work to provide care to their entire attributed population; however, to help focus initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

To support the identification of Year 1 areas of focus, you will be provided with information about your attributed population including health status and health care spending data.

Describe the proposed population that your team would focus on in Year 1 and provide the rationale for why you’ve elected to focus on this population. Include any known data or estimates regarding the characteristics of this Year 1 population, including size and demographics, costs and cost drivers, specific health care needs, health status (e.g., disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

If this Year 1 population differs from the one you proposed in your Self-Assessment,

please provide an explanation.

Maximum word count: 1000

The Year 1 patient population identified in the Self-Assessment submission focused on a subset of patients with chronic conditions that have a significant prevalence in the community, as identified in CLHIN NYW sub-region and HRH coded data. This aligned with the attributed population dataset provided, and the corresponding Health Profile Groups (HPGs) represent a significant number of patients from each Health Profile Category (HPC).

NWT Year 1 Population
1. Congestive Heart Failure (CHF)
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Mental Health & Addictions – Schizophrenia and Psychotic Disorder (MH&A SP&D)

The attributed population size based on HPGs for CHF, COPD and MH&A SP&D was 7,780, which accounted for $102,787,883 total healthcare expenditures in FY17/18. Included below are size, cost, cost drivers, and health status for this patient population, with additional information provided in the supporting documents, tables 4 to 8. Social determinants of health were included in Section 1.3.

Attributed Population (FY17/18)

Congestive Heart Failure (CHF)
• Population size: 3,326 cases – 21% of Major Chronic HPC (HPG codes: E003C, E004C, E007C, E008C)
• Cost Drivers: the main expense for CHF patients was inpatient, followed by specialist fees, ODB drug, long-term care and home care. The majority of patients that visited the ED with CHF were admitted and had a high readmission rate, below. There is opportunity to better support patients following their acute episode, and long-term proactive strategies to better manage CHF in the community would be beneficial to reduce acute care utilization.

Chronic Obstructive Pulmonary Disease (COPD)
• Population size: 1,868 cases – 4% of Moderate Chronic HPC (HPG codes: D030C, D031C)
• Cost Drivers: the main expense for COPD patients was ODB drug followed by specialist fees. Patients with COPD decline gradually in the community, and when left unmanaged, were admitted or readmitted to hospital. There is an opportunity to better support patients with COPD in the community for proactive management and reduced utilization of more costly healthcare resources.

Mental Health & Addictions – Schizophrenia and Psychotic Disorder (MH&A SP&D)
• Population size: 2,586 cases – 28% of Major Mental Health HPC (HPG codes: Q008, Q009)
• Cost Drivers:* the main expense for this patient population was inpatient mental health, followed by specialist fees and ODB drug. Through a NWT OHT survey with

family physicians, survey respondents expressed that MH&A services were challenging to access, and felt they did not have adequate expertise/supports to treat these patients. When patients are not managing well in the community or cannot access a specialist, they are admitted to hospital. This patient population would benefit from stepped care in the community where the intensity of services is linked to patient needs, in addition to strengthening family physician access to specialists.
*Note: data for community MH&A was not included in attributed population dataset.

HRH Coded Data (FY18/19)

Congestive Heart Failure (CHF)
• Emergency department (ED) visits: 1003 visits presented with “heart failure” and 286 were discharged home
• ED visits 2+: 786 visits were repeat 2+ during FY18/19
• Inpatient admissions: 1001 (CHF & COPD represent 12% of medicine admissions)
• 28-day readmissions: 94 (9% of patients were unplanned readmissions)
• Average age: 78 years of age, these patients are frail seniors with other complex medical needs
• Percent patients with family physician: 96% patients had a family physician, representing opportunity to better support primary care providers to reduce avoidable ED visits and readmissions

Chronic Obstructive Pulmonary Disease (COPD)
• ED visits: 1543 visits presented with “pulmonary disease” or “bronchitis” and 936 were discharged home
• ED visits 2+: 988 visits were repeat 2+ during FY18/19
• Inpatient admissions: 474 (CHF & COPD represent 12% of medicine admissions)
• 28-day readmissions: 64 (14% of patients were unplanned readmissions)
• Average age: 77 years of age, these patients are frail seniors with other complex medical needs
• Percent patients with family physician: 96% patients had a family physician, representing opportunity to better support primary care providers to reduce avoidable ED visits and readmissions

Mental Health & Addictions – Schizophrenia and Psychotic Disorder (MH&A SP&D)
• ED visits: 999 visits presented with schizophrenia or psychotic disorder
• ED visits 2+: 673 visits were repeat 2+ during FY18/19
• ED visits 4+: 364 visits were repeat 4+ during FY18/19
• Inpatient admissions: 444 (41% of MH&A admissions)
• 30-day readmissions: 54 (61% of MH&A readmissions)
• Average age: 36 years of age, highlighting a younger patient population
• Percent patients with family physician: 62% patients had a family physician, representing opportunity to link patients to a primary care provider, a specific focus for the NWT OHT.

Year 1 care redesign and improvement efforts will focus on the most complex subset

of this population, specifically patients that are not managing well in the community resulting in a hospital admission and are discharged home (i.e. complex and chronic, rising risk), which accounts for 1,500 patients. Key priorities are to reduce 30-day readmissions and avoidable emergency department (ED) visits, improve access to primary care and follow-up post-discharge, and improve Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs). In parallel, NWT OHT partners will also focus on understanding specific determinants of health via the community health needs assessment, and focus on upstream factors to promote wellness and prevention, to improve health outcomes and reduce utilization; additional information included in Section 1.3.

NWT OHT partners elected to focus on this population as there are existing evidenced-based practices in this area, with pathways and models successfully implemented nationally and internationally. Our OHT has leveraged these strategies and will pilot our new model of care to realize outcomes aligned with Quadruple Aim, and iterate as needed. After successfully demonstrating proof of concept, this redesigned model of care will be scaled to our Year 2 population and maturity.

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

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

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

NWT has a unique patient population with significant diversity, immigrants, and considerations for low income, housing, education and seniors. Health equity and social determinants of health play a crucial role for this population and are a significant focus as these upstream factors contribute to poorer health outcomes. Figure 3 in the supporting documents illustrates a composite model of population health, adapted from the Institute of Health Improvement (IHI).

[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.

In the absence of sociodemographic information for the attributed population, LHIN North York West (NYW) sub-region data was used as a proxy. As described in Section 1.1, a Year 1 priority is data collection and analysis to provide a comprehensive and detailed understanding of population health needs and equity concerns. Below are distinctive demographic features for NWT grouped by marginalized/vulnerable populations:

North Western Toronto (NWT) Data, Time-period: FY17/18, from the Ministry Attributed Population Dataset

North York West (NYW) Data, Time-period: FY16/17, from Ontario Community Health Profiles Partnership, 2018 ©, used by Central LHIN.

Indigenous Population:
• NYW: 0.6% (Ontario: 2.8%)
There are no indigenous communities in NWT.

Francophone Population:
• NYW: 1.4% (Ontario: 4.7%)
There is a small francophone population in NWT.

Seniors:
• NWT - Aged 65+: 17.1% (Ontario: 17.6%)
• NWT – Aged 75+: 8.6% (Ontario 7.9%)
• NYW – Seniors Living Alone (65+): 23% (Ontario: 23%)
• NYW – Seniors Living Alone (65+) with challenges with Activities of Daily Living (ADLs): 48% (Ontario 46%)
• NYW – Frail Seniors (65+): 4% (from CHRIS & RAI-HC Assessment, as of Aug 31, 2017)
The number of seniors is projected to almost double in the next 20 years. Central LHIN has the highest number of seniors of all LHINs, and the NYW sub-region has the highest proportion of seniors in Central LHIN.

Diversity, Low Income, Housing & Education:
• Visible Minorities: 60.8% (Ontario: 29.3%)
• Immigrants: 54.9% (Ontario: 29.1%)
• Immigrants Arrived within the last 5 Years: 7.8% (Ontario: 3.6%)
• English is Not Mother Tongue: 50.5% (Ontario: 30.5%)
• Living in Low-Income: 22.6% (Ontario: 14.4%)
• Unemployed: 9.6% (Ontario: 7.4%)
• Dwelling in need of major repairs: 8.8% (Ontario: 6.1%)
• Lone Parent Families: 42.6% (Ontario: 17.1%)
• Education less than High School level: 20.2% (Ontario: 10.4%)
There is a significant number of new immigrants and visible minorities in NYW, along with low-income, low-education, and housing concerns. As identified in the Institute of

Health Improvement (IHI) Model in figure 3 of the supporting documents, these upstream factors and individual factors contribute to disease/injury and utilization of healthcare resources. A focus on health equity and social determinants of health will significantly improve health outcomes in NWT.

Prevention and Screening:
• Mammograms: 61.5% (Ontario: 63.2%)
• Pap Smears: 52.2% (Ontario: 55.1%)
• Any Colorectal Cancer Screening: 57.8% (Ontario: 58.9%)
• Colonoscopy: 35.1% (Ontario: 37.0%)
• Fecal Occult Blood Test: 34.2% (Ontario: 35.4%)
Data with respect to Prevention and Screening available for NYW provides evidence of poorer health behaviors demonstrated through lower screening rates across all measures compared to Ontario. This information is aligned with the Institute of Health Improvement (IHI) model in figure 3 of the supporting documents, and social determinants of health data provided above, identifying an opportunity to improve health behaviors.

These vulnerable and marginalized populations warrant specific focus to improve health equity and behaviors, by targeting upstream and individual factors to improve health outcomes. The NWT OHT has developed a draft health equity framework, and has included a Health Equity Committee in the operational structure to better promote health outcomes in Year 1 and at Maturity. Seniors are a specific consideration for the CHF and COPD populations as the majority of patients were 75+; a seniors friendly approach with evidenced-based practices in seniors care were/will be used in care redesign.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

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

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

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

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

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

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

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

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

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

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

Max word count: 500 NWT OHT membership was approached strategically to ensure partners offer complimentary services that support patients/clients, families and caregivers across the care continuum. The NWT OHT provide services that span across 12 of the 13

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

sectors identified in the OHT Guidance Document. All providers have existing relationships/partnerships in NWT that have demonstrated positive outcomes, and will leverage and expand these partnerships to deliver more integrated services to provide full and coordinate care for seamless transitions, improved health outcomes and patient experience. A unique advantage to this form of representation early on is the ability to engage patients and caregivers across the spectrum of services to ensure redesigned care models are co-designed. NWT does not foresee any changes in moving forward with respect to membership in Year 1.

The NWT OHT is well positioned to deliver care to our Year 1 population. Our OHT intends on partnering with additional primary care practitioners, and will continue to work within our community 'onboard' more providers that will further support patients across their care continuum. At maturity, the NWT OHT's focus is population health targeting upstream factors and determinants of health including environmental, social, economic, cultural, behavioural, as well as clinical. To improve health outcomes, our team will continue partnering with other sectors that are able to support patients including housing, education, etc. Membership will expand strategically to meet the needs of our community.

NWT OHT has a number of unique strategic advantages in relation to the health and healthcare needs of our Year 1 and maturity populations including:
• First Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO) OHT, redesigning integrated care through evidenced-based practice
• Strong digital infrastructure with existing solutions that can be scaled including the Humber River Hospital Command Centre, iPlan, Maple, and Ontario Telemedicine Network (OTN)
• All current partners are not-for-profit, aligned with health equity needs in our community
• All current partners have a strong clinical and fiscal track record
• All current partners have Patient & Family Advisory Councils (PFACs), and embrace patient centered care and co-design with well-established programs. This is being brought together to form a NWT OHT Patient Advisory Council, embedded in our Year 1 Governance Structure, Section 4.2
• Community engagement and reach, specifically Family Health Teams and Community Health Centres
• Previously established relationships resulting in increased trust across partners and the desire to formalize working relationships to deliver population health management, and a history of successful and emerging partnerships as identified in Section 2.4
• Services that span across the care continuum with representation from most health sectors

2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Form of affiliation** *Indicate whether the member is a signatory member of the other team(s) or another form of affiliation*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (e.g., member provides services in multiple regions)*
See supplementary Excel spreadsheet			

2.4. How have the members of your team worked together previously?

Please describe how the members of your team have previously worked **together** in a formal capacity to advance integrated care, shared accountability, value-based health care, or population health (e.g., development of shared clinical pathways or shared patient care, participation in Health Links, Bundled Care, Rural Health Hubs; shared back office, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities).

As part of your response, identify specific initiatives or projects that illustrate the **success** of your teamwork. Include detail about project scale and scope (e.g., patient reach), intended outcomes and results achieved (including metrics), **which** team members were involved, and length of partnership. Note: information provided should be verifiable through documentation by request.

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the team who have ***never*** previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

Max word count: 2000

NWT OHT partners have all worked together previously in a formal capacity to advance integrated care with shared accountability, value-based health care, and population health. Below are some examples of specific formal partnerships, verifiable through documentation upon request. There are additional formal partnerships between partners and other providers not listed, and a number of informal partnerships that exist as well.

NWT OHT partner acronyms:
• Black Creek Community Health Centre (BCCHC)

• Humber River Family Health Team (HRFHT)
• Unison Health and Community Services (Unison)
• Humber River Hospital (HRH)
• Runnymede Healthcare Centre (Runnymede)
• West Park Healthcare Centre (West Park)
• Lumacare
• SE Health
• Addiction Services for York Region (ASYR)
• COTA Health (Cota)
• LOFT Community Services (LOFT)
• The Canadian Mental Health Association Toronto Branch (CMHA Toronto)
• Villa Colombo Home for the Aged Inc. (VCT)

NWT RNAO BPSO OHT
Overview: NWT partners have committed to collectively provide care that is connected to patients in the local community working as one coordinated team. The BPSO OHT commits to the implementation of four RNAO BPGs.
Outcomes: RNAO BPGs that will be implemented: 1) Person and Family Centred Care, 2) Care Transitions, 3) Assessment and Management of Pressure Injuries for the Interprofessional Team, and 4) Preventing Falls and Reducing Injury from falls.
Partners: RNAO, ASYR, BCCHC, CMHA Toronto, Cota, HRFHT, HRH, Lumacare, Runnymede, SE Health, VCT, West Park
Length of Partnership: July 2019 to July 2023

Bundled Care, Hip & Knee
Overview: provide integrated care through partnership between hospital and community providers for seamless transitions with shared risk and gains, incenting collaboration with providers accountable for quality outcomes. The bundled care model at HRH was designed in collaboration with front-line staff, patients and providers, and hinges on early education and pre-hab delivered by the Regional Assessment Clinic (RAC) Advanced Practice Physiotherapists. Pre-op teaching patients are screened for post-acute service needs and a care plan is initiated in collaboration with the surgeon and orthopedic navigator. The orthopedic navigator thereafter, becomes the point of contact for transitions in care and continues to collaborate with inpatient and outpatient rehab providers to ensure each patient meets their target outcomes.
Outcomes: anticipated outcomes include patient centred care and reduced unwanted or unwarranted variation in the care pathway for: 1) streamlined patient experience, 2) improved clinical outcomes, 3) reduced utilization and per capita cost.
Partners: HRH, SE Health, Runnymede, West Park
Length of Partnership: April 2019 to present

Health Links
Overview: team of providers working together to provide coordinate care to patients with multiple complex conditions, often seniors, with patients at the centre.
Outcomes: 1) improve access to family care for seniors and patients with complex

conditions, 2) reduce avoidable emergency department visits, 3) reduce unnecessary re-admission to hospitals shortly after discharge, 4) reduce time for referral from primary care doctor to specialist appointment, and 5) improve the patient's experience during their journey through the health care system.
Partners: BCCHC, LOFT, Cota, CMHA Toronto, Lumacare, HRFHT, HRH, and other non-OHT partners
Length of Partnership: 2012 to present

Runnymede & HRH Partnership, shared rehabilitation, integrated EMR, shared IT
Overview: a new and ongoing partnership between Runnymede and HRH for shared rehabilitation, integrated EMR and shared IT resources across both sites. The scope of this partnership allows for continued to growth and integration.
Outcomes: shared resources for effective utilization to provide better care for patients.
Partners: Runnymede, HRH
Length of Partnership: July 2019 to present

West Park & HRH Partnership, ED Avoidance, Dialysis Education/Service Delivery, Diagnostics Imaging
Overview: completed an IDEAS project to reduce transfers from West Park to HRH, and improve communication between sites. HRH is also the ORN designated acute care partner for dialysis services at West Park, and manages West Park's onsite diagnostic imaging services.
Outcomes: 26% reduction inpatient transfers. Successful ongoing delivery of dialysis and diagnostic imaging services.
Partners: HRH, West Park
Length of Partnership: IDEAS Project: Oct 2018 to present, dialysis: 2 years, diagnostic imaging: 20+ years

BCCHC & HRH, System Navigation
Overview: identify patients in the ED without a general practitioner and refer to BCCHC. A BCCHC navigator is present at HRH 2-3 days/week.
Outcomes: 65 referrals sent to BCCHC in 6 months.
Partners: HRH, BCCHC
Length of Partnership: Apr 2019 to present

HRH & VCT, ED Aversion
Overview: implemented the tool PREVIEW-ED in LTC to decrease avoidable transfers from VCT to HRH ED.
Outcomes: 28.75% reduction in transfers to HRH ED since implementation.
Partners: HRH, VCT
Length of Partnership: Feb 2019 to present

Rapid Access Addiction Medicine (RAAM) Clinic
Overview: RAAM clinics are low-barrier with no appointment necessary, designed for individuals seeking pharmacotherapy and/or psychosocial services to individuals seeking information and/or support for substance use. Referrals primarily come from

HRH ED, however may come from other areas of the hospital.
Outcomes: approximately 40 new clients per quarter, with 90-170 RAAM clinic visits, resulting in an 85-95% reduction in unscheduled ED visits/admissions.
Partners: HRH, ASYR
Length of Partnership: March 2018 to present

Wellness Collaborative
Overview: leading the provincial opioid strategy within Central LHIN.
Outcomes: 30% increase in case management services, peer support, pharmacotherapy programs (RAAM clinics), and day programs for individuals affected by addictions.
Partners: ASYR, BCCHC, Across Boundaries, and other non-OHT partners
Length of Partnership: Fall 2017 to present

Access to Resources and Community Supports (ARCS) Program
Overview: intensive case management for patients with MH&A primarily discharged from the ED, promoting improved outcomes and connecting to longer-term resources in the community. The team consists of 2.5 mental health case managers, an addictions case manager, and a peer support worker.
Outcomes: approximately 150 referrals per quarter and with 66% patients not visiting the ED post management.
Partners: HRH, Cota, and a non-OHT partner
Length of Partnership: April 2015 to present

Child & Adolescent Transition Program
Overview: a collaborative program with the Toronto District School Board (TDSB) serving elementary and high school youths, improving health to allow them to maintain their academic standing when they are too ill to function at school. Staffing includes 2 TDSB teachers/teaching assistant, 1 HRH RN, and 1 HRH Child Youth Worker, with the capacity to manage 16 students at any given time.
Outcomes: 175-180 youths receive serviced annually.
Partners: HRH, TDSB
Length of Partnership: Sept 2006 to present

Behavioral Support Transition Resource (BSTR)
Overview: The Behaviour Support Transition Resource (BSTR) team from LOFT Community Service provides services to older adults designated ALC in hospital who are facing barriers to discharge due to responsive behaviours related to dementia, cognitive impairment, mental health and/or substance use.
Outcomes: 94 patients were supported through this service at HRH in 2017/18. 70 from HRH and 24 from the Finch Reactivation Care Centre.
Partners: LOFT, HRH
Length of Partnership: 2.5 years

Geriatric Mental Health Outreach Team (GMHOT)
Overview: assist long-term care homes in managing challenging behaviors and

mental health conditions. The team provides assessment, consultation, treatment and short-term follow-up to 16 LTC homes. The team consists of a psychogeriatrician and 3.5 RNs from HRH, and another psychogeriatrician from a neighbouring hospital.
Outcomes: 2,249 visits in FY18/19, with a 1.3% ED revisit rate.
Partners: HRH, VCT, 15 LTC homes, and a neighbouring hospital.
Length of Partnership: February 2010 to present

Psychogeriatric Outreach
Overview: West Park partnered to provide purchased services from the Seniors' Mental Health Service (SMHS) to support clients in supportive housing with Reconnect (formerly St. Clair West Services for Seniors) and VCT. SMHS provides recommendations and support to community-dwelling seniors experiencing mental health challenges, their caregivers and providers through comprehensive mental health assessments conducted in clients' homes.
Outcomes: on an annual basis, approximately 45 individuals, and 40 anonymous service recipients are seen; with a total of >610 encounters (face-to-face and non-face-to-face).
Partners: West Park, VCT, and another non-OHT partner
Length of Partnership: 2009 to present

Supportive Housing & Case Management, Housing First
Overview: a collaboration using an evidenced-based housing first model trialled and reported on by the Mental Health Commission of Canada to provide housing and flexible supports to homeless clients with mental health and substance use issues.
Outcomes: 94% clients remained in their units one year post service, with 3% repeat ED visits within 30 days for mental health issues, and 1% repeat ED visits for substance abuse. 98% of clients were connected to primary care within 6 months, and 92% rated care as good or excellent.
Partners: CMHA Toronto, ASYR, Across Boundaries, and other non-OHT partners.
Length of Partnership: December 2013 to present

Mental Health and Substance Use, Mental Health & Justice Housing
Overview: uses a housing first approach to provide housing and support services to people with mental health and justice issues who are involved in the justice system.
Outcomes: 550 clients were housed and only 12.8 discharged in the one year of study. Hospitalization rate was 9.4%.
Partners: CMHA Toronto, Cota, LOFT, Across Boundaries, and other non-OHT partners.
Length of Partnership: 2005 to present

Englemount-Lawrence Neighbourhood Care Team Pilot
Overview: working in partnership with patients whose complex health and social needs exceed the capacity of individual partners, with providers working differently to better respond to patients needs.
Outcomes: developed a common consent process, assessment process with shared results across organizations, and continue to work with new patients to further

develop cross-organizational processes and relationships for integrated seamless care and services.
Partners: SE Health, Unison, LOFT, Lumacare, and other non-OHT partners
Length of Partnership: November 2018 to present

Home at Last (HAL)
Overview: provides smooth transitions from hospital to home, and supports patients in remaining safe at home while coordinating community services, including direct service referrals for care coordination, crisis intervention, homemaking/personal care, meals on wheels, day programs, and transportation.
Outcomes: reduction in readmissions due to falls, medication compliance, failure to thrive, and ALC length of stay.
Partners: Lumacare, HRH, and other non-OHT partners
Length of Partnership: 2008 to present

Biomedical Engineering & Respiratory Therapy
Overview: West Park biomedical engineering technologists are responsible for the preventative maintenance of medical equipment, and order and maintain an accurate inventory of spare parts, along with coordinating external service provider support as required.
Outcomes: the biomed team works onsite at Runnymede 3 days/month and completes approximately 30 work orders/month, and approximately 200 devices undergo preventative maintenance each year. This work minimizes the impact of equipment related risk to patients and staff.
Partners: West Park, Runnymede
Length of Partnership: 2014 to present

ABIBS Behavioral Outreach
Overview: the ABIBS Community Outreach Program provides education, and help with managing, common behaviour difficulties that may occur following an Acquired Brain Injury (ABI). Behaviour therapists provide education, resources, and consultation. The Community Outreach Team emphasizes education in brain injury rehabilitation and various models of practice as a foundation to client-need driven interventions. Early intervention and long-term follow-up are recognized as key and the Community Outreach Team is equally inclusive of clients immediately post-acute and those who are longstanding survivors of Acquired Brain Injury.
Outcomes: the team of Behaviour Therapists supports approximately 80 new and unique clients each year and averages 1700 client encounters annually.
Partners: West Park, Cota, and another non-OHT partner
Length of Partnership: 2018 to present

Prenatal Collaborative
Overview: focuses on streamlining prenatal education across NWT with key stakeholders including Family Health Teams, Westend Midwifery, BCCHC and HRH. This collaborative was initiated with the intent of standardizing prenatal education content, screening for depression and anxiety in the prenatal phase and aligning the

right resources for patients and their families. HRH's perinatal adjustment program aims to target early intervention for prenatal and post-partum depression and anxiety.
Outcomes: standardized content across participating organizations, with a full series of prenatal classes accessibly to the community in the near future.
Partners: HRFHT, BCCHC, HRH, and Westend Midwifery
Length of Partnership: Sept 2018 to present

iPlan
Overview: innovative technology that automates standardized discharge-planning workflows between hospital and home and community care staff, and supports the LOFT BSTR team, implemented across 5 hospitals in CLHIN.
Outcomes: decrease in ALC days, rate and increase in acute inpatient capacity. HRH observed a 4,458 decrease in ALC days one year post-implementation, which has been sustained.
Partners: HRH, CLHIN Home & Community Care, and neighboring hospitals
Length of Partnership: Oct 2017 to present

2.5. How well does your team's membership align to patient/provider referral networks?

Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through this analysis, your team has been provided with information about which patient/provider referral networks the physician and hospital members of your team are part of.

How would you rate the degree of alignment between your current membership and the provider networks revealed through analysis of patient flow and care patterns (high, moderate, low)? Where alignment is moderate or low, please explain why your team membership may have differed. Given the provided data, have you updated your team membership since the Self-Assessment?

Max word count: 500
The NWT OHT attributed population is 419,255, with the majority of residents residing in Toronto (66%), Vaughan (11%), Brampton (7.2%) and Mississauga (3.5%). The attributed population and associated PEMs are situated near and primarily serviced by NWT OHT partners, resulting in a high degree of alignment between current membership and provider networks revealed through analysis of patient flow and care patterns.

Of the 21 PEMs identified in the attributed population dataset, the Humber River Family Health Organization (33 physicians) are members of the NWT OHT, and our OHT intends on collaborating with other PEMs revealed through the analysis. The

Jane and Finch Family Health Team and Finch Weston Health Centre Family Health Organization have expressed interest in partnering with the NWT OHT, which will be explored further in Year 1. Select solo practitioners have also expressed interest in being members, and more will also be engaged in Year 1 with membership anticipated to increase. A map of attributed PEMs, NWT OHT partners, and the North York West sub-region has been included in the supporting documents, figure 4.

2.6. Who else will you collaborate with?

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

2.6.1. Collaborating Physicians

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

2.6.2. Other Collaborating Organizations

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

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

Indicate what proportion of your Year 1 target population you expect to receive **integrated care (i.e., care that is fully and actively coordinated across the services**

that your team provides) from your team in Year 1. Please provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who require integrated care will receive it.

Max word count: 500

The Year 1 population will initially target the most complex patients that have Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and/or Mental Health and Addictions (MH&A) Schizophrenia and Psychotic Disorders (SP&D). Following the community health needs assessment in Year 1, targeted strategies will be developed that focus on patients who are well or have minor to moderate chronic conditions to support their management, health, and wellness, along with preventative strategies.

The total Year 1 population is 7,780 clients as described in Section 1.2, and the most complex patients are 1,919 (i.e. those with a hospital admission). As partnerships currently exist between the hospital and rehab/long-term care facilities, only Year 1 patients discharged home will receive integrated care as defined in Section 3. The specific proportion of Year 1 patients discharged home was 1,500 based on hospital FY18/19 coded data, DAD & OMHRS.

Current NWT OHT partners, along with LHIN home and community care resources, have the capacity to deliver integrated care to the identified patient population. Redesigned care will create a single standardized care pathway (i.e. care bundle) that spans the continuum of care, with partners adhering to the same protocols, guidelines, policies, outcome targets, etc. This will allow for the delivery of coordinated care with seamless transitions for improved patient experience and outcomes, and efficient utilization of healthcare resources.

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

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

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)

See supplementary Excel spreadsheet				
Interprofessional team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				
Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				
Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

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

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

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

Max word count: 500

NWT OHT will use the population health management approach and framework described in Sections 1.1 and 3.1 to deliver meaningful care with targeted strategies for population segments across the care continuum. Foundational elements of this approach include:

- Acute bundled care
- Chronic/community bundled care, with a focus on chronic disease management/prevention
- Care Management, for 24/7 care coordination
- Seamless system navigation and care transitions

NWT OHT partners will implement evidence-based care bundles for the Year 1 population, with the principles of high reliability, digitally enabled/automated and efficient, aligned with Quadruple Aim; to be scaled to Year 2 and maturity populations. Figure 5 in the supporting documents demonstrates this value-based care redesign model.

The Year 1 population for NWT is Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and/or Mental Health and Addictions (MH&A) Schizophrenia and Psychotic Disorders (SP&D). Partners are taking a phased approach in redesigning care: 1) discover/create, 2) validate/iterate, and 3) scale. Our team has completed the first phase for our Year 1 population. Following implementation, partners will validate and iterate as needed, then scale to Year 2 populations.

Year 2 priorities include:

- Frail Seniors, which represents a significant population in NWT
- Dementia, identified as the top ranked HPG by total cost
- Substance Use Disorders, second largest MH&A ED visits and repeat visits at HRH
- Anxiety Disorder, largest MH&A ED visits and repeat visits at HRH
- Stroke, significant number of inpatient admissions at HRH
- Pneumonia, significant number of inpatient admissions at HRH
- Hip and Knee, significant volumes at HRH
- Diabetes, sixth top ranked HPG by total cost

These priorities were identified using the attributed population dataset provided by the Ministry and HRH coded data, DAD, NACRS, and OMHRS FY18/19. Current signatory partners are well positioned to design/deliver care in Year 2. Our team will continuously engage and on-board interested providers and primary care physicians in Year 1, and will include additional partners as needed. For patients that do not fit within a specific care bundle, they will continue to receive care in an integrated manner due to formal partnerships with standardized practices across providers, and can benefit from care management in the community.

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

Max word count: 500

The Humber River Family Health Organization is a member of the NWT OHT as indicated in Table 2.1.1, along with physicians from Black Creek Community Health Centre and Unison Health and Community Services. Through the chief of family practice at Humber River Hospital, a primary care physician engagement session was held, along with a family physician survey circulated to those attributed to the NWT OHT. Primary care physicians were also included in all working groups, and a number have reached out expressing their interest joining as identified in table 2.6.1.

Primary care physicians are the first point of contact for many patients, and their engagement is essential. With the support and suggestions of select physicians in NWT, our OHT has embedded primary care physician representation within our governance structure as identified in Section 4.2 including a primary care physician lead for the OHT, a primary care executive committee, and a primary care physician advisory council.

This group of physicians will continue to be engaged in Year 1 to expand primary care partnerships, with our next session scheduled for December 7th, 2019 at the HRH Annual Clinical Day.

2.10. How did you develop your Full Application submission?

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

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership,

engagement, or consultation activities that took place and whether/how feedback was incorporated.

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

Max word count: 1000

Process to develop the Full Application submission

The NWT OHT partners, in collaboration with patients, families, caregivers and primary care, worked collaboratively across all levels of leadership to arrange a formalized structure to systematically complete the Full Application. This governance structure included:

• Board Chair Meeting, to engage the boards of all partners early in the process, with continued meetings on an ongoing basis.
• Steering Committee, which met weekly for 2 hours every Wednesday evening from 5:30pm to 7:30pm to ensure patient representatives and primary care physicians could attend. The steering committee received regularly updates from all committees/working groups mentioned below to ensure alignment across all teams.
• A Communications Committee, for patient, family, caregiver and community engagement.
• A Primary Care Physician Advisory Group
• A Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO) OHT working group, striving towards BPSO OHT designation.
• A Health Equity Team, to develop a health equity framework through patient, community and provider engagement.
• Clinical Working Groups, with representation from relevant providers, physicians (primary and specialists), patients and caregivers.
• Digital Health Working Group, with representation from all providers, patients and primary care.

This meeting structure was included in the supporting documents, figure 6. No third parties including consultants, writers, lawyers, etc. were engaged at any stage in the development or completion of the full application. This application and contents within were created exclusively by NWT OHT partners, in partnership with patients, families, caregivers, and primary care physicians, and with feedback from the community. Moreover, all partners provided unanimous consent to all contents developed, and collaboratively designed the NWT OHT Population Health Management approach, referencing leading practices from successful health systems nationally and internationally.

Patient, family, and caregiver engagement

Patient, family, caregiver and community representatives from partner organizations were invited to become members of the Steering Committee and all working groups. In total, 13 representatives were directly engaged in the design and planning of the full application.

There were numerous multifaceted approaches to patient, family, caregiver and community engagement to ensure meaningful participation and feedback, which was used in design and planning including:
• Anonymous and confidential surveys (500+ received, analyzed, and incorporated in care redesign and planning)
• 1:1 interviews with individual patients, families, and caregivers
• Focus group sessions with Patient and Family Advisory Committees (PFACs) and patients/clients from partner organizations, with leaders from partner organizations
• Discussions at President's Forums and Town Halls
• Senior Social Events, Neighbourhood Fairs, and Education Sessions
• An OHT booth at the HRH Annual Open House Sept 21, 2019, soliciting feedback from patients and families and the community

Primary care engagement

Primary care physicians were invited to participate in working group sessions and a total of six were directly engaged in the design and planning of the full application, alongside three specialists. A primary care physician meeting was held, and an OHT booth will be arranged at the annual clinic day hosted at HRH on December 7th, 2019, which was attended by approximately 150 family physicians in the previous year. A primary care physician survey was also sent with 40+ responses received and feedback incorporated in the full application submission.

Community engagement

Community engagement was established as a key priority. NWT OHT partners reached out to the community to inform the development of the full application through confidential surveys, which were disseminated widely, as well as population-

focused focus groups, and other events. NWT OHT partners leveraged relationships with community partners and worked with community based organizations and associations to engage with their patients/clients and members to provide their feedback and insight.

A total of three focus groups were conducted and we received over 500+ survey responses. All the feedback was aggregated and themed as outlined below:
• Biggest challenges when trying to access healthcare: Wait times, difficulty accessing specialists, not sure what programs were available, difficulty obtaining an appointment from family doctor, and inability to take time off work.
• How healthcare workers can help patients: Flexible appointment times/extended hours, communication on agencies the patient can visit in their neighborhood for support, 24/7 access to care coordination, access to their healthcare information online, and information regarding OHTs online
• How to improve the patient experience: Shorten wait times, provide online appointment scheduling, improved system navigation, supporting patients in partnering on care goals, and improve customer service

Engagement with Francophone and Indigenous populations was also considered a priority. NWT OHT facilitated engagement with these stakeholders through ongoing relationships with Entite 4, our local French Language Planning Entity, Anishnawbe Health Team, and the Friendship Centre.

Senior leaders and representatives of NWT OHT member organizations connected with community members at a total of 28 events, which included neighborhood fairs, community meetings, education sessions and focus groups.

Feedback from the community through surveys, focus groups and events was instrumental in the review of the current NWT healthcare system and provided valuable insight into opportunities for improvement. That insight was used to inform the development of this application, and will be used going forward to inform the redesign of healthcare programs and services for the NWT OHT. The team is also committed to ongoing meaningful engagement with patients, families, caregivers, community partners, staff, physicians and volunteers, and the broader community as we continue to plan and implement strategies to improve patient care and realize the Quadruple Aim.

Community support

NWT OHT partners reached out to local municipalities, government officials, community partners, and other organizations that are affiliated with/support partners, and received support for the NWT OHT full application submission. A total of 12 letters of support were received and included in the support documents.

3. How will you transform care?

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

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

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

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

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

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

Max word count: 1000

The NWT OHT aims to deliver a comprehensive population health management approach for our attributed population. Key priorities in care transformation include:

• Quadruple Aim with specific health system integration measures identified below
• Shifting from an illness-based model to a wellness paradigm (i.e. health promotion and prevention)
• Care Bundles; evidenced-based pathways in acute and community settings for high reliability in integrated care delivery, with seamless transitions across the continuum of care
• Addressing health equity and employing social prescribing for improved system navigation, via the care manager as described in Sections 3.2 and 3.3
• A digitally enabled OHT, leveraging innovative technologies including the Command Centre and other solutions for enhanced home monitoring, predictive modelling and virtual care

NWT OHT partners are cognisant of current priorities in Ontario including improving healthcare and ending hallway medicine. Hallway medicine is the result of increased acute care utilization, hospital admissions, and challenges transitioning patients designated Alternate Level of Care (ALC) to their most appropriate care setting. The root causes are situated in the community and determinants of health; improving wellness, integrated care, and access will better improve the health of the population.

The NWT OHT identified five measures as the most important performance improvement opportunities in Year 1, aligned with community needs, healthcare utilization, and Ministry direction:

Quadruple Aim
Better Patient and Caregiver Experience
1. Timely access to primary care
Better Patient and Population Health Outcomes
2. 7-day physician follow-up post discharge
3. Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs)
Better Value and Efficiency
4. 30-day inpatient readmission rate
5. Avoidable emergency department visits
Better Provider Experience
• A measure(s) for provider experience will be identified in Year 1

Baseline performance data for the NWT OHT Year 1 target population was included below:

1. Timely access to primary care - baseline data: 48.7% (note: specific data was not available for the Year 1 population, data from the attributed population dataset was used - Q4, FY17/18.

2. 7-day physician follow-up post discharge: 50.2% (note: specific data not available for Year 1 population, data from attributed population dataset was used - Q4, FY17/18).

3. PREMs & PROMs: Not applicable as they are currently under development by the Ministry

4. 30-day inpatient readmissions rate
• Congestive Heart Failure (CHF): 9.4% (Data Source: HRH DAD, FY18/19)
• Chronic Obstructive Pulmonary Disease (COPD): 13.5% (Data Source: HRH DAD, FY18/19)
• Mental Health and Addictions (MH&A) Schizophrenia & Psychotic Disorder (SP&D): 12.2% (Data Source: HRH OMHRS, FY18/19)

5. Potential avoidable emergency department visits
• Congestive Heart Failure (CHF): 15% Visits (Data Source: HRH NACRS, FY18/19, CTAS 3,4,5 - not admitted, discharged home)
• Chronic Obstructive Pulmonary Disease (COPD): 44% Visits (Data Source: HRH NACRS, FY18/19, CTAS 3,4,5 - not admitted, discharged home)
• Mental Health and Addictions (MH&A) Schizophrenia & Psychotic Disorder (SP&D): 12% Visits (Data Source: HRH NACRS, FY18/19, CTAS 3,4,5 - not admitted, discharged home)

Provider Experience measure(s) were not available and will be developed in Year 1.

NWT OHT partners have appropriate assets and partners to achieve improved health outcomes in Year 1, with extensive expertise and knowledge in CHF, COPD and MH&A SP&D. Formalized partnerships will allow for one cohesive approach to deliver comprehensive integrated care across the care continuum, with a foundation to expand the model to Year 2 and Maturity populations. Evidenced-based pathways that span the spectrum of services will improve health outcomes. In parallel, targeted strategies for health promotion and prevention will improve upstream factors to enhance and support wellness and health behaviors.

As mentioned in Section 1.1, a comprehensive environmental scan and community health needs assessment will be performed in Year 1, and performance improvement opportunities will be re-evaluated to ensure continued alignment with community health needs assessment and Ministry direction.

3.2. How do you plan to redesign care and change practice?

Members of an Ontario Health Team are expected to **actively work <u>together</u>** to improve care for their patients. Please describe how you will work together to redesign care and change current practices in your first 12 months of operations to address the performance improvement opportunities you identified in section 3.1.

In your response, please consider what specific outcomes you're aiming to achieve, as measured by one or more of the indicators listed above (or others, as relevant), and what targets, if any, you have set from baseline.

Note that detailed commentary on how you propose to provide care coordination and system navigation services, virtual care, and patient self-management are requested in subsequent sections.

Max word count: 2000

NWT OHT partners performed a comprehensive environmental scan to identify health systems that have successfully implemented population health management including and not limited to: Kaiser Permanente (USA), Geisinger Health System (USA), Ascension Health (USA), Mayo Clinic (USA), Gesundes Kinzigtal (Germany), Counties Manukau (New Zealand), Jonkoping County Council (Sweden), Clalit (Israel), etc. Through this review, our OHT identified key success factors associated with each system, including population segmentation and risk stratification, as the foundation to develop our NWT OHT population health management approach.

NWT OHT key population segments by risk status:

Complex. A small group of patients with the greatest care needs. This group is approximately 10% of the population and has multiple complex illnesses, often including psychosocial concerns or barriers. Care models of this population require intensive, proactive care management. The goal for this group is to provide integrated care and lowest-cost care management services to achieve better health outcomes while preventing high-cost emergency or unnecessary acute care services.

Rising Risk. The next tier is approximately 25% of the population chronic conditions and multiple risk factors that, if left unmanaged, would result in them transitioning to the highly complex group. This cohort of patient's benefits from structured care management programs that include managing medical, social, and community needs. It is essential to ensure this group receives appropriate chronic disease management as well as preventative services.

Well (Low Risk). This is the largest tier of patients that are generally stable or healthy. These patients may have minor conditions that can be easily managed. The goal of the care model for this group is to keep them healthy and engaged in the health care system.

The Geisinger Health System resonated with NWT partners, specifically their innovative approach using care bundles across both acute and community settings specific to population segments, along with health navigation/care coordination services referred to as ProvenCare® Acute, ProvenCare® Chronic, and ProvenHealth Navigator® respectively. This model was redesigned to respond to the needs of the NWT attributed population, and aligned with the OHT Guidance Document. Figure 7 in the supporting documents demonstrates the NWT population health management

model, which includes care coordination (24/7), system navigation, seamless care transitions, virtual care, patient self-management, health literacy, and digital access to health information. Summarized below are the specific care approaches by patient risk status:

Complex, receiving concentrated care
• All of the strategies below, plus…
• Care Manager/Coordination (24/7 Access)
• Predictive Analytics + Home Monitoring
• Care Team Performance Management Meetings
• Patient Education; Tertiary Prevention

Chronic - Rising Risk, receiving chronic disease care
• All of the strategies below, plus…
• System Navigation
• Seamless Care Transitions
• Patient Identification & Risk Stratification
• Self-Management & Education; Secondary Prevention

Well, receiving advanced primary/community care
• Patient Education & Activation; Wellness & Primary Prevention
• Patient Identification & Risk Stratification
• Patient Access to Health Information
• Virtual Care

The NWT OHTs approach to redesigned care includes:
1) Segment the attributed population by risk status
2) Identify prevalent conditions
3) Identify opportunities for care bundles for specific conditions, specific to each population segment, including both acute and community bundles,
4) Bundle development, creating a standardized evidenced-based care pathway across the continuum of care and spectrum of services, involving all partners that provide services to patients
5) Operationalize bundles using the Collaborative Care Model to deliver integrated and coordinated care. The Collaborative Care Model was based on the Edward Wagner model for Chronic Disease Management, adopted to include MH&A, a key priority for NWT

This approach was illustrated in figures 5, 7, 8 and 9 in the supporting documents.

Key benefits to creating standardized evidenced-based pathways across the care continuum using this method include:
• A structured approach to providing quality care across all relevant health sectors
• Coordinated and organized care that aligns with population health management and reduces costs, by reducing unwanted variations in clinical and health outcomes
• The ability to provide care to different population segments, and move towards

upstream factors including health behaviors and social determinants of health, and apply standardized practices in the community to address root causes and promote wellness and prevention
• A well-defined patient population that would receive care with measureable outcomes
• Increased adherence to evidenced-based practices by providers and care plans by patients and/or caregivers
• Shared priorities and outcomes across sectors

Key components of the Collaborative Care Model were included in the supporting documents, figure 8. Collaborative Care interventions include:
• A stepped care model with treatment intensity depending on measurement
• Focus on education support and monitoring of treatment response
• Specific management strategies coordinated through the Care Manager including integrated care plans and systematic case reviews using OTN, virtual care and face-to-face
• Shared responsibility for outcomes
• Active strategies to change culture of care from single provider to collaborative care
• Patient is an active member of the care team (self-management and goal oriented)
• Active supports for primary care to manage patient care as part of the team

NWT Year 1 Population: CHF, COPD, and MH&A SP&D

Current state & opportunity

CHF, COPD and MH&A SP&D service provisions and transitions in care are currently fragmented, with independent providers delivering care with different standards, practices, policies and systems. As a result, inconsistent messaging and education is provided to patients, families and caregivers. Providers currently have different priorities and outcome targets, each aligned to different aspects of the patients journey, which contributes to disparate care delivery, unless partnerships are established.

The redesign of the care model to more integrated collaborative care will enhance coordination of service delivery, ensure seamless transitions and provide continuous connection between patients and caregivers to their Care Team, spanning the patient's journey. Through this approach, patients and caregivers will now benefit from the Care Manager who will be their partner post discharge, to support their recovery and strengthen patient self-management and health literacy, during this vulnerable period. The Collaborative Care Model is evidence-based and has demonstrated effective outcomes.

Redesigned model of care (i.e. Care Bundles via the Collaborative Care Model)

Care redesign in Year 1 will initially start with the most complex patients that were not managing well in the community resulting in a hospital admission. During Year 1,

NWT OHT partners will also work to better understand upstream factors contributing to health utilization or hospital admission, and expand models to focus on patients who are healthy or with low to moderate chronic conditions, to improve wellness and prevention through this standardized approach.

CHF & COPD Care Bundle

Patients with CHF and COPD who are not managing well in the community are admitted to hospital. These patients will be identified during their hospital admission (i.e. confirmed diagnosis of CHF or COPD), and will be assessed initially by a Care Manager. The patient will be assessed by the rest of the Care Team, who will follow them from hospital to community. Details regarding the role of the Care Manager and Care Team have been provided in Section 3.3.1 of this submission.

The Care Team will work with the patient and caregiver(s) to identify shared goals, and develop a care plan in partnership with all involved in the patients care; designed using evidenced-based practices. The Care Team will educate the patient as a part of their care plan, ensure 7-day follow-up with primary care occurs, and continually reassess the patients care needs for positive outcomes. Referrals to appropriate providers will be facilitated by the Care Manager to ensure patients are linked to appropriate services as needed.

This combination of patient education and personalized system navigation ensures patients have a partner in their care, to better prepare them and their caregiver(s) to manage their condition, as well as work towards addressing upstream factors including health equity and social determinants of health. Family and caregiver education will be standardized and made available to better empower them to support their loved one through their recovery and for ongoing management.

This care pathway is time-limited and will be in place for 60-90 days, with a warm handoff to the patient's primary care provider. If a patient is not connected to primary care, the Care Manager will work to connect them. NWT OHT partners identified that solo practitioners may not have adequate supports to care for their patients, and are exploring opportunities to leverage a combined approach utilizing the Humber River Hospital Command Centre and Seamless Care Optimizing the Patient Experience (SCOPE), which includes virtual offerings to integrate and strengthen primary care services in NWT.

After hours and weekend on call will be a key component of this model. The after-hours and weekend on call will be one central number where patients, families and caregiver(s) can access support, and connect to services or service delivery as required. The Humber River FHO Telephone Health Advice Service (THAS) will be leveraged, and additional opportunities including the 24/7 Command Centre will be explored to expand offerings.

MH&A SP&D Care Bundle

Patients with MH&A SP&D that are not managing well in the community may visit the emergency department or are admitted to hospital. These patients will be identified during their hospital visit or admission, and will be assessed by hospital staff or a Care Manager respectively. The patient will be referred to a Care Team who will follow them from hospital to community. Details regarding the role of the Care Manager and Care Team have been provided in Section 3.3.1 of this submission.

The Care Team will work with the patient and caregiver(s) to identify shared goals, and develop a care plan in partnership with all involved in the patients care; designed using evidenced-based practices. The Care Team will educate the patient as a part of their care plan, and continually reassess the patients care needs for positive outcomes, including medication adherence, reviews, and arranging appropriate services. If appropriate, the Care Team will refer patients to longer-term open-ended stepped-care or step-down support service, with warm hand-offs. Services currently offered by MH&A providers include Cota (ARCS), CMHA Toronto (stepped-care), LOFT (transitional care), etc. demonstrating capacity, and redesigned for a coordinated approach aligned with this bundled model. The combination of stepped care and step-down support services will allow for the right intensity of services to be provided to the patient based on their care needs. For patients with comorbid medical conditions, community care plans (CCPs) will be developed with systematic case reviews across providers to ensure coordinated care.

This approach ensures patients have a partner in their care to better prepare them and their caregiver(s) to manage their condition, 24/7 access for support, as well as work towards addressing upstream factors including health equity and social determinants of health. Family and caregiver education will be standardized and made available to better empower them to support their loved one through their recovery and for ongoing management.

This NWT OHT model will ensure Year 1 patients and caregivers are well supported following their acute episode to improved health management and outcomes, aligned with priorities identified in Section 3.1. An illustration of current and future care delivery was included in the supporting documents, figure 9.

Following the community health needs assessment, information will be available to enable care the development of community care bundles to promote improved screening, proactive management, promote wellness and prevention; and in turn, reduce healthcare utilization and cost, aligned with Quadruple Aim.

This approach will leverage and is aligned to NWT BSPO OHT, and Best Practice Guidelines that will be implemented:
1. Person and Family Centred Care
2. Care Transitions
3. Preventing Falls and Reducing Injury from Falls

4. Assessment and Management of Pressure Injuries for the Interprofessional Team

This BPSO designation will support integrated care delivery through shared practices, guidelines, policies and pathways for a single coordinated approach to patient care, and has been outlined further in Section 6.1 of this submission.

Command Centre Generation 3 requirements will begin in Year 1, with opportunities for improved communication across providers, virtual care, home monitoring, and ensuring patients care plans and key activities occur consistently and according to standardized care pathways. This infrastructure can also support patient tracking and reporting on a real-time basis, and allow for advanced and predictive analytics.

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

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

3.3.1. How do you propose to coordinate care?

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

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

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

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

Max word count: 1000

A key finding in the First Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine highlighted the need for more effective coordination at both the system level and at the point-of-care, and how the current design of the health care system does not always work efficiently.

Although NWT OHT partners have extensive experience in providing coordinated care, partners have typically delivered these services in solos. Most providers have care coordinators, system navigators, case managers, and/or care managers that have typically operated independently. The NWT OHT model allows partners to leverage these existing resources, and deliver services in a coordinated and cohesive manner, through a standardized care pathway with shared measures/outcomes to allow for a seamless journey for the patient. As mentioned in Section 3.2, the Care Manager and Care Team will provide a single point of contact for Year 1 patients, and partner with them on their care using a standardized care bundle. As described, this role initially targets complex patients, and will be scaled in the future to target patients who are chronic or well, with community care bundles and approaches for health promotion and prevention.

The Care Manager will deliver care coordination to ensure accessible, safe, appropriate and effective care. Key functions for this role include:

- Carry a case load
- Professional affiliation depending on function (i.e. RN, NP, RRT, etc.)
- Structured and predictable liaising and engaging with patient and/or caregiver, primary care, and specialty care, and the interprofessional team
- Perform systematic case reviews to support care coordination, and arrange interprofessional team meetings
- Develop, reinforce, and monitor care plans (treat to target, measurement-based care)
- Connect patients to community resources
- Ensure teaching of self-management and medication adherence

CHF & COPD Care Manager

Patients with CHF or COPD will be connected to a Care Manager and a Care Team following discharge from acute care for the identified Year 1 population. The Care Team in partnership with the patient and/or caregiver(s) will develop a plan of care

and connect the patient to the appropriate services to address social determinants of health. The Care Team will have a shared responsibility for outcomes. The Care Manager and Care Team will follow the patient throughout their journey connecting with them more intensively during the initial period post discharge, and again as needed. The primary care provider remains responsible for the patient, with the Care Team actively supporting the primary care provider.

Specific activities for the Care Manager include leading the development of a care plan in partnership with the patient, family and/or caregiver, engaging Care Team members, coordinating systematic case reviews, delivering care, connecting the patient to services, and ensuring self-management education is delivered and sustained.

The Care Team will implement collaborative care interventions using a stepped care model of varying treatment intensity based on the patients care needs. The care intervention is time limited to an average of 60-90 days post discharge. The patient will continue to be monitored via primary care and access the care manager via a single point of access 24/7.

MH&A Care Manager

Year 1 MH&A patients will follow a similar model to CHF and COPD patients with select differences. For MH&A SP&D, patients will be connected to a Care Manager and Care Team following an emergency department visit if eligible or when discharged from acute care. There will be two Care Teams available: 1) short-term intensive, and 2) long-term stepped with varying intensity, as described in Section 3.2. Patients will be linked to appropriate providers in the community to provide the right level of care, and similar activities to those mentioned previously will support patient recovery and self-management.

To effectively deliver care via the Care Manager in Year 1, the NWT OHT will leverage LHIN Care Coordination resources. NWT OHT partners will engage Central LHIN to empower existing home and community care coordinators to function as Care Managers to deliver this redesigned model of care and achieve desired outcomes.

The ideal state for the Care Manager and care bundle is a bundled funding approach, where a carve out is made available for this patient population to allow NWT OHT partners to deliver these services in an efficient manner. As mentioned in previous sections, NWT OHT aims to deliver a population health management approach leveraging care bundles in acute and community settings, with preventative/management bundles to promote wellness and reduce costly acute care utilization through better patient management in the community.

This model standardizes the organization of patient care activities and sharing of information among all involved in the patient care including patients, caregivers, and providers, to achieve better patient outcomes. As this model referenced the Geisinger

Health System, included below are anticipated outcomes and time to realize benefit as provided in the publication ProvenCare, How to Deliver Value-Based Healthcare the Gesinger Way (2018):

Year 1: Care Manager for Complex Patients with CHF or COPD
Anticipated outcome: reduced admissions and avoidable ED visits
Time to realize benefit: 3-6 months

Year 1: Care Manager for Complex Patients with MH&A SP&D
Anticipated outcome: reduced admissions and avoidable ED visits
Time to realize benefit: 6-24 months

Year 2: Interventions for low-risk chronic disease patient
Anticipated outcome: improved control, avoid complications
Time to realize benefit: 2-5 years

Year 2: Preventative care, screening, lifestyle changes, wellness
Anticipated outcome: earlier identification and treatment, decrease incidence of chronic diseases
Time to realize benefit: 2-5+ years

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

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

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

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

Max word count: 1000

The First Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine highlighted patients and families are having difficulty navigating the health care system and are waiting too long for care, which was also reflected in our NWT community survey.

There are numerous services available in the community, and patients and providers are typically not aware of the resources available to them, many of which are funded

by the Ministry. Moreover, when services in the community are arranged, they are often delivered through multiple service providers, each with different accountabilities and priorities. This process results in gaps in services provided, poor navigation, and can result in patients feeling lost in the system.

The NWT Year 1 population will have personalized system navigation via the Care Manager to ensure patients are well-educated and supported in accessing health and social services. As mentioned previously, the most complex patients will be enrolled/registered with a care plan that spans the spectrum of services, and is available to the care team in real-time to allow for coordinated system navigation. This ensures all providers have access to the patients care plan and health information. Both providers and patients will follow this plan, and the Care Manager will access services as needed to provide stepped care with the appropriate treatment intensity. In Year 1, existing digital solutions will be leveraged to share this information across providers providing an immediate solution. This will be further automated as outline in the digital vision included in this submission.

To improve system navigation for all patients as the NWT OHT works towards maturity, a community health needs assessment with be conducted to further identify referral patterns and utilization of health care services. This will allow for the creation of proactive system navigation strategies promoting wellness and prevention. This approach will target upstream factors and determinants of health, strengthening access and health equity. Moreover, it is essential to leverage and empower primary care providers, as they are the first point of contact for patients. Broad system navigation services will focus on primary care, and NWT OHT partners will explore solutions such as the Command Centre and Seamless Care Optimizing the Patient Experience (SCOPE) to empower primary care providers, streamlining access to services and navigation for patients linked to providers. In Year 1, existing services will be leveraged including the Access Point for MH&A patients and Telephone Health Advice Service (THAS) offered by Humber River Family Health Organization.

3.3.3. How will you improve care transitions?

Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population. Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

Describe how you will determine whether you have improved transitions of care.

Max word count: 1000

Transitions in care are vulnerable periods for patients, and effective communication including the accurate and timely exchange of information is essential to minimize any potential misunderstandings. NWT OHT patients will experience seamless transitions

while transitioning from one care setting to another, as they will be consistently connected to a NWT OHT provider/member. The NWT OHT will have shared standards, practices and protocols to ensure patients receive consistent messaging and experience evidenced-based care.

Care transitions will be standardized across all providers leveraging evidence-based practices. One of the Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines (BPGs) for our OHT is care transition, and evidence from the Health Quality Ontario (HQO) Transitions of Care document was/will also be referenced in developing shared standards.

Year 1 patients will be connected to a Care Manager prior to discharge from hospital allowing for a warm handoff, and the Care Manager will remain with them throughout their recovery in the community, with a second warm handoff to their primary care provider following services. If the patient does not have a primary care provider, the Care Manager will work to connect them. Furthermore, patients will have 24/7 access to care management. In Year 1 and beyond, solutions including the Command Centre and Seamless Care Optimizing the Patient Experience (SCOPE) will be explored to empower solo practitioners to transition patients to NWT providers in a seamless manner as required, which will ensure patients are consistently receiving the right level of care in a timely manner on a continued basis.

The NWT OHT will also leverage SMART (Signs, Medications, Appointments, Results, Talk) Discharge Protocol, which was implemented at Humber River Hospital in 2018; and is based on evidenced-based practices from the Institute for Health Improvement (IHI), and aligned with Patient Oriented Discharge Summary (PODS). A key component of SMART Discharge at Humber is an admission package with a SMART Discharge Summary. This summary will include standardized information from relevant OHT partners to support care transitions. Furthermore, patient will have access to their health information as identified in Appendix B.

As this model referenced the Geisinger Health System, included below is the anticipated outcome for care transitions and time to realize benefit as provided in the publication ProvenCare, How to Deliver Value-Based Healthcare the Gesinger Way (2018):

Year 1: Transition of Care Management
Anticipated outcome: reduced readmissions
Time to realize benefit: 3 months

3.4. How will your team provide virtual care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their

healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

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

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

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

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

Max word count: 500

Patient, family and caregiver education, health literacy and self-management are essential for the NWT population due to equity concerns and the highly diverse community, in order to improve health behaviors and support chronic disease management in the community. The NWT OHT seeks to empower patients and caregivers in a manner that is aligned with the Patient Declaration of Values for Ontario.

Year 1 patients will have a Care Manager that will leverage standardized educational materials to teach patients and caregivers, and support them in managing their health. There are a number of offerings including face-to-face education, virtual, print, educational videos and links to educational materials. NWT OHT will leverage existing materials from partners, and will continue to build on this foundation to standardize education across providers.

Self-management and health literacy offerings for Year 1 patients
• Face to face education to patients and caregivers, provided by the patients care manager
• Education provided upon discharge, via SMART Discharge Protocol
• NWT OHT evidence-based and standardized discharge and self-management

education
• Virtual care, leveraging OTN, TIP, PCVC, and tele-home care and home monitoring
• Educational Videos for COPD: 1) Anxiety and Depression, 2) Exercise and Lung Impairment, 3) Nutrition, 4) Body Mechanics, 5) Energy Conversation, 6) Healthy and Impaired Lungs, 7) Pills and Puffers, 8) Breathing Tests, and 9) Travelling with Oxygen
• Wellness Recovery Action Plan (WRAP) workshops for mental health and addiction patients, an evidenced-based intervention that supports individuals to identify and develop personalized wellness and recovery plans, and promotes a strength-based approach to self-management

The NWT OHT will continue to engage patients and caregivers to discuss and review service design, continue our iterative co-design process, and measure patient experience and outcomes, ideally using the Ministry defined Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs).

3.5.2. How will you support caregivers?

Describe whether your team plans to support caregivers and if so how. In your response, include any known information about caregiver distress within your community or attributed population, and describe how your plan would address this issue.

Max word count: 500
In 2012, statistics Canada reported that approximately 1 in 3 people aged 15 and over provide care to a family member or friend with a long-term health condition, disability, or problem associated with aging. Caregivers are a key resource in the patients care team that can be leveraged to promote better patient outcomes, continued management of chronic conditions, and/or wellness.

Section 1 highlighted unique equity considerations for NWT including a high prevalence of chronic conditions, a rapidly aging population, and high number of immigrants and diversity. Many patients living with chronic conditions require education and training to better manage their condition, and often rely on caregivers to provide ongoing care to support management and wellness.

The NWT OHT seeks to empower caregivers to promote better patient management in the community. NWT OHT partners will actively engage and involve caregivers as contributors to the Care Team, and will seek to support them through meaningful approaches including and not limited to:
• Education, in-person or online via the Care Manager or digital solutions respectively
• Interactive experiential learning
• Building capacity including knowledge, skills, behaviors and linking to available physical assets in the community

Standardized education will be developed for Year 1 patients, and educational materials will be co-designed with patients and caregivers through an iterative

approach. Existing solutions for Mental Health and Addictions including the National Alliance on Mental Illness (NAMI) Family to Family Education Program, the Canadian Mental Health Associations Family Outreach and Response Program, along with other programs will be leveraged to provide this service.

Caregiver assessment measures will also be explored including the Caregiver Distress Scale (CDS) currently utilized by home and community care, to measure caregiver burnout.

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

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

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

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

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

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

Max word count: 500
The NWT OHT will focus on complex patients for the Year 1 population whose journey begins in hospital. Humber River Hospital and select NWT OHT partners are well versed in tracking patients throughout their care continuum, with experience in bundled care for hips and knees. Existing solutions used to track bundled patients will be expanded to the Year 1 patient population.

The patients Care Manager will maintain regular contact with the patient by virtual means and in-person visits. Digital solutions including the Command Centre, iPlan, RM&R and Novari will be explored further to provide real-time situational awareness on patient progress, along with shared patient information, automated patient tracking and reporting, and the potential for advanced and predictive analytics to better support providers in delivering care via evidenced-based care plans. Providers will also use existing solutions including One Mail to connect patients, and will explore digital solutions to improve communications across the care team as described in the digital health sections of this submission.

3.7. How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

Considering your response to question 1.3 and according to the health and health care needs of your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

3.7.1. How will you work with Indigenous populations?

Describe whether the members of your team **currently** engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term.

How will members of your team provide culturally safe care? Does your team include Indigenous-led organizations as members or collaborators? Why or why not?

Max word count: 500

Members of the NWT OHT are currently engaging with Indigenous peoples and have programs and resources in place to ensure equitable and inclusive healthcare delivery. SE Health offers an accredited First Nations, Inuit and Métis (FNIM) program that provides virtual, in person, and vocational training and education to healthcare providers working in First Nation communities. The program has been offered nationally since 2011 and now reaches 70% of First Nation, Inuit and Métis communities across Canada. The FNIM program is focused on creating and maintaining meaningful community partnerships, which requires a high level of mutual trust, respect and collaboration. All program content is developed in full partnership with First Nation communities to ensure it is relevant and culturally rich. An Elder Network provides insight and advice to the program team as appropriate, as well as guidance in the areas of tradition and culture. Also, vocational training is developed with and for community-based healthcare workers and delivered by Indigenous Registered Nurses in partnership with SE Health's Career Colleges.

Black Creek Community Health Centre employed an Indigenous System Navigator to provide support and advocacy for the First Nation, Inuit & Metis (FNIM) and Non-Status populations in the Black Creek community. The navigator facilitated access to programs and services for this population and focused on the development of patient-

centered case management pathways that were culturally and spiritually relevant for this population. The goal was to assist Indigenous clients to navigate the healthcare system in a culturally safe and relevant manner and the navigator was also responsible for networking with Aboriginal and non-Aboriginal partners to advocate for their clients.

Villa Colombo Toronto, a designated ethno-specific long-term care (LTC) home is currently working with Anishnawbe Health Toronto, to help them in the design and delivery of their new culturally sensitive LTC programs and services that will address the needs of the Aboriginal community.

The NWT OHT does not currently include Indigenous-led organizations as members or collaborators as a small proportion of the population self-identified as Indigenous (0.6%) and no First Nation communities are within the NWT region. Partners recognize that Indigenous peoples may not self-identify and we are committed to meaningful engagement with all members of our diverse and vulnerable population. As part of this commitment the NWT OHT partners will work together to continue the development of a Health Equity Framework in Year 1 through meaningful collaboration and engagement with community partners and all stakeholder groups to ensure the design and delivery of equitable, inclusive and culturally safe care. This will expand upon the current engagement activities that are currently in place and enable our team to address the healthcare needs of Indigenous populations.

3.7.2. How will you work with Francophone populations?

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

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

Max word count: 500

As indicated in Section 1.3, currently 1.4% of the population served by NWT OHT identifies as Francophone. This population is engaged directly through Black Creek Community Health Centre (BCCHC) which provides access to a bilingual community health worker, navigator, nurse, and receptionist to ensure equitable and inclusive healthcare delivery. BCCHC has the French Language Health Service Provider designation under the French Language Services Act and collaborates with Entité 4, our local French Language Planning Entity to identify and address the needs of the broader Francophone population.

The NWT OHT is committed to ongoing engagement with the Francophone population to identify and address issues specific to their needs through community consultations, partnership with Entité 4 and participation in the North York FLS Committee. The first step is to communicate clearly and broadly about the availability of French Language Services (FLS). It is also important to ensure that services are always available, easily and readily accessible, and are equivalent to the quality of services offered in English. To support this goal, the team will enhance communication efforts by focusing on signage, notices, social media, and engagement during initial contact with Francophone patients/clients.

To enhance FLS capacity, it is important that the full scope of healthcare services is available in French. Our team will aim to work together to offer navigation and care-coordination services in French and increase integrated access to services for this population. We will also leverage existing relationships with home and community care to utilize bilingual care coordinators so that we can work together to provide equitable and inclusive healthcare.

The FLS-designation criteria and our relationship with Entité 4 can also be leveraged to support the design and implementation of equitable policies and procedures such as an OHT FLS capacity recruitment strategy, an FLS policy, and appropriate communication standards. As described in Section 1.1, a key Year 1 priority is data collection and analysis to provide a comprehensive and detailed understanding of our population needs and equity concerns. This will include the collection of our patient/client linguistic identities. The NWT OHT will also encourage staff and partners to complete the FLS Active Offer training to better serve Francophone clients, their caregivers and families.

The NWT OHT partners will work together to continue the development of a Health Equity Framework in Year 1 through meaningful collaboration and engagement with community partners and all stakeholder groups to ensure the design and delivery of equitable, inclusive and culturally safe care. This will determine the best way for us to expand upon the engagement activities that are currently in place and enable our team to continue to address the healthcare needs of our Francophone population.

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

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

Max word count: 500

Currently 17.1% of the population in NWT are aged 65 years and over, 16.2% of seniors aged 65 and over live in low-income households and 38.24% of seniors live

alone, which can lead to social isolation. As a direct result of this a number of the NWT OHT partners have senior friendly strategies in place and engage directly with seniors, families, and caregivers to understand and address their specific healthcare needs in various ways. This includes health promotion events, community engagement activities and events, specific socialization and day programs, community programs and services, strategic planning processes, Patient and Family Advisory Committees and Resident Councils. Some NWT OHT partners also have positions on seniors organizations committees and working groups to ensure they have a comprehensive understanding of seniors needs and concerns.

Lumacare one of our community-based partners engages directly with our LGBTQ population and has established partnerships with LGBTQ community leaders to understand and address their unique needs. They have leveraged this feedback and insight to create an inclusive environment that recognizes the diversity of healthcare needs and this is woven throughout every aspect of the organization from policies and procedures to program delivery and staff training.

NWT OHT partners engage with our low income and newcomer populations in a variety of ways. These include community-based programming with a focus on food security and poverty reduction, and developing partnerships with local farm and grassroots groups (i.e., Jane and Finch Action Against Poverty). Health promotion programs and services are offered in local neighborhoods and on weekends for increased accessibility and outreach workers support the most vulnerable members of this population. Newcomers are supported through community health workers who provide assistance in navigating health and community services and programming specifically tailored to their needs (e.g., English conversation circles).

Through ongoing community engagement, data collection and analysis NWT OHT will explore the areas in which to focus our efforts on expanding and/or modifying engagement activities in Year 1 based on the identified needs of our community, This could include increasing access to programs and services that have the longest wait list, increasing the number of long-term care beds to meet the growing demand, reducing wait times for programs and services and expanding assisted living services to keep seniors safe in their homes.

The NWT OHT is committed to meaningful engagement with all members of our diverse and vulnerable population. As part of this commitment, the NWT OHT members will work together to develop a Health Equity Framework in Year 1 through meaningful collaboration and engagement with community partners and all stakeholder groups to ensure the design and delivery of equitable, inclusive and culturally safe care. This will determine the best way for us to expand upon the current engagement activities that are currently in place and enable our team to continue to address the healthcare needs of our population.

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

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

Max word count: 1000

Patient, family, caregiver and community engagement is crucial to the success of the NWT OHT. At present, each organization has existing patient/client representative and community engagement models. This existing infrastructure will be redesigned from a systems lens to represent all services that support the entire care continuum.

The NWT population is very diverse and all partners have a demonstrated commitment to working towards health equity and inclusion. Our partners are committed to equitable and inclusive engagement with patients, families, caregivers and the communities we serve to gather meaningful feedback and encourage open dialogue. Their feedback is integrated into everything that we do, and ensures that the values and priorities of these important stakeholders have a strong voice in the development of mutually beneficial healthcare goals and services.

Patient, Family, and Caregiver Engagement, Consultation & Partnership

Patient and family centered care will be a core value of the NWT OHT culture that drives all that we do and helps patients meet their healthcare needs by taking control of their own health through a hands-on approach. We will continue to apply a systems lens to define a formal patient, family, and caregiver engagement strategy that oversees the integration and redesign across the full scope of services within our OHT and ensures a coordinated approach across all OHT partners. This will ensure that we continue to reflect patient, family, and caregiver values, needs, experiences and preferences to improve healthcare quality and patient experience.

A key priority is to ensure that feedback is incorporated at different points in the healthcare process, including and not limited to when:
- Patients are making their personal healthcare decisions
- Designing new programs and making improvements to existing services
- Developing policy, strategy and governance frameworks

To capture timely and longitudinal data on the care being provided, we will encourage a culture of patient, family, and caregiver engagement at the point of care with healthcare providers. From Year 1 to maturity, we will work to establish a centralized mechanism for informal feedback to be captured (e.g., online feedback forms for staff, generic email address or other digital capture points for comments).

When continuing to design new programs and improving existing services we will continue to use a co-design approach. This involves bringing patients, families,

caregivers, and healthcare professionals together to oversee the redesign efforts as partners. This process is iterative and often includes a series of engagements to ensure a comprehensive understanding of the subject matter and informed decision-making. Feedback is gathered and incorporated at each of the various stages of program development/improvement.

As noted in section 4.2, patient, caregiver, and family representation is embedded in the NWT OHT's formal governance framework. This will ensure that there is continued input from these stakeholders when important decisions are being made around policy and strategy.

In addition, the NWT OHT will continue to employ a variety of tools and activities to facilitate engagement and encourage community participation including:
• Establishing an integrated NWT OHT Patient & Family Advisory Council, as outlined in Section 4.2
• Ensuring consistent communication and engagement with existing PFACs across member organizations
• Distributing online, hardcopy and telephone surveys
• Facilitating community workshops and focus groups
• Holding town halls and open house events with in-person, virtual and telephone options
• Communicating through local media, social and digital media, and newsletters
• Including an engagement component in existing or planned provider events, as well as establishing a regular presence at relevant community events

How will we measure success?

An evaluation framework will be built into the patient engagement framework to evaluate success and will include satisfaction surveys, tracking and monitoring of participation, and regular solicitation of feedback on the quality of engagement as well as opportunities to improve. In addition, we will close the feedback loop with stakeholders by reporting the results of our engagement efforts and including our action plans to address the feedback received.

The key performance indicators identified by the NWT OHT will ultimately be the best measure that our engagement efforts are driving the desired outcomes, in particular Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs). Ensuring stakeholder input to – and/or co-design of – our integrated healthcare solutions will have an impact on:
• 30 day readmission rate
• Avoidable emergency department visits, for conditions best managed elsewhere
• PREMs & PROMs
• Timely access to primary care
• 7-day physician follow-up post discharge

Ontario Health Teams
Full Application Form

4. How will your team work together?

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

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

Max word count: 500

NWT OHT will develop a strategic plan and directions consistent with the vision and goals of the Ontario Health Team model in Year 1. A current state assessment of partner organizations mission, vision, values, and organizational goals was performed to identify common goals, values, and practices in the context of the OHT model, along with differences across providers. A Modified Grounded Theory approach was used to perform this analysis. Many common themes across providers were observed and categorized below using Quadruple Aim:

Quadruple Aim

Better Patient and Caregiver Experience
- Responding to the needs of the community
- Equity and inclusion
- Exceptional engagement and experience

Better Patient and Population Health Outcomes
- High quality care and improving patient outcomes

Better Value and Efficiency
- Accountability
- Strong fiscal management

Better Provider Experience
- Integration and partnerships
- Exceptional staff, physician, volunteer engagement and experience

This is aligned with the OHT model components, specifically patient care and experience, patient partnerships and community engagement, leadership, accountability and governance, performance measurement, quality improvement and continuous learning, and funding and incentive structure.

Differences were observed across providers, most notably in terms of the community

services. For instance, Villa Colombo Toronto Home for the Aged predominantly serves the Italian community, CMHA Toronto services are geared towards mental health and addictions populations, and Runnymede is focused on rehabilitation and care for medically complex patients. These differences were anticipated and was a key driver in forming partnerships to ensure all health sectors in the community were represented to provide services that span the continuum of care.

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

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

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

- ***How will your team be governed or make shared decisions?*** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?
- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.
- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***
- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?*** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

Max word count: 1500
The NWT OHT is committed to collaborative governance in order to deliver

coordinated services to our Year 1 population and achieve key performance measures and outcomes aligned with Quadruple Aim.

As the first step towards Governance, NWT OHT partners collaboratively developed Guiding Principles for the Year 1 governance structure:
• Change happens at the speed of trust
• Patient/client, family and caregiver focus: in development/redesign, and development of appropriate models/frameworks that are aligned with this principle to guide complex decisions (e.g. Health Equity is a NWT OHT priority, and NWT partners are creating a Health Equity Framework)
• Transparency
• Innovation
• Interconnectedness and a high degree of interdependence
• Collaborative governance and recognize power imbalances
• Shared measurement of performance to understand progress
• Information sharing
• The capacity for one strategic plan
• Mechanisms to ensure accountability and performance compliance
• Collectively implement/continue implementing bundled care
• Actively engage stakeholders
• Organizations will operate under existing agreements, along with the new OHT agreement provided by the Ministry
• Stewardship: recognizing the NWT OHT (i.e. partners) are overseeing public resources; ensure optimized value, efficiency and effectiveness in relation to utilization of resources and finances
• The ability to add others and/or work in alignment with important organizations that may not be able to integrate (such as local government)

The proposed NWT OHT Governance Structure was included in the supporting documents, figure 10.
Key features of this model include:
• NWT OHT Partner Organizations Board Chairs, quarterly meeting.
• A Senior Executive Committee (SEC) with representation from all signatory partners to provide approval to models of care designed by the Operations Committee and sub-committees/working groups.
• Inclusion of an Elected Patient Representative as a decision maker on SEC, who will chair a Patient & Family Advisory Council to represent the voice of Patients, Families and Caregivers in our community. The Patient & Family Advisory Council will have representatives specific to the Year 1 Target Population (with opportunity to expand to Year 2 and longer-term populations), and will have representation from different geographic areas to add diversity and address health equity and determinants of health.
• Inclusion of a Primary Care Physician Lead as a decision maker on SEC, who will chair a Primary Care Physician Advisory Council to represent the voice of Primary Care Physicians attributed to the NWT OHT, and may include non-physician members as well. This physician lead will also chair a Primary Care Physician

Executive Committee of four members plus the chair. The Primary Care Physician Executive Committee will meet monthly (more frequently at onset). The Primary Care Physician Lead will require a stipend and Executive Committee members a reimbursement model recognizing time contribution; the NWT OHT suggests that all approved OHTs and the Ministry(s) review as a standardized provincial model will be important to promote primary care physician engagement.
• Operations Committee with committees and/or working groups specific to target population and key areas including digital health. Current committees and working groups include: 1) Clinical, Digital Committee, RNAO BPSO OHT Team, Communications Committee and a Health Equity Committee. These groups will have appropriate representatives (e.g. clinical, business, digital, etc.) from relevant providers to implement, improve, and iterate the Year 1 care and digital redesign efforts. Patient and Primary Care Physician representation is essential and included in each working group to provide input and co-design. The proposed NWT OHT Operations Committee was included in the supporting documents, figure 11.
• Interested and relevant Future Partners will be engaged on an ongoing basis and on boarded in a meaningful manner, determined by valuable contribution the OHT Coordinated Services.
• Additional funding and/or potential carve out of LHIN Home & Community Care dollars can be utilized to support, increase capacity, and scale the Year 1 model for the target population and for bundled care.

This proposed governance structure will formalize working relationships among members and enable interconnectedness, with the ability to collaboratively design solutions including evidenced-based clinical care pathways, digital offerings, patient materials, etc. across the entire continuum of care, and will allow the implementation of the OHT model in a meaningful manner as legislative changes continually occur. This model will also position NWT OHT partners to receive additional funding and utilize dollars towards coordinated care delivery. Decision-making and approvals will be carried out by the SEC through consensus.

Performance Management and Conflict Resolution will mirror the current Multi-Sector Service Accountability Agreement (MSAA), specifically Article 7.0 Performance. NWT OHT partners are committed to information sharing and the development of shared digital solutions in Year 1. Form will follow function, and meaningful information will be identified and the development of digital solutions to enable seamless sharing of information.

This model will be reviewed periodically (i.e. semi-annually) in Year 1 to ensure value and alignment with signatory partners, Ministry, and achievement of Quadruple Aim. All NWT OHT partners are committed to continue working towards a more integrated model as we work towards maturity, aligned with OHT principles and Ministry direction.

4.3. How will you share patient information within your team?

At maturity, Ontario Health Team will have the ability to efficiently and effectively

communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team?

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

Max word count: 1500
At Maturity

Our digital strategy is to leverage existing assets as much as possible; only share information that is relevant in context; minimize ingestion of foreign information; empower care teams to share with only those that need to know; and leverage solutions such as the command centre to improve equitable access and patient outcomes.

Within the NWT OHT, patient health information is captured in many point-of-service systems. [Eventually] All of this information is uploaded to Provincial repositories. Little of this information is currently aggregated in the context of a care plan. None of this information is aggregated to allow patients simple access through a single interface.

We envision a medical grade social network where care team members including patients and caregivers can leverage an “app” to connect, collaborate, and aggregate health information in the context of a specific care plan or progression of care.

The foundation is the care plan. This will be captured digitally and shared with a care team. Team members can add relevant health information from existing sources through various means: push from point-of-service systems through interoperability interfaces, manually upload scanned content, add pictures and video from smart phones and vital sign information from wearable devices. This keeps all other team members informed of the progression of care. It also has the capability to feed analytics and early warning algorithms. The command centre to assist in keeping people informed and supporting the progression of care.

As part of an action, a team member may capture new health information such as

notes, pictures, video, vital signs, etc. Similarly, team members may collaborate through virtual care: chat, video call, voice call.

Actions, new health information and collaboration using virtual care are all part of the medical record and will be stored in a medical grade repository that organizes information by patient and care plan. In support of the Digital First strategy, new health information captured as part of a care plan will be uploaded to the Connecting Ontario clinical data repository in compliance with the published interface standards.

Access to care plan related information will be constrained to care teams and controlled by care team members, including patients and family members.

The aggregation of content in the context of a care plan provides patients with a simple and single interface to access content that is meaningful to them and their family members. Rather than simply exposing all health information out of context, this approach creates context and supports opportunity for patients and family members to collaborate with the care teams using virtual care.

The use of a medical grade social network combined with already existing infrastructure such as the command centre, iPlan, Integrated Assessment Record (IAR), etc. empowers coordinated and seamless care across the continuum.

Achieving Information Sharing at Maturity

Implementing a medical grade social network to support digital information sharing at maturity will require net new investment in technology:
• Purchase of a medical grade social network application that supports personalized care plans
• Implementation of interoperability integration with existing point-of-service systems
• Integration with Provincial repositories

In addition, investment will be required to support the implementation of analytics to promote care coordination. For instance, NWT OHT can leverage Command Centre functionality and future design to support analytics across the care continuum.

With respect to operations, digital information sharing at maturity will require net new investment in:
• Change management
• Operations teams
• Patient, family and caregiver engagement

Regarding data sharing and custodianship, the NWT OHT will serve as both a HIC and a HINP:
• The medical grade repository that hosts care plans and associated health information requires the OHT to serve as a Health Information Custodian
• Some of the health information in the medical grade repository will originate from

other source systems and thereby, the OHT will be a Health Information Network Provider from the OHT members

The combination of a HIC and HINP presents an opportunity for the OHT to develop a single data sharing agreement to which all members are a party. Further, this presents an opportunity to streamline data sharing agreements with other Provincial assets and parties (TBD).

Note: Preliminary assessment indicates that all OHT members have the legal authority to collect, use and disclose PHI. However, this will become very specific as part of developing the data sharing agreement,

With regard protecting PHI, the medical grade repository will comply with Digital Health Access, Privacy and Security policy. Key assets within the OHT regarding protecting PHI are:
• All members of the OHT are familiar with protecting PHI and have implemented solutions for their own systems and data
• Humber River Hospital is uniquely positioned due to the scale of its digital footprint, to leverage security technology, policies, operational monitoring and privacy/security on-boarding

4.3.2. How will you digitally enable information sharing across the members of your team?

Please refer to Appendix B – Digital Health to propose your plan for digital enablement of health information sharing.

5. How will your team learn & improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any?

Identify whether any of your team members have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

Where there are issues, describe whether there is a plan in place to address them. Indicate whether participation on the team will help and why. Indicate whether there will be any formal accountability structures in place between individual team members and the team as a whole for ensuring that individual performance or compliance issues are addressed.

Max word count: 500

NWT OHT partners have not had any recent issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation. Moreover, all partners have a proven track record of strong clinical and fiscal management, and where relevant, have been Accredited with Exemplary Standing by Accreditation Canada. Verifiable information available on request.

Participation in the NWT OHT will leverage proven leadership of each partner to provide coordinated and integrated care at the system level to connect care for patients and their families. Specific benefits include:

• Ability to design of innovative care models with shared accountability across the full continuum of care, including formal, standardized, evidenced-based pathways improving care transitions and navigation
• Better position partners to address social determinants of health and embed upstream planning into redesigned care with appropriate supports
• Increased access to programs and services provided by OHT partners
• Shared communication across providers to provide a complete and holistic picture of the patient and their medical requirements
• Expand knowledge of programs and staff by leveraging expertise of partners across different health sectors

5.2. What is your team's approach to quality and performance improvement and continuous learning?

Ontario Health Teams are expected to pursue shared quality improvement initiatives that help to improve integrated patient care and system performance.

5.2.1. What previous experience does your team have with quality and performance improvement and continuous learning?

Describe what experience each of the members of your team have had with quality and

performance improvement, including participating in improvement activities or collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).

Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.

Describe your members' approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.

Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all member organizations/providers.

Max word count: 1000

Quality and performance improvement is a core component of the NWT OHT population health management approach and redesigned care model. Measureable outcomes that are aligned with community needs, and report on patient experience, patient/population outcomes, cost/efficiency, and provider experience are essential to demonstrate success and allow for continuous learning and iterations. All NWT OHT partners capture performance metrics and have a demonstrated track-record for quality and performance improvement, and report on their respective Quality Improvement Plans (QIPs). Partners review quality metrics with their board of directors, and most have specific board quality committees.

Specific Year 1 performance improvement priorities have been identified in Section 3.1 of this submission, and additional shared indicators across partners are listed below:

- Patient/resident/client experience
- Percent patients/clients attached to primary care
- Service utilization
- Employee engagement
- Wait-time to access services, with each provider/program reporting against different targets
- Decrease in ALC days
- Information transfer at transitions in care, receiving discharge/transfer information/notifications within a specified time-period (e.g. hospital to primary care, discharge information received within 48 hours)

The NWT OHT will develop an OHT Quality Scorecard/Dashboard that will include key metrics identified in Section 3.1, along with select shared indicators that will be updated monthly to ensure quality and performance improvement, and achievement of Year 1 indicators. This will be reviewed at Operations Committee, reported up to the Senior Executive Committee Meetings, and shared with NWT OHT Board Chairs during the quarterly meeting as described in Section 4.2.

Demonstrating commitment of quality improvement across the health system, NWT OHT partners have formally agreed to work towards becoming the first BPSO OHT. NWT OHT providers will implement BPGs across the system to improve access, transitions and coordination in care.

NWT OHT partners have extensive experience in quality and performance improvement, with demonstrated successes across respective organizations. Some examples have been provided below, with a comprehensive list available on request.

NWT primary care providers including Humber River Family Health Team, Unison Health and Community Services, and Black Creek Community Health Centre have numerous metrics that focus on screening, improving access to primary care and system navigation, with quality improvement plans that reflect multiple indicators. Each organization has targeted interventions to increase performance on key metrics with demonstrated success. For instance, Humber River Family Health Team has made an 11% improvement in patient access to physicians or nurse practitioners same or next day, and a 20% increase in immunization for children.

Humber River Hospital (HRH) has a quality improvement department that has multiple publications leading evidenced-based care delivery, along with innovative uses in technology to improve clinical outcomes. HRH has a Quality and Safety Framework that is aligned with StuderGroup principles for hardwiring excellence and high reliability. HRH has a strong track-record in improving patient flow, implementing the first hospital Command Centre in Canada, and is ranked #1 in the pay for result metric – time to inpatient bed for very high volume hospitals. Furthermore, HRH is ranked #1 in patient experience across Central LHIN hospitals. HRH has proven experience developing and designing real-time, system-level performance improvement dashboards through iPlan, a solution that has been implemented across five hospitals and home and community care. To improve health leadership and support continuous learning, HRH in partnership with Schulich Executive Centre offers the Health Leadership Development Program, a masters certified program awarding a certificate for Master in Health Leadership.

The NWT OHT rehab and/or complex continuing care organizations, Runnymede and West Park have a quality framework and plan, with continuous improvement on key metrics. For instance, Runnymede has demonstrated a decrease in their Average Length of Stay (ALOS) for their rehab programs: High Tolerance Short Duration (HTSD) actual ALOS 10 days better than target, and Low Tolerance Long Duration

(LTLD) actual ALOS 30 days better than target. West Park implemented a number of IDEAS projects related to chronic disease management, reduction in acute transfers and transferring of Long Term Ventilator Patients to WP to significantly reduce ALC days in ICU.

NWT Home and Community Care partners, SE Health and Lumacare participate in many innovative approaches to delivering care in the community. For instance, Lumacare is an executive member of the CSS Network and guides the direction for the committee. SE Health provides services to many organizations across Ontario, and establishes key performance indicators for each program to demonstrate outcomes and for continuous improvement. Results from one program from 2016 and ongoing include: 15% decrease in postoperative hospital length of stay (i.e. 3 hospital bed says saved per patient), 25% decrease in 30-day hospital readmissions, 33% decrease in 30-day emergency department visits, and 96% patients satisfied with the program.

The NWT OHT has four Mental Health & Addictions providers, which leverage OCAN, OPOC, HSP 360, and other systems to report on quality improvement and their respective QIPs. CMHA Toronto has quantitative and qualitative research and data analytic capacity, and is able to analyse mental health provider OCAN data to monitor outcomes and drive service improvement. All partners have significant expertise and experience related to Mental Health and Addictions, with innovative programs listed in Section 2.4 of this submission.

Villa Colombo Toronto (VCT) reports quality indicators regionally and provincially. VCT leverages Think Research Clinical Tools Utilization to meet and exceed provincial targets, benchmarked with Alliance Organizations for Long-Term Care. VCT is an active member of the CSS network, OCSA, and AdvantAge Ontario.

All NWT OHT partners have extensive experience in quality and improvement practices. Partners performed an internal survey to self-report experience in quality and performance improvement, as well as data analytic capacity, available on request. While all providers have a strong foundation in quality improvement, some partners have more experience/capacity than others, and belonging to the NWT OHT will allow for strengthened support to members. Some partners expressed opportunity to further develop their data analytic capacity, and the NWT OHT will leverage collective resources to this end, and will create a shared dashboard across the OHT.

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

Please refer to Appendix B – Digital Health to provide information on how your team will leverage digital health tools for improvement.

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient,

family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

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

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

Max word count: 500

All NWT OHT partners have a demonstrated track-record of meaningful patient, family and/or caregiver engagement, and have structured forums and processes for partnership activities; this includes the co-design of protocols, materials and systems, standing meetings/councils, and/or inclusion of patients on leadership committees. All providers have Patient Family Advisory Council (PFAC) members, and these existing representatives were used in the development of the full application as identified in Section 2.10. A unique strength of the NWT OHT is the diversity in partnerships, as members span the different health sectors, and patient representatives are able to provide their insights across each sector to represent the care continuum. As outlined in the NWT OHT Governance Structure, Section 4.2, patients will be embedded across various levels of leadership including the senior executive committee, as meaningful change occurs in partnership with patients and the community.

Specific examples of patient engagement across providers to embed input and information into strategies, policies and operational aspects of care were included below. Additional examples are available on request.

- Lumacare – actively recruit clients and caregivers to sit on the Board of Directors
- West Park – implemented partnership councils on complex continuing care units to co-design process and care delivery changes with patients, families and caregivers
- Humber River Hospital – have reinventing patient care councils (RPCCs) across all clinical programs and the organization to support co-design of operational aspects of care including the Command Centre, and a Post Discharge Call Centre (PDCC) to capture patient feedback and identify opportunities for improvement
- LOFT – CEO and senior service directors hold meetings with clients across programs to understand opportunities, capture surveys, theme results, and developed targeted strategies to improve experience

As outlined in Section 2.4, partners have extensive experience in redesigning care pathways across multiple sectors including bundled care and health links, actively engaged patients in development, evaluation and on an ongoing basis for continuous quality improvement.

5.4. How does your team use community input to change practice?

Describe whether the members of your team formally or informally engage with the broader community (including municipalities), and whether the outcome of engagement activities influence the strategic, policy, or operational aspects of your care.

Max word count: 500

NWT OHT partners actively engage the broader community to inform, advise and align priorities to community needs. As identified in Section 4.1, a specific reference to community was made across most NWT OHT partners in their mission and vision statements. Community engagement and linkages is essential as our OHT serves a diverse community with unique health equity concerns. An example of Black Creek Community Health Centre was provided below and specific community groups that are affiliated with each NWT partners is available on request. NWT partners actively engaged the community as identified in Section 2.10. Moreover, letters of support from specific community groups have been included in the supporting documents.

Black Creek Community Health Centre sits on a number of local City of Toronto Planning tables and network groups including: Rustic Neighbourhood, Humber Summit, Jane Finch, Glenfield-Jane Heights, Jane Finch Action Against Poverty, Black Creek Community Collaborative, Jane Finch TSNS Task Force, Central LHIN Wellness Collaborative, North End Harm Reduction Network, etc. These tables provide opportunities to engage with residents and local agencies to identify and prioritize issues and build capacity for collective strategy and action; collaboration in these groups may help inform operational, strategic or policy priorities within our organization.

Many partners also have formal and informal engagements with Public Health, Police, School Boards, and other community agencies, to better understand the needs and incorporate into strategic, policy and operational aspects of care, as well as align with the over mission and vision.

The NWT OHT will be engaging communities in the attributed population during the development of the NWT OHT mission, vision and strategic directions in Year 1.

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

Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever

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

Max word count: 500

The NWT OHT is well positioned to manage cross-provider funding and tracking patients/patient costs across multiple sectors. Seven partners have experience with managing cross-provider funding for integrated care, pooled funding, and/or tracking patient costs and health care spending across different sectors, below.

Managing cross-provider funding for integrated care:

- Humber River Hospital – Bundled care for hips and knees, and the Reactivation Care Centre (RCC) where eight partner hospitals have inpatient units across two Humber River Hospital sites
- West Park – bundled care for hips and knees, and cross provider funding decisions related to integrated COPD care pathway in West Toronto
- Runnymede Healthcare Centre – inpatient rehabilitation provider for Humber River Hospital bundled care for hips and knees
- SE Health – subcontracted models of care with hospitals, retirement homes, and homecare provider where funding is integrated
- Lumacare - funds Bayshore to provide Physiotherapy in its Adult Day Programs, and is the lead agency for the Home at Last program, coordinating hospital discharge supports to partner organizations when appropriate
- CMHA Toronto – fund holder for the national employment project that includes twelve sites, and fund holder for the mental health and justice supportive housing project, alongside LOFT, Cota, and Houselink

Pooled financial resources:

- Humber River Hospital – have pooled financial resources for select initiatives as identified in Section 2.4
- West Park – Long-Term Vent, where funding was provided to community based agencies to provide care in the community for these patients for continuity of care and supporting patient choice to be cared for at home
- LOFT Community Services – hub and spoke program in mid west Toronto where FTEs are shared between LOFT and West Toronto Support Services, and in North West Toronto with Griffen Centre

NWT OHT partners identified above, and in the initiatives mentioned above and in Section 2.4 actively track patient costs and health care spending for services provided across different sectors. The NWT OHT will leverage this expertise to track patient costs and health care spending in Year 1, and continue to build this capacity across the team while working towards Maturity.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones will you use to determine whether your implementation is on track.

Max word count: 1500

The NWT OHT value-based care redesign leverages four functional elements of disruptive innovation: 1) patient/caregiver experience, 2) business model, which includes standardized evidence-based care pathways that span the continuum of care and the care manager, 3) technology to support the business model, and 4) value proposition to ensure solutions developed are cost efficient.

Patient/caregiver experience is essential to empower clients in managing their condition(s) to promote better health outcomes, wellness and prevention. The design thinking methodology will be used as an iterative process to continuously engage and understand the patient/caregiver experience across the care continuum, and redefine problems to identify alternate strategies and solutions that might not be apparent from our initial level of understanding.

NWT OHT partners have developed standardized evidenced-base care pathways for the Year 1 population, along with a defined role for the care manager and care team to support complex patients, as identified in Section 3 of this submission. Educational materials currently exist and will be leveraged when implementing the model. Redesigned care will be evaluated and redesigned using an iterative approach through Plan Do Study Act (PDSA) cycles in Year 1 to ensure performance priorities identified in Section 3.1 are met in the most effective and efficient manner. Existing technology solutions will be leveraged on implementation, and will be expanded/built upon in an iterative manner to ensure patients, caregivers and providers are well supported in achieving positive health outcomes.

Specific 30, 60, 90 day and 6 month plans are included below with key milestones.

Month 1 (i.e. 30 day)
NWT OHT partners will have a kick-off meeting when selected to implement the OHT model. As the care pathway, care manager, care team, educational materials and initial technology solutions are defined, the first month will focus on training and education, specifically for the care manager and care team. Year 1 patient tracking will be arranged with KPIs aligned with performance opportunities identified in Section 3.1. Metrics and data sources for the Community Health Needs Assessment (CHNA) will be finalized to being collecting and analyzing information.

Month 2 (i.e. 60 day)
The intake process will begin. Year 1 patients will be linked to a care manager and team post-discharge, and followed in the community with improved care coordination and navigation services available. These patients will be tracked to ensure

performance opportunities are captured. If available, PREMs and PROMs will be measured, otherwise patient experience will be captured via a questionnaire. During this month, NWT OHT partners will begin working on the OHT strategic plan and directions.

Month 3 (i.e. 90 day)
Data from the CHNA will be analyzed to identify key opportunities in the community. Additional information required will be identified to complete the CHNA report.

Month 4
The first cohort of patients who were initially provided with integrated care will be transitioned to their primary care provider. Performance metrics, patient experience, provider experience, educational offerings, and technology solutions will be evaluated to identify opportunities for improvement. The clinical, digital committee will iterate as appropriate, and identify any gaps existing technology solutions, and whether they can be scaled or built upon.

Month 6
The second evaluation and iteration will occur in Month 6. The CHNA report will be complete. Month 6 will mark the start of Year 2 planning, which includes planning for Year 2 patients, and preventative strategies for Year 1 patients, as initially the NWT OHT focused on the most complex subset of this patient population. Performance opportunities will be re-evaluated to ensure they align with community needs and Ministry direction.

Month 9-12
The third evaluation and iteration will occur if needed. The Year 2 model of care and preventative strategies will be available in draft and finalized. A first draft of the NWT OHT strategic plan and directions will be available and finalized by end of Year 1.

Patient, caregiver and primary care physician engagement are crucial as they are key players. Patients and caregivers must be empowered and supported to manage their conditions, and primary care providers supported to better provide timely, comprehensive and accessible care to patients. Patients, families and caregivers are included across all levels of governance and are deeply embedded in activities on a monthly basis.

Primary care physicians will be engaged on an ongoing basis and on-boarded as members of the NWT OHT throughout Year 1 (and beyond). Many interested providers have reached out to our OHT and will be engaged initially to inform them of the model of care and process going forward, with potential new signatory partners identified in Month 6 following the CHNA and for Year 2 planning.

Digital solutions will be evaluated at onset on their effectiveness to support Year 1 redesigned care as identified above. Requirements for the Command Centre Generation 3 will be developed in Year 1 to better support integrated care, seamless

transitions, and 24/7 care coordination, by providing real-time data, and advanced and predictive analytics.

The NWT OHT will continue working towards becoming the first BPSO OHT. The focus of the first year of this agreement is co-planning and co-creation of an infrastructure to support the BPSO OHT, with subsequent years addressing guideline implementation and evaluation (year 2 & 3), and sustainability planning (year 4). When all deliverables are met, the BPSO OHT will go on to become a "Designated BPSO." As a designated BPSO, the BPSO OHT will focus on sustainability, spread and scaling up the implementation and evaluation of best practice guidelines. The BPSO designation is renewable every two years thereafter.

6.2. What is your change management plan?

Please describe your change management strategy. What change management processes and activities will you put in place before and during implementation? Include approaches for change management with primary care providers, and how you propose to leverage clinician leaders in helping their peers to embrace and embed change.

Max word count: 1000

OHTs represent a significant change in the health care system and deliberate change management strategies are essential and embedded within the NWT Year 1 model. Key change management principles include:

Start with the end in mind. This was facilitated by the Full Application submission process as all relevant sectors, leaders, patients/caregivers and primary care physicians co-designed the Year 1 model of care, and are embedded in both governance and operational leadership structures as identified in Section 4.2. Everyone impacted by changes in care are engaged upfront, and any new changes (i.e. Year 2 priorities) will include all relevant stakeholders.

Understand each organizations culture. This was facilitated by the Full Application process, specifically Section 5. The NWT OHT aligns with each organizations current priorities, and will be further integrated through a shared strategic plan and directions.

Communicate, communicate, communicate. There are many stakeholders including a diverse population, local communities, sectors, providers, partners, and staff that span across all levels of leadership. The communications committee is cognizant of the different groups and targeted, multi-pronged communication and engagement strategies for each group have and will be employed to ensure everyone is aware, engaged, and/or is partner in delivering valuable and meaningful change.

Create win-wins and align incentives. A foundational element of the NWT OHT is to ensure patients, caregivers and providers benefit from this innovative model of care. Incentivised solutions are deliberate and support change management enabling all to embrace and embed change.

Measurement-based care. The NWT OHT has a specific defined Year 1 population with specific outcomes. This is a key component of the Collaborative Care Model and essential to ensure redesigned care is having the desired outcomes. This information will be shared on an ongoing basis through many forums to promote transparency and trust, and demonstrate the impact of the new model of care, and any changes/evolutions.

These principles are embedded within the implementation plan to ensure engagement, trust and transparency on a continued basis. Moreover, NWT OHT partners have sufficient capacity to support change, and a proven track record in implementing successful change management in initiatives identified in Section 2.4 of this submission.

To support NWT BPSO OHT work, a BPSO lead is being recruited to support change. Furthermore, the Chief of Family Practice at HRH and other primary care physician leaders that are members of the NWT OHT have been crucial change agents with the primary care physician community in this area.

The NWT OHT Senior Executive Committees administrative support will develop standardized content that will be used monthly to share information across each organization leveraging existing forums such as Presidents Forums and Town Halls. Moreover, the communications committee identified in the operational leadership structure will support with community engagement and education.

6.3. How will you maintain care levels of care for patients who are not part of your Year 1 population?

Indicate how you will ensure continuity of care and maintain access and high-quality care for both your Year 1 patients and those patients who seek or receive care from members of your team but who may not be part of your Year 1 target population.

Max word count: 500

Section 3 described the NWT OHTs approach to redefining care. This approach creates a standardized pathway across the continuum of care that touches all relevant providers, with the intent to create these standardized pathways for the different population segments and conditions, for targeted interventions focused on management, prevention, and/or a combination thereof.

While developing these bundled models of care, and further expanding the role of the care manager to support wellness, early identification, and prevention in the community, current patients receiving services will continue to receive care through regular means.

Our OHT will not be adding new resources to the system; rather we will redefine the current model of care for patients that would receive similar services in a fragmented manner. The NWT OHT's approach provides a mechanism to incrementally

standardized care across prevalent health conditions, minimizing variability in practice and patient outcomes, with coordinated service delivery, to shift current offerings to a population health management focus.

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

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

Max word count: 1000

For the NWT OHT, Ontario Health Teams is an opportunity to deliver a population health management approach, with teams responsible for health outcomes for a target population, and allowing for proactive service delivery with the ability to promote strategies focused on wellness and meeting the patient's social determinants of health versus illness. Many health systems globally have successfully implemented population health management aligned with the principles of Quadruple Aim; delivering better care, with better outcomes, reducing health utilization resulting in more efficiency, and ensuring providers are well supported to deliver care.

Health Service Providers in NWT OHT are well positioned to innovatively deliver this model of care, and are very passionate to create a better model for the health system. It is essential to empower providers with the opportunity to do so, which will create a win-win scenario for the population, providers, various sectors, and the Ministry.

In the current legislative and regulatory environment, and with the current funding models in place, this significantly hinders innovation. The NWT OHT is cognisant of these challenges, and will advocate for meaningful enhancements to current structure, however understands certain systemic barriers cannot be removed in the immediate future, or indefinitely.

For planning purposes, transparency from the Ministry with regards to what legislative, regulatory, policy and/or funding changes are currently being considered and may change in the near future, what may change in the next 2-5 years, and what will not. This will help ensure the internal resources (i.e. front-line, physician, leadership, and executive) are effectively utilized and are empowered to create innovative and operational plans to drive meaningful change.

In addition, to better leverage home and community care resources and the modernization of services, direction from the Ministry pertaining to the role of the LHIN and upcoming or anticipated changes would be valuable to allow for meaningful

planning.

The NWT OHT has identified specific risks in the implementation of the OHT model, and has proposed interim mitigation strategies. NWT OHT partners are appreciative of the Ministry's intent to support teams in this valuable transformation of the health system, and would value ongoing opportunities to understand current direction to ensure meaningful utilization of resources and effective planning.

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

Please identify what centralized resources or supports would most help your team deliver on its Year 1 implementation plan and meet the Year 1 expectations set out in the Guidance Document. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

The NWT OHT has identified a number of centralized resources that would support our team (and others) to deliver the Year 1 implementation plan and meet the Year 1 expectations set out in the guidance document, below.

Timely response to questions. NWT OHT partners recognize that answers to certain questions posed may not be known or available, and would like anticipated timelines on responses, and/or prioritization of answers to support the delivery of the year 1 model.

Additional information on available funding from the Ministry of Health. There have been certain announcements eluding to funding to support Ontario Health Teams, specifically on digital initiatives. This was communicated via an interview and not through formal channels. Information regarding anticipated funding would be valuable to support planning.

Planning sessions with selected Year 1 OHTs. It would be valuable to regularly and directly connect with Ministry leadership with OHT leadership to allow for dialogue on progress, supports, and upcoming changes. This forum would enable leadership to collectively and cohesively align the OHT vision (and potential evolutions) with the operational model.

Ministry education to the public around OHTs. During engagement sessions, the NWT OHT provided a significant amount of education around OHTs to patients, providers, physicians, etc. as they were unaware of what OHTs were. NWT OHT partners believe it would be beneficial for the Ministry to create an education campaign to inform the public around OHTs, which can be leveraged by teams during engagement sessions. This will help create a common language.

Comprehensive population dataset. The attributed population provided a unique view

on referral patterns, however many questions remained unanswered including:
• Where does the attributed population reside (i.e. Forward Sortation Area (FSA) data). Do they reside near a PEM or further away. This would allow for a better understanding of patient demographics and referral patterns.
• How many physicians belong to each PEM, how many patients are rostered to that PEM and to the individual physicians, how many are admitted and to which hospital.
• What are the health equity concerns for the attributed population and their social determinants of health. To leverage a population health approach, a detailed understanding of all factors regarding the attributed population is necessary.
• How many patients utilize community health centres, community mental health and addictions, are uninsured, etc.
The above are some examples of questions our OHT has with respect to our attributed population, and in Year 1 will be conducting a community health needs assessment, similar to those performed by accountable care organizations in the United States. As the health system in Ontario is publically funded, it would be beneficial if the Ministry could provide a comprehensive dataset to provide a clear picture to OHTs that would support functional planning. The NWT OHT would be very receptive to working alongside the Ministry to support in the development of this dataset, with the intent to create meaningful metrics that will support all OHTs including ours with functional planning and on a continued basis. This would also support the Ministry in identifying meaningful investments that will better support the health system, aligned with Quadruple Aim. Furthermore, as the Ministry is working with ICES, our OHT would value the opportunity to support this collaborative, and work with the Mental Health and Addictions Centre of Excellence to refine indicators and measures.

Templates and tools for patient engagement. Alongside standardized education, it would be valuable to have standardized tools that can be leveraged by OHTs for meaningful patient, family, caregiver and provider engagement. Our experience in communicating with neighbouring OHTs is that each team is currently developing these tools, and it would be valuable to pool these resources, refine and standardize, and make available to all OHTs.

6.6. Risk analysis

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

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

Patient Care Risks	**Resource Risks**

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

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

6.7. Additional comments

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

Max word count: 500 A number of references were used in this submission. The format provided (i.e. Full Application Fillable Form) was used, and all references are available on request, as well as additional information for all sections.

7. Membership Approval

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

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

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

APPENDIX A: Home & Community Care

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

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

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

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

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

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

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

Max word count: 1500 A key priority in the OHT model is to redefine and modernize home and community care services to enable patients to: • Safely live at home longer

• Support patients through improved coordination of care between primary care and home and community service providers
• Timely, seamless access to acute services when required
• Ease of transition across the continuum of care, and the spectrum of services

As identified in Section 3, the NWT OHT population health management approach divides the attributed population into key population segments through risk stratification, with targeted strategies for each population segment. These strategies are identified below and are deeply linked to services in the community, and provide a high level framework of specific service offerings:

Complex, receiving concentrated care
• All of the strategies below, plus…
• Care Manager/Coordination (24/7 Access)
• Predictive Analytics + Home Monitoring
• Care Team Performance Management Meetings
• Patient Education; Tertiary Prevention

Chronic - Rising Risk, receiving chronic disease care
• All of the strategies below, plus…
• System Navigation
• Seamless Care Transitions
• Patient Identification & Risk Stratification
• Self-Management & Education; Secondary Prevention

Well, receiving advanced primary/community care
• Patient Education & Activation; Wellness & Primary Prevention
• Patient Identification & Risk Stratification
• Patient Access to Health Information
• Virtual Care

NWT OHT partners had a community-visioning event, and included patients, primary care physicians, Central LHIN home and community care, which resulted in priorities for the reimagined home and community care vision, along with core elements. This vision aligns closely with the Geisinger Health System previously referenced, including ProvenHealth Navigator ®, Advanced Medical Home, and Geisinger at Home.

Priorities:
• Keep patients healthy and out of the hospital for as long as possible, through prevention
• Embedded care manager in the community, perhaps based in primary care offices, that can support early identification and risk stratification, care, coordination and system navigation, which ensure patients are linked to appropriate services proactively
• Support with patient education and activation

• For chronic patients, ensure adherence to care bundles in the community
• For complex patients, ensure adherence to acute care bundles to avoid repeat admissions

Key Components:

1. Neighbourhood Care Models
These local neighbourhoods would allow for integrated care pathways and partnerships, and include a strong connection and/or partnership between primary care physicians and home & community care, to provide 360-degree, 24/7 continuum of care. This may also include an “embedded” Care Manager to coordinate care and perform home visits as required. These local neighbours would ensure primary care and community care are interconnected, with this approach allowing the NWT OHT to measure and address provider satisfaction, as well as burnout.

2. Care Manager
Care Managers have been highlighted in Year 1 care redesign, and will initially focus on the most complex patients. This offering will be expanded to patients who are chronic or well. Patients can either self-refer for management and prevention, or can be identified through their interactions (or lack of interactions) with the healthcare system for proactive outreach. This may include a paramedic system auto triggering a referral and emergency visits resulting in a referral. Furthermore, care managers can strengthen inter-professional care, and as they belong to the NWT OHT, have access to the spectrum of services available across providers.

3. Focus on the Caregiver in addition to the patient
There is a significant amount of literature that suggests social relationships and networks affect mental health, health behavior, physical health and mortality risk. This is increasingly important as the severity of a patient’s health condition worsens or if a patient has chronic condition(s). Although primary care physicians are typically the first point of contact for patients with the health system, families and caregivers are usually the first and last point of contact for patients as they support them in managing their conditions on a continued basis. In 2012, Statistics Canada reported 28% of the population aged 15 and over provide care to a family member or friends with a long-term health condition, disability, or problems associated with aging. Given the demographics provided in Section 1 of this submission, caregiver support is a key priority and essential in NWT and across Ontario. The NWT OHT will develop tools, education, resources, and aids to empower caregivers to support patients in the community, and help proactively mitigate caregiver burnout. NWT partners will design and deploy caregiver wellness plans, and co-design care bundles with patients and caregivers, to recognize and include caregiver support to improve health outcomes for patients. As caregiver support is currently not funded, a key recommendation to the Ministry is to consider funding for caregivers, with a business model to demonstrate effective health outcomes and an efficient use of healthcare resources.

4. Central list of volunteers in the community

It is well-known that hospitals have a significant number of volunteers that support patient navigation and other activities within the walls of the hospital. Recruitment and a central list of volunteers in the community expands this concept, and allows for an altruistic and efficient means to support patients in the community setting. It is well-known that compassion and social interaction has a significant impact on quality of life and health outcomes. Through a formalized approach with standardized education, volunteers can support patient self-management, health literacy, and certain elements of system navigation.

5. Bundled care in the community
An innovative approach from Geisinger Health System included ProvenCare® Chronic, that provides a systematic approach for the reliable delivery of evidenced-base care in the outpatient setting. NWT OHT partners will develop community bundles and prospectively identify patients who would benefit from this care. This preventative/management approach has proven outcomes for diabetes, CHF, coronary artery disease, and hypertension. As highlighted in the submission, CHF and diabetes are Year 1 and Year 2 populations for NWT. Furthermore, ProvenCare® Chronic includes an adult prevention bundle that promotes screening in the community, which aligns and can improve the current poor screening rates in NWT.

6. Access and virtual care
The NWT OHT conducted a survey for residents in NWT and received 500+ responses. 93% respondents indicated they had a primary care physician; 25% expressed difficulty in getting an appointment with their family doctor and 20% mentioned they could not get time off work. This indicates a key challenge in patients trying to access the healthcare system. After hours, access to “neighbourhood care models” and community resources is essential, along with virtual care to enable patients to access the system from home or work. Health equity is an essential consideration for NWT; to further enhance access, specific considerations include affordable transportation, multiple languages, and access to care for those who are not insured and/or do not have OHIP.

7. Digitally enabled
Technology is advancing at a rapid pace, and the NWT OHT strives to be a leader in digital innovation with specific initiatives identified in Section 4 and Appendix B. From a communications standpoint, home and community care would use a common communication platform where they cannot only access community data (i.e. CHRIS), but also access essential patient data aligned with their care plan.

These key concepts for represent the NWT OHTs long-term vision for home and community care, to keep patients healthier in the community. Resources and reallocation will need to reflect an increased focus in the community as our OHT shifts from illness focused to a wellness paradigm. NWT OHT providers will have shared accountability and community resources will be closely interconnected with all health sectors (and others) as our OHT moves towards maturity.

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

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

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

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

Max word count: 1000

The NWT OHT redesigned model of care for Year 1 was identified in Section 3 and targets the most complex patients (i.e. those discharged from hospital), utilizing the bundled care model that spans from acute to community. Year 1 CHF and COPD patients may require home and community care services, with an anticipated population of 1,056 patients.

Our innovate model of care leverages the Geisinger ProvenCare® approach, and operationalizes it through the Collaborative Care Model with defined responsibilities for the Care Manager and Care Team. This approach leverages population

segmentation and stepped care from the collaborative care model, resulting in individualized care plans with the right treatment intensity and providers for wrap around care, within the patients care bundle. The NWT OHT will work with the LHIN Care Coordination team to support this model, which will include training to be able to deliver all elements of integrated care including system navigation, and improving patient self-management and health-literacy. This new model of care will better utilize the expertise of the Care Manager to deliver meaningful value-based care to patients.

Patient intake will begin in the hospital with a standardized referral to the Care Manager for patients being discharged with CHF or COPD. The Care Manager will assess the patient using a screening tool to determine eligibility for services. The Care Manager will coordinate with the Care Team to assess the patient and develop a care plan in partnership with the patient and their caregiver(s). The Care Manager will carry out this care plan using a stepped model adjusting treatment intensity for 60-90 days, with frequent communication with both the patient and care team, with offerings to include 24/7 access. The final phase includes a warm handoff to primary care.

This model ensures patients are partnered with a Care Manager to support their recovery, and supports in building trust between the Care Manager and patient, as well as establishes a foundation for future community based activities as described in A.1 of this submission.

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

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

Max word count: 1000
In Year 1, the NWT OHT will work with LHIN Home and Community Care resources to deliver our redesigned model of care, using workflows identified by the NWT OHT vs current LHIN service offerings. Specifically, a team of care coordinators will help prioritize Year 1 patients and participate with the NWT OHT to be educated in the new model of integrated care. Care coordinators will continue leveraging current digital access and share local knowledge and expertise, and would benefit from the resources offered by NWT OHT partners. The ideal state is a bundled funding model enabling the NWT OHT to carve out funding for the Year 1 population to deliver these services in a more efficient manner.

A.4. Have you identified any barriers to home and community care modernization?

Identify any legislative, regulatory, policy barriers that may impede your team's vision for modernizing home and community care with regards to improving health outcomes, enhancing the patient and provider experience, and ensuring system sustainability. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000
There are a number of barriers that require resolution to effectively implement the NWT OHTs vision for the modernization of the home and community care at maturity, which include:
• Home and Community Care is currently under the Central LHIN. If these resources were transferred to the NWT OHT or providers, pay equity would be a significant consideration, and if not addressed, could result in an increase in salary for current home care staff, which would increase healthcare costs
• The potential impacts of the Public Sector Labour Relations Transition Act (PSLRTA)
• Home and community care will need access to patients health information to effectively understand and carry out care interventions as defined by the NWT OHT; the Personal Health Information Protection Act (PHIPA), and the Freedom of Information and Protection of Privacy Act (FIPPA) would need to be considered
• As the NWT redesigned care redefines the role of Home and Community Care staff, scope of practice regulations would need to be considered and addressed to ensure staff are able to carry out defined responsibilities

• Health equity and determinants of health is a significant concern in NWT. Specific considerations with respect to home and community care may include and are not limited to:
    • Language considerations
    • Transportation costs
    • Costs not covered by insurance/OHIP
    • Co-payment barriers for those who cannot afford
    • ODB as not all drugs are covered and some patients cannot afford out of pocket expenses
• Long-Term Care (LTC) access is currently provided exclusively through Home and Community Care as per current legislation. This will need to be reconsidered if resources are being transitioned to the NWT OHT.
• The care manager role is a key component of the integrated collaborative care model and supports the redesign of care delivery for patients with CHF, COPD and MH&A. Redistribution of LHIN Home and Community Care resources aligned with the long-term vision, will be essential to the success of this model.

Ontario Health Teams
Full Application Form

APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

The digital health strategy is founded on connecting care teams and coordinating action defined by the care plan. "Connecting" is inherently virtual care:

- It facilitates communication between the care team and the patient using chat, video call and voice call (aka "virtual visits")
- It supports monitoring of patients in the home and community setting which helps patients manage their condition
- It gives patients access to their health information in context to support literacy and self-efficacy
- It ensures that patients are connected to the care they need

The Year 1 plan is to start simple, work out requirements for maturity and identify the operational details to ensure sustainable use.

Key objectives in Year 1 are:

a) Share care plans

We have a number of technology platforms that can be leveraged to share care plans and facilitate collaboration among care teams. These may include:

1. Integrated Assessment Record (IAR)
o IAR is an assessment tool that can be shared among health service providers for the coordination of care, and health system planning at various levels
o The IAR is a tool that provides a central repository for data collected from multiple assessment for clients, and allows authorized health service providers within the circle of care to view a client's pervious assessment information from other care providers

2. iPlan
o iPlan automates standardized discharge-planning workflows between hospital and home and community care
o iPlan was developed by Humber River Hospital as part of a LHIN collaborative which includes five partner hospitals and home and community care, and can be extended to support the care plans for COPD, CHF and MH&A cohorts

3. ASCOM Collaborate
o ASCOM Collaborate is a communications "app" that is specifically designed for clinical communication between care teams. It supports voice, video and chat communication (similar to Equinox) but all in the context of a patient

4. One Mail
o One Mail offers a very simple and no cost approach to sharing care plans. However, it does not support the closed loop communication concepts desired at maturity

5. Sharepoint Secure Document Collaboration
o Sharepoint is a document management and collaboration platform widely used in enterprises. It is a potential method for sharing care plans and capturing notes, actions, and progressions of care
o Sharepoint is a secure enterprise solution within the Humber River Hospital Tier 3 data centre

In addition to the above, we will explore commercial solutions such as Careteam: a health platform that enables patient-centered care collaboration for complex, chronic diseases.

b) Command Centre Monitoring Tiles
Generation 3 of the Humber River Command Centre has been sufficiently conceptualized to allow a pilot project to test out the concepts of monitoring vital signs and other care plan actions from the Community setting.

We may leverage the early warning concepts already deployed as part of Generation 2 Command Centre to monitor for clinical deterioration.

c) Command Centre Flow Tiles - Connecting Patients to the Right Care Plan
A key concept to ensure patients are connected to the right care plan is to segment the population into specific categories and provide targeted interventions: “risk stratification” (refer to Section 1.1 and 3.1). Segmentation can be conducted either retrospectively through cost, or in real-time by a care manager. By leveraging the Command Centre there is opportunity to automate risk stratification. We will leverage machine learning algorithms to more accurately segment patients automatically.

Expanding Virtual Care to All Team Members
Almost all of the team members in the NWT OHT are executing virtual care today. The predominant form of virtual care is virtual visits through OTN.

As part of Year 1:

1. We will expand virtual visit capability to all of the team members.
o Using OTN or the communication tools described above.
o The foundation for such expansion is the care plan and empowering patients to communicate with the designated care team members about the plan and associated actions

2. We will implement monitoring of patients in the home and community setting as part of our Generation 3 Command Centre trial

Achieving Success in Year 1

The requirement is to achieve a virtual encounter for 2-5% of our target patient population. Based on our current state assessment and care plan sharing strategy, we do not see any challenge in achieving this requirement.

The steps to achieving success includes:

1. Connect Patients and Family Members to Care Teams –

o As described, we have a choice of tools that allow patients and their family members to connect and communicate with care team members digitally i.e. empower virtual visits
o We will enable the select target group with a communications app and facilitate connection to the care teams in the context of the care plan.
o Through the use of the care plan, we will ensure that patients and family members collaborate with care teams following the 5 rights:
I. The right information is made available…
II. To the right people…
III. At the right time…
IV. At the right place (anywhere) and…
V. In the right mode (text, voice, video)

2. Monitoring Patients in the Home or Community Setting –
o Monitor patients for change in clinical status to allow early intervention
o Leverage wearables that upload information; there are many solutions available and part of Year 1 trial is to explore the most effective option

3. Supporting risk stratification –
o Automate risk stratification and assist care managers in linking patients to the correct care plans.

Success for the provision of virtual care will be measured through utilization of solutions identified previous and their contribution to the achievement of performance priorities as identified in Section 3.1.

2.2 Digital Access to Health Information

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

Max word count: 1000
The digital health strategy is founded on connecting care teams and coordinating action defined by the care plan. Patients and family members are inherently a part of the "care team" and thereby, they will have access to information pertaining to the care plan.

The intent is to share care plans and the progression of care against that plan. This is health information in context that should assist in self-efficacy.

The Year 1 plan is to start simple, work out requirements for maturity and identify the operational details to ensure sustainable use.

Key objectives in Year 1 are:

a) Share care plans
As described in section 4.3.1 and B2.1, we will share a care plan with patients and their family members using tools at our disposal: iPlan, secure email, Sharepoint and (possibly) Careteam.

Through these tools, we will give patients access to the care plans as well as other content that supports their ability to contribute to self-efficacy, namely education materials, action schedules, tracking tools, etc.

b) Command Centre Monitoring Tiles
As described in section 4.3.1 and B2.1, we will seek to monitor patients in the home and community setting. For the trial target group, we will provide patients with their monitoring information. This can be provided through a patient centric dashboard that shows vital signs and progress against the care plan.

In addition to the above, in Year 1 NWT OHT team members will continue to share health information to their patients through current tools.

Achieving Success in Year 1

The requirement is to ensure 10-15% of our target patient population accesses health information digitally. Based on our current state assessment and care plan sharing strategy, we do not see any challenge in achieving this requirement.

The steps to achieving success include the following:

1. Sharing Care Plans –

o As described, we have a choice of tools that allow us to share care plans with patients and their family members.
o The complexity lies in educating patients on how to use the selected tool as well as on-boarding patients to the solution.

2. Monitoring Patients in the Home or Community Setting –
o The NWT OHT has identified approaches to collecting monitoring information from home and community settings. Humber River Hospital and GE Healthcare Partners have also identified candidate vital sign monitoring "wearables."
o As part of the Generation 2 Command Centre project, the Humber River Hospital and GE Healthcare Partners team has implemented and deployed early warning algorithms and associated assessments. These serve as a foundation to implementing "tiles" to monitor patient vital signs and other actions that pertain to the progression of a care plan.
o With the experience of implementing 2 generations of Command Centre, the Humber River Hospital is well positioned to support in implementation operating procedures pertaining to the home monitoring concept, alongside NWT partners.

3. Expanding adoption of patient portals
o In addition to sharing care plans and implementing patient monitoring in the home and community setting, the NWT OHT team will pursue expanded adoption of patient portals to support the Digital First for Health objectives. More specifically:
- Runnymede Healthcare Centre will cluster with Humber River Hospital's Meditech Expanse implementation and, thereby, offer all of it's patients access to the Meditech Patient Portal
- West Park Healthcare Centre will continue to drive adoption of their MyChart patient portal
- Humber River Hospital will execute a campaign to drive adoption of it's Meditech Patient Portal

2.3 Digitally Enabled Information Sharing

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

Max word count: 1000

The digital health strategy is founded on connecting care teams and coordinating action defined by the care plan. The intent is to share the "right" health information to care teams using digital methods, specifically through applications that work on desktops, laptops and smart devices over cell service. The right information is relevant information to the context of the patient. That maybe all health information, a subset of health information, conversation pertaining to care coordination, and actions pertaining to care delivery.

The intent is to connect and coordinate care teams using “action and closed loop” concepts. Rather than simply sharing information, care plans and actions are shared and assigned among the care team, including patients and family members. Recognizing and confirming action helps to drive seamless care and ensure patients follow care plans as required.

Actions, new health information and collaboration using virtual care are all part of the medical record and will be stored in a medical grade repository that organizes information by patient and care plan. In support of the Digital First strategy, new health information captured as part of a care plan will be uploaded to the Connecting Ontario clinical data repository in compliance with the published interface standards.

The Year 1 plan is to start simple, work out requirements for maturity and identify the operational details to ensure sustainable use.

Key objectives in Year 1 are:

Creating care plans
As described in section 4.3.1 and B2.1, we will share a care plan with care team members using tools at our disposal: iPlan, secure email, Sharepoint and (possibly) Careteam. For Year 1, we will focus on patients discharged from Humber River Hospital. As such, the Care Plan will originate at the time of discharge.

To keep things simple and low cost, the care plan will be created and added to the chosen solution manually. As an example:
• If we use iPlan, we already push patient demographics from Meditech using HL7 ADT. We will need to add tools to allow manual creation a care plan for our target patient population
• If we use Sharepoint, the process will be entirely manual, requiring staff to create a patient record and then add a care plan
• If we use Careteam, the solution comes with care plan templates that can be configured for the discharged patient. Careteam supports an ADT interface and thereby we can push patient demographics to Careteam to expedite some degree of automation

Sharing care plans

As described in section 4.3.1 and B2.1, we will share a care plan with care team members using communication tools such as: iPlan, Equinox, Collaborate, One Mail, Sharepoint.

A key challenge in “sharing” is knowing the care team member and the contact information.
• In year 1, we will manage this using a Care Manager.
• We can leverage One ID as a directory for all care providers. However this excludes patients and their family members.
• As we move towards maturity “knowing” will be managed by the members themselves through “duty assignment” concepts. The latter is used today at Humber River Hospital where nurses and members of code teams sign themselves into a role. This is part of the ASCOM Collaborate solution. Careteam uses a similar technique where care team members sign into the application so that other care team members know who is “on-line” and available.

Sharing other Health Information
Health information pertinent to the care plan may reside in one or other of the medical record systems used across the NWT OHT. As part of Year 1, we will identify:
• What information needs to be shared in the context of a care plan
• Effective methods of sharing such content. This may be directly from a NWT OHT member EMR or from one of the Provincial repositories
• Solutions that support a medical grade repository to host actions, new health information and collaboration

In addition to the above, we are exploring opportunities for certain NWT OHT members to cluster on the Humber River Hospital Meditech 6.1 Expanse HIS/EMR. As an example, Runnymede Healthcare Centre has signed a partnership agreement and will be leveraging Meditech 6.1 Expanse, thereby creating a unified record across the two entities.

Data Analytics
A key requirement is to understand population health needs and cost drivers, population segmentation, and integrated care pathway design. As per Section 1.1, we will perform Community Health Needs Assessment to thoroughly understand our population, cost, cost drivers, determinants of health, etc. From this assessment, we will identify data requirements and methods of data capture and analysis.

2.4 Digitally Enabled Quality Improvement

Describe how the members of your team currently use digital health tools and information to drive quality and performance improvement. How will your team build off this experience and capability so that it exists at the team-level?

Max word count: 500

Within the NWT OHT, there are a number of digital health tools to drive quality and performance improvement. These are detailed as follows:

LOFT – Reducing Avoidable Emergency Room Visits using Business Intelligence

Technology and Business Intelligence (BI) were combined with standardized procedures to help drive the necessary changes. Modifications were made to the client information system (CIS) interface and standard data entry protocols were developed to ensure proper data capture. Through integration of the CIS database and the Enterprise Data Warehouse, the BI platform was leveraged to send alerts to appropriate staff at the time of an incident report, to ensure there is always a review and follow-up. The incident-related data was also rolled up into an incident management dashboard to allow users to further analyze the information. Summary reports have been designed to automatically report the status to senior management on a monthly basis. These changes were designed to modify behavior and act as constant reminders of the new processes. This solution is something the NWT OHT will explore in the context of our objectives.

Lumacare – PSW Care Plan Tracker

Lumacare has developed a proprietary application that

- Communicates schedule to PSWs
- Tracks care plans and service completion
- Provides a secure communication vehicle between PSWs and supervisory staff
- Performs real-time information capture
- Geo-tracking capability

Black Creek Community Health Centre -Tickit

Tickit Health is an on-line client experience survey tool that runs on mobile devices. It helps organizations identify the needs of their entire population.

Powered by digital empathy, Tickit is a proprietary platform that captures high-fidelity person-reported data. Tickit empowers organizations to understand each unique individual they serve, to improve outcomes for the entire population.

Humber River Hospital

Humber Rivers Hospital has implemented a number of digital tools that enable quality improvement.

Generation 1 Command Centre – Focuses on patient flow and logistics. It contributes to eliminating hallway medicine by increasing capacity and reducing cost. Leveraging real-time data and sophisticated analytics, including machine learning algorithms, the Command Centre empowers our coordination team to optimize the flow of patients in and out of the hospital.

Generation 2 Command Centre – Focuses on quality and patient safety. Leveraging proven early warning algorithms and best practices, this 2nd generation will empower our teams to eliminate error. Areas of focus include:
1. Perinatal
2. Clinical Deterioration
3. Harm Prevention
4. Seniors Care

iPlan – iPlan is an innovative technology that automates standardized discharge-planning workflows between hospital and home and community care staff, and supports the LOFT BSTR team, implemented across 5 hospitals in CLHIN.

QBP Automation – A number of the QBP pathways have/are implemented in MEDITECH 6.1 Expanse to drive automation. The Stroke QBP is currently in use and we are implementing the COPD and CHF pathways.

As the NWT OHT works towards maturity, it will focus its digital tools to achieve the Quadruple Aim. The digital tools described above clearly contribute this Quadruple Aim and demonstrate a solid foundation for achieving goals as detailed in Section 3.1 and 5.2.1.

2.5 Other digital health plans

Please describe any additional information on digital health plans that are not captured in the previous sections.

Max word count: 500
Not Applicable.

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

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

for your team.

Name:	Peter Bak
Title & Organization:	Chief Information Officer (CIO), Humber River Hospital
Email:	pbak@hrh.ca
Phone:	(416) 242-1000 ext. 82126