# 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**<br>*Please indicate an individual who the Ministry can contact with questions regarding this application and next steps* | Name: Matthew Anderson |
| | Title: President & Chief Executive Officer |
| | Organization: Lakeridge Health |
| | Email: manderson@lh.ca |
| | Phone: (905) 576-8711 x 34399 |
| **Contact for central program evaluation**<br>*Please indicate an individual who the Central Program Evaluation team can contact for follow up* | Name: Susan deRyk |
| | Title: EVP & Chief Transformation Officer |
| | Organization: Lakeridge Health |
| | Email: sderyk@lh.ca |
| | Phone: (905) 576-8711 x 15132 |

## 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 Durham OHT intends to serve all residents of Durham Region, which has an estimated population of 671,839 (Census, 2016). While it is recognized that the Ministry of Health (MOH) attribution model attaches 478,442 citizens to the Durham OHT, current referral patterns reflect existing, preferred health service utilization, with some residents forced to leave the region to seek services elsewhere due to lack of services in the geography (e.g. rural Durham) or current unavailability of local services (e.g. Heart Function Clinics, Cognitive Neurology, Specialty Memory Clinics).

Among the 478,442 citizens attributed, it is estimated that the Durham OHT will be accountable for 92,800 individuals over age 65 who will seek service in the Durham OHT (in contrast to the MOH reported 79,544). Of these, an estimated 22,451 adults over age 65 will be living with complex medical and social conditions (i.e. frailty) and will be one of the populations of focus at maturity. The alignment between this population and the MOH attributed population for our service area is moderate.

The alignment between the target populations identified in our self-assessment (older adults living with frailty (OALWF) and people living with complexities (PLWC) and the MOH attributed population for our service area is moderate. In reviewing the attributed data, the following gaps have been highlighted:

- The attributed population does not include residents of the communities of Ajax or Pickering
- Sections of the North Durham population have not been not accounted for (i.e. Brock and part of Port Perry)
- Community Health Centres (CHCs) also have not been included in the attributed population.
- The care of seniors with frailty by CHCs, primary care nurse practitioners (NPs), Community Support Services (CSS), and specialty NPs (e.g. GAIN) who provide care is not included in the MOH attribution model
- Patients who leave the region for services not available locally are impacting

attribution data

The attributed data provided by the MOH suggests there are significant system costs associated with the Durham OHT populations. An initial focus on these populations will allow the Durham OHT to address and learn from the most significant system challenges and apply these learnings and identified savings to the entire Durham OHT population by maturity.

As the Durham OHT works towards maturity, the following challenges in serving the needs of the population have been identified:

- Significant growth in population aged 65 and older
- Increase in chronic disease (multiple co-morbidities)
- Increase in challenges with mental health and addictions (i.e. opioid crisis)
- Access to services in rural communities
- Equity challenges for the diverse communities served
- Understanding of socio-economic challenges

Opportunities to address these challenges will include:

- Connected care between primary care, hospital, home and community
- Virtual care services
- Support and integration of mental health and addictions services
- Promotion of health and wellness (education and health literacy)
- Primary care services for chronic disease management, as well as preventive health care
- Providing appropriate access to all residents
- Advocacy for healthier public policies that enable access to affordable necessities
- Inclusion of patients, families and caregivers in the planning of services

The Durham OHT has experience implementing a population health approach and will build on the successful collaborative models (described in Section 2.4) to improve population health.

At maturity, the Durham OHT will provide a full and coordinated continuum of health and social care to the entire population living and working in Durham and surrounding areas. This will include 24/7 access to care and system navigation services to ensure patients experience seamless transitions.

### 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*

In Year One, the focus of the Durham OHT target populations remain the same as identified in the self-assessment. The Durham OHT will continue to prioritize building more connected services and improve patient pathways to address two high-needs groups across Durham Region:

- Older adults living with frailty (OALWF) or at-risk of frailty and caregivers, and
- People living with complexity (PLWC) or at-risk of developing complex conditions and caregivers (may include some OALWF).
  - This includes adults, young adults, and children with high-need complex conditions; and
  - Includes patients living with three of more co-morbidities (COPD, CHF, Diabetes) and challenges with mental health and/or addictions.

The Durham OHT also recognizes the key role that mental health and addictions play for these populations.

While at maturity the Durham OHT will cover all health and social care for the full population of Durham, Year One will have a targeted focus on:

- Highest needs segment of Year One populations
- Community based care model
- People with high utilization of emergency departments (ED)
- Care coordination and navigation
- Access and connection to primary care
- Neighbourhood approach (bringing care closer to home)
- Development of interprofessional teams
- Inclusion of patients, families, and caregivers in the development of the programs

Additionally, the Durham OHT will focus on the OALWF who are 65+ and meet two or more of the following criteria:

- New diagnosis of one of the top ten costly HPG ranked disorders (MOH data)
- Have a caregiver with a high caregiver burden score
- Are isolated/no supports and/or experiences low socioeconomic status (that

impedes access to needed resources)

- DIVERT Score 3 or higher
- DIVERT Score 2 with PPS Level 70% or less
- Long stay in hospital
- May be currently designated Alternate Level of Care (ALC)
- At risk of premature institutionalization/hospital use
- Are considered to be individuals their clinical team/primary care providers are most worried about

As much of the data related to the above criteria is unavailable, the Durham OHT has used an algorithm created by D. Seitz (2019) that isolates variables indicative of frailty from ICES data to estimate the overall population of focus for Year One. In 2018, the population 65+ with indications of certain frailty related conditions in Durham Region was approximately 20,439. Of this population, 13,066 had an ED visit (one of the criteria), and 1,704 had more than three ED visits. In Year One, the Durham OHT will focus on the first 450 highest ED users within this population.

There may be some overlap with the target population for PLWC or at-risk of developing complex conditions with the identified older adult population. This population includes people of all ages with high-need complex conditions and was selected as a focus area due to the high needs nature of the care these patients receive.

The Durham OHT identified 493 individuals who met the identified criteria for being considered PLWC within the Durham Region, having three or more co-morbidities and both mental health concerns and/or substance use disorders. While accounting for only approximately 0.001% of the Durham OHT's attributable population, these individuals were responsible for 2.33% of all inpatient visits, 1.23% of inpatient discharges and 2.08% of ED visits. This population offers the opportunity to develop and pilot solutions to provide effective and efficient care and care transitions for those with the greatest needs, resulting in potentially scalable solutions for reduced health system costs and improved quality of life for the whole attributable population as the Durham OHT matures.

Looking specifically at paediatric complex care, Grandview Children's Centre's quaternary level developmental paediatrics and specialty teams serves over 6,000 unique children per year, including more than 1,500 children and youth with autism spectrum disorder (ASD) and 400 children and youth with cerebral palsy. The children's treatment centre experiences over 100,000 visits per year. As a targeted focus in Year One, the Durham OHT will collaborate with the Hospital for Sick Children to identify 25 children currently waiting for services who live in the Durham Region and who have also consented to having their name listed for contact, as it would be ideal to be able to deliver services to these children within their local community.

### 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

The Durham OHT has noted equity concerns related to: service access in rural communities, employment equity across the Community and Social Services (CSS) sector, culturally specific services for Indigenous and Francophone populations, disproportionate and growing socio-economic pressures specific to this region, and the pressures of overall population growth exceeds current capacity of many local resources.

The demographic and health status data provided identifies three socio-demographic groupings (Indigenous persons, immigrants/newcomers, and low-income individuals) that will require additional focus and specially designed initiatives to drive improvement in their health outcomes as the Durham OHT matures.

Durham Region is one of the fastest-growing areas in Canada, with the population expected to double by 2041 and with the overall growth in population, there has been a substantial increase in new immigrants. Based on the Central East LHIN Sub-Region data reported in 2016, over 30% of the Durham West Sub-Region are immigrants, totaling more than 107,000 individuals. This demographic subgroup is concentrated within Ajax as well as in Pickering, north of the 401. Chronic conditions such as diabetes rates are higher for this patient population, and the Durham OHT will need to consider specific engagement initiatives and outreach to immigrant services to provide equitable access to care and care outcomes.

[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.

Approximately 13,000 Indigenous persons live within the Central East LHIN. The local Indigenous community (i.e. Scugog First Nations) includes a small number of older adults who report challenges with the availability of local Indigenous health services related to personal support worker (PSW) retention (wages lower than outside the community), and limited capacity for dementia specific care.

Over 13,000 Francophones reside within Durham Region and there is limited French language service capacity (e.g. the Francophone Adult Day Program only operates two days per week). With a targeted emphasis in Year One on OALWF, the Durham OHT will need to pay additional attention to the Francophone population as it trends slightly higher in age than the general population to ensure that French language services are available as needed. The Durham OHT is engaging with Entité 4 to put mechanisms in place to identify Francophone patients and direct them to the services they require in a seamless and expedient manner.

The Durham Region's Healthy Neighbourhoods data identifies neighbourhoods that experience poorer health outcomes, such as downtown Oshawa and Lakeview. These neighbourhoods will require specific focus as they are low-income populations, represent the most significant percentages of Indigenous persons within the region, have a higher rate of complex conditions such as cardiovascular disease, diabetes and lung disease, and increased hospitalizations due to these conditions.

Residents of rural communities face a variety of barriers to access that limit their ability to obtain the care they need. Transportation, barriers to care including workforce shortages, and health literacy all require consideration as potential areas of focus for this population.

The loss of major employers in the region (e.g. closure of Sears in 2018, impending closure of General Motors in 2019, and the decommissioning of the Pickering Generating Station in 2024) is also having a dramatic impact on the socio-economic outlook for the region. If service fees are applied to health services or parking at health facilities, some individuals may choose to forgo treatments, prescriptions, and preventative health activities due to cost.

As the Durham OHT continues to evolve and develop, there is a commitment and identified importance of including Francophone and Indigenous communities in the evolution of the planning process moving forward.

## 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**.*<br><br>*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.*<br><br>*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.*<br><br>*Note here if a FHT is a member but not its associated physician practice(s) .*<br>*Also note here if a physician practice is a member by not its associated FHT (as applicable).* |

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| *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*

In April and May 2019, Lakeridge Health organized two half-day partnership summits to bring together Durham Region organizations to discuss the initial vision for an OHT in Durham. Partners ranged from healthcare, education, social services, to local

[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

municipalities and beyond. Following the first summit, a survey was sent to all attendees allowing them to self-select a level of partnership and involvement in the development of an OHT self-assessment submission.

Three levels of partnership were identified: supporter, affiliate, and formal alliance.

Supporter organizations wanted to be kept informed of the OHT development, participate in community consultation sessions, and receive regular communications about the progress of the OHT.

Affiliate organizations wanted to participate and contribute in the future to the OHT development, engage in co-creation around the vision and development of the future state care delivery approach for the OHT, and identified that they would consider transition to a formal alliance partner over time.
Formal Alliance members committed to provide resources to plan and implement the development of the OHT and to fully contribute and support the development of the self-assessment submission.

Through this process, 16 organizations identified as formal alliance members, with an additional organization committing to becoming a formal alliance member during the self-assessment development process. These 17 organizations, along with PFAs and several resource organizations have worked to develop the full OHT submission and over time, other organizations have identified as wanting to move from Affiliate to Formal Alliance.

At the time of this submission, the Durham OHT includes 17 formal members along with PFAs and several resource organizations.

The Durham OHT includes organizations that span the full continuum of care to well position the OHT to support the identified Year One populations of OALWF and PLWC and at maturity, the entire population of Durham Region. The Durham OHT recognizes that mental health and addictions services are critical to support Year One populations and includes local services, such as Durham Mental Health Services, to strengthen related service offerings.

Engagement and education about the Durham OHT to foster stronger primary care relationships will continue.

**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)**<br>*List the other teams that the member has signed on to or* | **Form of affiliation**<br>*Indicate whether the member is a signatory member of the other team(s)* | **Reason for affiliation**<br>*Provide a rationale for why the member chose to affiliate* |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | *agreed to work with* | *or another form of affiliation* | *itself with multiple teams (e.g., member provides services in multiple regions)* |
| *See supplementary Excel spreadsheet* | | | |

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

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

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

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

*Max word count: 2000*

The signatory organizations of the Durham OHT have a demonstrated past of successful collaboration and partnership to drive improvements in the healthcare system. These strong partnerships have advanced integrated care, shared accountability, value-based health care and population health. By integrating services, people have had a more seamless experience as their care needs change.

The following programs demonstrate some of the ways that the Durham OHT has already successfully partnered to impact health in the region and programs underway to continue to improve care in the future.

Members of the Durham OHT have made great strides in providing supportive home care to the growing population base living with Alzheimer's and dementia and people with age-related frailty living at home. An example of an active network within the Durham OHT that supports patients and their families and demonstrates an integrated

approach to care that provides value-based health care to the system is the Geriatric Assessment and Intervention Network (GAIN).

GAIN is a community focused interprofessional geriatric team that provides services and supports for individuals living with dementia and age-related frailty to support them to remain at home. Referrals can be from physicians, self and family referrals, EDs, and other providers and agencies. Interprofessional care teams include members from multiple disciplines and professions with extensive knowledge of this population and include geriatric specialist physicians. A standardized approach through an interprofessional comprehensive geriatric assessment means care for people is integrated and coordinated through a single care plan. This comprehensive assessment has been used for over 98% of new patients entering the program. In 2018/19, in the Durham OHT catchment, GAIN provided approximately 1,500 vulnerable older adults with the ongoing support they need and more than 500 people with dementia were assessed and/or diagnosed and supported.

The GAIN program operates under a unified governance approach that includes regional planning, co-design, standards development, process improvement, performance measurement, and shared funding, coordinated by Seniors Care Network. Many of the Durham OHT partners are already collaborating through this network. It was estimated that the program has saved nearly $3.9 million on long-term care costs for OALWF in Durham, based on the assumption that Durham based GAIN patients with a Clinical Frailty Score of 7 or higher (n=72) had their long-term care admission delayed by at least one year. In many cases the delay to admission was longer. Case management and active intervention is able to be provided at approximately $1500 per patient per year.

Numerous performance measurement indicators are tracked and reported including: the number of patient encounters; total caseload; the percent of referrals by referral source; number of cancellations and no-shows; and the third next available appointment post triage.

The Carriage House Reactivation Program, a partnership between Lakeridge Health and SE Health, as well as one of the Durham OHT’s other collaborating organizations, the Carriage House Retirement Residence, was a successful, innovative pilot (2019). This program created more efficient transitions from an acute care setting to post-acute care, allowing the patient to return to the community in a healthier state.

Recognizing an opportunity to improve patient care, quality of life and experience, while reducing the strain on acute care capacity, the three organizations partnered to develop and manage an alternative approach to caring for patients designated as ALC, or individuals at risk of becoming ALC. An immediate discharge destination, the Carriage House Retirement Residence, provided a lower-cost alternative for patients, reduced time spent within a hospital setting, and a better quality of life.

As a result, 29 patients experienced improved transitions into the community, through the 120-day pilot program. System savings of approximately $438,000 were realized through care being delivered in the lower-cost setting of a retirement residence.

Key success factors of the pilot program included the joint efforts of partners to determine patient eligibility, as well as open and consistent lines of communication between all partners. Shared accountabilities were embedded into the program through the development of a shared governance model. Please refer to Section 4.2.

Programming for the patients was collaboratively designed to improve strength, mobility, endurance and self-care ability – preparing patients and their families for a successful discharge home or to the community.

Several metrics were tracked and reported over the course of the pilot including: Hospital and Carriage House LOS; ALC days; number of care goals met; functional improvement measures; discharge destination; ED visits; and patient experience. During the pilot program, there were 106 admissions at Lakeridge Health and 47 discharges from the Carriage House. While the average length of stay was approximately equal, 17.1 days at Lakeridge Health and 17.4 days at Carriage House, there was a much longer maximum length of stay at Lakeridge, reaching 80.1 days compared to the maximum of 29.0 days at Carriage House. Of the 106 Lakeridge patients, 49 were designated ALC, totaling a combined 290 ALC days, an average of 5.9 days/ALC patient.

The North Durham Family Health Team (NDFHT) and Lakeridge Health have a Joint Discharge Project at the Port Perry Hospital. Through this partnership, a navigator from the family health team coordinates with their hospital counterparts to identify patients who are expected to be discharged shortly. This partnership was implemented to allow the navigator to connect with the identified patients while in hospital to ensure a seamless transition post-discharge into the community. This program has provided the opportunity to connect patients with services at the NDFHT immediately after discharge. Furthermore, the program facilitates making an appointment with a primary care provider within 7 days of discharge. The effect of this program on readmission rates is actively tracked and has just expanded to include ED visits. At present, this program focuses on patients who are connected to a primary care provider at Medical Associates of Port Perry (MAPP) and the NDFHT, but with the right partnerships in place could be expanded to include all patients

MAPP and Lakeridge Health worked closely together immediately after a fire at Port Perry Hospital to establish an enhanced urgent care at the MAPP clinic across the street from the hospital, as the hopsital had to close for a period of one year while repairs were completed. The enhanced urgent care saw many patients that would have otherwise had to redirect to other EDs across the region. The hospital provided some of the equipment necessary to run the enhanced urgent care and MAPP hired additional staff to run it. MAPP physicians who would normally provide service in the ED provided that service in the enhanced urgent care. These two partners worked

closely with the MOH to effectively respond to an unexpected event, a hospital fire. Sharing resources, funding, and equipment all led to the provision of many services that could now be delivered in the community despite the hospital being closed. This also helped to ensure that surrounding hospital sites were not overwhelmed with volume due to the closure. MAPP also worked with Uxbridge Hospital and provided additional physician resources to assist that hospital with the increase in volume.

A formal collaboration is in place between Lakeridge Health and Grandview Children's Centre to support infants and their families who access the Lakeridge Health NICU follow-up clinic. Grandview Children's Centre Occupational Therapists and Physiotherapists who have paediatric expertise attend the Lakeridge Health Oshawa NICU follow-up clinic and work with Lakeridge Health staff and the infant and children's family to provide the best possible care. Infants and children identified as needing the ongoing supports and services at Grandview Children's Centre, or who meet the organization's program criteria, receive a direct referral from Lakeridge Health and can transition to Grandview as early as possible for continued and often multiyear ongoing support and care. Through this partnership, the patient and their family are able to experience a seamless transition to Grandview with the same therapist supporting them from the NICU follow-up clinic. Families are also able to access additional required services provided by Grandview. The partnership has also allowed each partner to learn more about the other's supports and services, build capacity with their own knowledge base, ensure the right care is being delivered at the right time by the right provider, improve the quality of care and enhance the level of education provided to patients and families.

Partners in Community Nursing (PICN) collaborates with Lakeridge Health Oshawa surgeons to provide Enterostomal Therapy, which includes wound ostomy and continence care. This agreement has been in place since 2006. Services include pre-operative stoma markings and teaching to the patient and family. The continuum of care resumes upon discharge from hospital at home, as nursing services are requested and where teaching and patient engagement are a priority. As a result of patient and family feedback, PICN now provides further support through a free monthly West Durham Ostomy Clinic. This continuum of care has prevented ED visits and unnecessary admissions to hospital by having virtual and live visits to a population of patients with complex conditions. This collaboration creates a seamless transition of services and provides the patient with clear navigation and support from hospital to home.

Lakeridge Health and Durham Mental Health Services (DMHS) have developed a longstanding relationship to foster strong collaboration of clinical services between the two organizations. Two Memorandums of Understanding (MOU) are in place currently. The first was to create a new clinical team referred to as "Hospital to Home", focusing primarily on patients who were frequently visiting the Lakeridge Health Oshawa ED for mental health and addictions challenges. The second MOU resulted in the secondment of a recreation therapist and an addictions counsellor into DMHS programs with a focus on older adults. These are professional disciplines

available through the staff of Lakeridge Health that DMHS is not currently providing, increasing the range of services DMHS patients are able to access.

March of Dimes Canada (MODC) has existing relationships with various partners of the Durham OHT. MODC and Victorian Order of Nurses (VON) have a shared data agreement for the provision of the interRAI CHA tool for continuing assessments within community care. Additionally, MODC utilizes training and best practices through SE Health across the province for delegated health requests, and utilizes CBI training for in home activities of daily living.

The VON through the Durham site leads the Durham Palliative Care Community Team (PCCT), which is a formal partnership of providers across the spectrum of Palliative Care. VON staffs the PCCT hub, ensuring RN service navigation and spiritual support, community education, and other supports are available to assit the collaborative team. The PCCT is a multidisciplinary team who along with the circle of care provides holistic person centred palliative care to individuals from early diagnosis through to bereavement. This care includes community hospice support, disease management, physical, psychological, social, spiritual, practical, end of life care/death management, loss and grief support.

CBI is currently working with provincial hospital partners to transition patients out of the acute care setting into a restorative transitional setting, where they provide treatment geared at meeting their rehabilitation goals.

The Regional Municipality of Durham – Hillsdale Estates Long-Term Care Home and Lakeridge Health participate in a collaborative agreement to support the care of patients requiring peritoneal dialysis who become residents of Hillsdale Estates. The Provincial Peritoneal Dialysis (PD) Initiative was launched by the MOH in response to the continued rise in end stage renal disease, the escalating pressure needed to sustain current dialysis modality utilization practices, and the need for evidence-based, cost effective care to meet the needs of the elderly population and continued decline in the use of PD in Ontario.

The Region accepts up to six PD patients to Hillsdale Estates. The Hospital assumes responsibility for the PD care of these residents through a third-party service provider and the long-term care home manages all other care needs. The Hospital PD primary care nurse ensures proper coordination and communication with other health care providers at the long-term care home. Through this partnership, these higher acuity patients can be admitted into long-term care, and provide greater choice to applicants in the community who require this service.

Community Advantage Rehabilitation (CAR) works with Grandview Children's Centre to provide services to all five school boards in Durham - 257 elementary schools and 182 secondary schools. Working in collaboration with teachers and educational assistants, CAR services over 2,107 patients annually and performs over 14,500 visits within the schools.

The Alzheimer Society Durham Region (ASDR) works in partnership with Community Care Durham to provide respite options to persons living with dementia and their caregivers. In addition, ASDR works closely with Adult Day Programs across the region and provides dementia specific training and education to a wide variety of health service providers, including OHT partners, community agencies, and social service agencies. ASDR works in collaboration with multiple specialized geriatric programs (e.g. GAIN teams) providing navigation, counselling, and education to individuals living with frailty and their families.

Looking towards the future, the Brock CHC has started a capital project to develop a community health hub. Partnering with other Durham OHT signatory organizations, including Community Care Durham and the Regional Municipality of Durham, the Brock CHC intends to have dental operatories, community office space, and community gathering spaces at the site. Brock CHC is a community health centre located in the most northern part of Durham Region (Rurality Index of 40), operating out of three temporary rental locations in Brock Township with a “hub” type approach service to increase access to services for the community.

Currently, Pinewood Centre of Lakeridge Health, Ontario Shores Centre for Mental Health Sciences, Durham College, the Alzheimer’s Society of Durham, North House, Community Living, Silent Voices and the Ministry of Education Services Resource Teacher for the Hearing-Impaired access rooms to provide service to patients and community members. Brock CHC has a MOH capital project to build a 21,000 square foot permanent location which has been designed as a community hub. Funds for the non-MOH funded community sections of this project are being raised by the community. There will be dental suites, community rooms, Ontario Telemedicine Network (OTN) rooms, and community offices all in an accessible Cannington location. The Regional Municipality of Durham will be providing dental services in the dental suites, and Durham College Dental Hygienist Program has expressed interest in providing low cost dental services on site as well. Community Care Durham will also have permanent offices on location.

### 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 Durham OHT includes 17 organizations reflecting the broad range of health, community and social services and provider networks in the region (see Section 2.1.1 and 2.1.2). This includes representation from primary care (4), acute care (1), home care (6), long term care (1), community and social services (2), specialized children's services (1), mental health and addictions services (1), PFAs (3), and regional government (1). Members have formed a core initial partnership group (Steering Committee) charged with developing an integrated system of care via an OHT for Durham Region. Another 31 organizations that reflect a broad range of health and social services, specialized services, as well as Francophone and Indigenous services, have indicated their support of the vision for the Durham OHT in the self-assessment. An additional 40 organizations have come forward since to express interest in participating in the Durham OHT.

The Durham OHT includes all local CHCs, one of two local FHTs and a large FHO. Two additional large FHOs/FHGs have indicated support, and together these primary care enrollment models cover an estimated 197,000 enrolled patients. New partners that have expressed interest and commit to the Durham OHT vision and direction will be invited to formally join the OHT.

With representation across the full continuum of care and geographic area of Durham Region, the Durham OHT is well aligned with existing provider networks and with the deliverables planned in Year One and beyond. The Durham OHT is concerned that the current analysis of flow and care patterns completed by the MOH reflects the current, rather than the desired state, as many Durham residents leave the region to seek physician care that is not readily available locally (e.g. heart function clinics, specialized memory clinics, some specialized children's services, neurology services, specialized diagnostics such as positron emission tomography (PET) scans etc). Despite this outflow, these same patients will expect and require home care, community care, and social supports close to home, within Durham. For this reason, the attributed population is considered moderately aligned to our membership and network, as we anticipate far more demand for Durham OHT's full range of health and social services than would be predicted through the MOH model. Additionally, the available data used by ICES to map patient referral networks may not fully incorporate the amalgamation of Lakeridge Health Ajax Pickering from the former Rouge Valley Health System, an adjustment that will result in additional patients being referred to services within the Durham OHT, as opposed to a neighbouring one.

### 2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with.

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

### *2.6.1. Collaborating Physicians*

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

### *2.6.2. Other Collaborating Organizations*

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

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

Indicate what proportion of your Year 1 target population you expect to receive **integrated care (i.e., care that is fully and actively coordinated across the services that your team provides)** from your team in Year 1. Please provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who require integrated care will receive it.

*Max word count: 500*

In Year One, assuming caseload consistent with a complex population, and the direct support expected from Care Coordinators, 27 FTEs (1:35) will be required to serve the anticipated OALWF (450) and PLWC (493) populations. By maturity, it is expected that between 30-60 Care Coordinators will be required. It is the expectation that up to 75 FTE of the existing 500 FTE care coordinators at the Central East LHIN will be made available to the Durham OHT. These resources will work in collaboration with the clinical leads for each patient to ensure close connection between clinical and

| |
|---|
| case management activities. |

### 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*

As the Durham OHT expands the patient population and model of care, new members and services to address any identified gaps will be required. In Year One, the Durham OHT will continue to engage and collaborate with partner organizations who provided a letter of support to ensure the OHT is offering a full and coordinated continuum of care.

Work is well underway to partner with local primary care providers. The Durham OHT has hosted two primary care sessions with representatives across Durham Region. All Durham OHT working groups included a primary care physician to provide direct input into the identification of the Year One desired outcomes and targeted consultation with select primary care groups has also occurred for feedback on the Durham OHT's Year One plan and approach.

As the Durham OHT increases the range and volume of services, the Durham OHT

will continue to engage and partner with primary care, other providers and non-traditional partners across the region to promote health and wellness.

The Durham OHT will also continue to work together with PFAs to plan for the Patient Partnering Office, which will improve coordination and system navigation services and ensure patients are able to access care when and where they need it. This centralized office will be led by a regional Patient Partnering Officer with a mandate to develop, enforce, and champion the OHT's Patient Declaration of Values.

As the Durham OHT moves towards maturity, there will be a need to expand partnerships to ensure that the appropriate providers are involved to offer an integrated and coordinated continuum of care for the people of Durham Region.

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*

As mentioned above, work is well underway to partner with local primary care providers. The Durham OHT has hosted two primary care sessions with representatives across Durham Region. All Durham OHT working groups included a primary care physician to provide direct input into the identification of the Year One desired outcomes and targeted consultation with select primary care groups has also occurred for feedback on the Durham OHT's Year One plan and approach.

As the Durham OHT increases the range and volume of services, the Durham OHT will continue to engage and partner with primary care across the region to promote health and wellness.

### 2.10. How did you develop your Full Application submission?

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

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership, engagement, or consultation activities that took place and whether/how feedback was incorporated.
- If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and

whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.

- If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your team's attributed population/network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

*Max word count: 1000*

The Durham OHT used a collaborative process through which all 17 formal alliance members, along with patient, family and caregiver advisors developed the Full Application. The formal alliance members, patient, family and caregiver advisors and a few additional key organizations were full voting members at the Steering Committee, where each individual had equal voting.

The Steering Committee identified a number of working groups that focused on specific streams of work to support the creation of the Durham OHT full submission including: Governance; Clinical (3 groups); Patient, Family and Caregiver; Home and Community Care; and Digital. Each of the working groups included representation from across the Durham OHT membership and additional health, social services, and primary care providers, including primary care physicians. All of the working groups included representation from patient, family and caregiver advisors.

Each working group took accountability for developing specific sections of the full application and worked in collaboration to bring forward a recommended approach. All working groups had co-chairs representing various sectors and partners, with no one partner chairing more than one committee. This approach supported the collaborative partnership which the Durham OHT is founded on.

Working group co-chairs brought plans and recommendations forward to the Steering Committee where through consensus all decisions were made about the future of the Durham OHT.

Terms of Reference were developed for the Steering Committee and each working group, which outlined a decision-making process. The preferred method of decision making was by consensus, and where consensus could not be achieved, each organization received one vote. This submission reflects a consensus across the

entire Durham OHT and all partners are supportive of the approach outlined and formal voting was not required.

Patient and family caregivers were actively involved in all planning discussions and in the development of the full submission and were full voting members at the Steering Committee. These representatives provided insight and advice into the full submission, the design of the Year One initiatives and the implementation plans, as well as formed the Patient, Family and Caregiver working group, which outlined a process and broad approach for patient, family and caregiver advisors to be involved and embedded into the Durham OHT in the future.

Each working group included a primary care physician to provide direct involvement in the creation of the Durham OHT submission as it relates to clinical activities and objectives.

The Durham OHT engaged with Entité 4, the local French Language Health Planning Entity, to understand the socio-economic data in relation to the official language minority population within Durham Region and acquired meaningful data on the socio-demographic profile of the local Francophone population. Working closely with Entité 4 allowed the Durham OHT to ensure that the Francophone lens is incorporated throughout the application process. The Durham OHT will continue to work closely with Entité 4 to ensure mechanisms are in place to identify Francophone patients and refer them to services available in French in an efficient and interconnected way. Entité 4 is a supportive member of the Durham OHT and will participate on the working groups as requested.

The Durham OHT used KPMG consultants to facilitate Steering Committee and governance working group discussions.

## 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 Durham OHT has identified a focus on improving care for two key populations in Year One: older adults living with frailty (OALWF) and people (including adults, youth, and children) living with complexity (PLWC). This focus is supported by data provided by the MOH that suggests there is significant system cost associated with these populations. Individuals and families also report considerable burden associated with living and caring for people who are frail or complex. The Durham OHT believes that an initial focus on these populations will allow the OHT to address and learn from the most significant system challenges and apply these learnings and identified savings to the entire Durham OHT population by maturity.

For the selected patient population, in Year One the success of the proposed service transformation model will be demonstrated through reported improvements on the following key performance metrics:

- Avoidable ED Visits

- Patients in Hallway Beds
- 30-Day Readmission Rate for Selected Conditions
- Timely Access to Primary Care
- Patient and Caregiver Experience

These metrics will be indicative of improvements in reduced time spent in hospital; reduced harmful use of substances; improved overall quality of life and wellbeing and quality of life of the caregiver; as well as appropriate attachment to primary care.

By focusing on the outcome of reducing time spent in hospital, the Durham OHT intends to address key measures of health system performance and also begin to address major local health system pressures. The Durham OHT is also prioritizing an action area that reflects the expressed wishes of patients and families to receive services in an appropriate care setting.

People within the selected patient populations often require ongoing care, and in the absence of appropriate access, patients often seek care in the ED through reoccurring visits and readmissions. Utilization of emergency services by OALWF and PLWC provides only episodic care that does not support the continuum of care needs. A full continuum of care can prevent patient deterioration/complications and if these vulnerable patients are attached to appropriate low acuity resources, can reduce the burden to the healthcare system. In addition, the absence of consistent primary care support subsequently impacts the readmission rates to hospital, contributing to surge volumes that result in hallway heath care, and creates low provider and patient satisfaction within the system. The proposed redesigned model will enable timely access to primary care to support the reduction of avoidable ED visits, which will subsequently support improvements in related performance metrics.

In addition, the redesigned model will focus on reducing dependence on harmful use of substances as a response to challenges facing our community related to addictions, with or without concurrent mental health concerns. Further, focus will also be maintained on the outcome of improved overall quality of life/wellbeing and caregiver quality of life, consistent with the recommendations of the International Collaborative for Health Outcome Measures (ICHOM) Older Persons Standards and other international standards. This focus also correlates well to evidence linking lower health service utilization with higher quality of life across different populations. The system redesign will also support attaching patients with primary care providers. The appropriate use of primary care services will allow for chronic disease management care as well as preventive health care.

By optimizing the use of Comprehensive Advanced Palliative Care Education (CAPCE) certified nurses through formal alliance members such as PICN, trips to the ED can be reduced as well as hospital admissions for the end of life population who value being at home. ALC rates can be reduced as well with comprehensive in home assessments by the CAPCE nurse, and continuous collaboration with the physician. Symptom management, a critical part of palliative care, can be achieved at home to

improve the patient, family and caregiver experience. Identifying opportunities to utilize nursing specialties, such as CAPCE, will act as an enabler in achieving better outcomes in patient service delivery. Continued education, 24/7 support, and digital technology will ensure access of services for our palliative population.

Durham OHT members are well positioned to address the identified Year One focus. To support population health management and health system improvements, Formal Alliance members have strategically aligned, identifying assets that can be coordinated, to ensure services required to support the long-term medical and social needs of the selected patient population are effectively and efficiently organized. Improvements will be realized through the system redesign, as it focuses on integrating and coordinating Durham OHT members to efficiently utilize existing assets in the system. As a strategically integrated team, the assets include the full range of health and social service providers, including primary care providers, in Durham Region. System efficiencies will result from increased access to care, focus on preventative care, information sharing, and coordinated delivery of treatment plans. The combined output of these improvements will enhance clinical outcomes and value in the system.

The focus in Year One for OALWF will be 450 of the 1,700 individuals who demonstrate key indicators of frailty and who used the ED more than three times in 2018/19. For PLWC, the Durham OHT will focus on 493 individuals who met the identified criteria, which include having three or more co-morbidities and both mental health concerns and substance dependence problems.

Current baseline data about the Year One target population and related performance metrics is not available and will be part of the initial current state data collection activities (see Section 6 for implementation plan). From the attributed population, the proposed service redesign will result in improving care for the following proportion of the targeted patient populations by program maturity: 10% of the PLWC, 100% of paediatric and 50% of adult populations. For the paediatric population, some investments may be required along with utilization of existing resources as the service and supports do not presently exist to support Durham's children and youth living with complexity.

### 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*

In Year One, the Durham OHT members have committed to four specific change ideas related to the priority populations of older adults living with frailty (OALWF) and people living with complexity (PLWC). These change ideas are outlined below and are specific to the outcomes (performance improvement opportunities) identified in Section 3.1(see Appendix C):

- Targeted, comprehensive care management (delivered by key workers) for high ED utilizers (including older adults with frailty: adults with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes and mental health and addiction concerns; and children with complex conditions,
- Utilizing a measurement of Quality of Life (QoL) and Wellbeing as standard measures to support care planning,
- Care management navigation and coordination built into basic function of primary care (reallocation of Home and Community Care resources),
- Developing/scaling of distributed interprofessional/inter-service model (teams) embedded in primary care, beginning with sites with known service gaps.

To advance these change ideas and improve the care for PLWC and OALWF, the Durham OHT will organize and coordinate their services through Primary and Community Care Hubs (PCCH).

PCCHs will build on the learning acquired through existing successful local community hubs, community health centres, and family health team models. The Durham OHT's PCCHs will support primary care by enabling core services, for the target populations including:

- Diagnosis and initial/ongoing treatment of chronic disease
- Primary mental health and addictions care
- Supportive care in hospital, home, or community care facilities
- Health assessment
- Clinical evidence-based illness prevention and health promotion
- Education and support for self-care
- Support for the terminally ill
- Arrangements for response to urgent problems 24-hours a day, 7-days a week
- Service coordination, referral, follow-up, and follow-through
- Coordination and access to rehabilitation

PCCHs will serve as the physical and virtual location of integrated care delivery, via multi-agency teams, focused initially (e.g. Year One) on selected patient populations. This means the Durham OHT will locate PCCH supports in physical locations that leverage existing infrastructure (e.g. locations with space). It also means the Durham OHT will work to build virtual care capacity (e.g. optimizing e-consults, virtual visits etc.). To the extent possible, PCCHs will be positioned in areas of high needs and underserved communities to provide integrated and wrap-around services to

individuals, as close to home as possible. Key design features of PCCHs are depicted in Appendix D and outlined below:

1.Participant Identification
The Durham OHT will identify and segment the attributed population based on primary health care needs to allow the development of focused supports. In Year One, the focus will be on improving care for PLWC (adult and paediatric) and OALWF patients who meet identified criteria and have had multiple visits (three or more) to the ED within the past year. As PLWC can have various comorbidities, the proposed redesign will be focused on individuals presenting to the ED with medical conditions identified as high-cost health population groups (HPG) by the MOH, specifically COPD, CHF, diabetes and paediatric patients with complexities. Individuals with these select chronic illnesses will receive targeted supports (e.g. care management and interprofessional teams), delivered through the PCCH construct. In addition, factors related to social conditions, specifically income, housing and social supports, will be identified and included as a component of individualized plans of care, with multi-agency and cross sectoral solutions developed.

2.Interagency Team Creation
The Durham OHT will identify specifically skilled resources to be organized into multi-agency interprofessional teams that are designed to address the service needs of the selected patient segment. These teams will form the core human resources component of the PCCH and will be constructed of a range of pooled health and social service talent to support the medial and social care needs of identified individuals. Comprehensive assessment and goal-based care plan development will be key functions of the care teams who will also collaboratively deliver interventions, treatments and ongoing supports. Resources will be matched to individual care needs. Refer to Appendix E for several examples of matched interagency teams for Year One targeted patient segments.

PCCH resources involved in providing comprehensive assessments will identify and support the full care cycle of the patient. Team members will function at full scope of practice to meet the patient's care needs. These resources will be supported with access to leverage other specialized providers that reside within any of the alliance partner organizations.

3.Clinical Integration
In addition to the coordination of Durham OHT resources within the PCCH model, this redesigned model of care will also provide access to specialists, primary care providers and specialized allied health resources who will function in seamless partnership. By maturity, these highly skilled resources will be embedded within the PCCH, mostly negating the need for referral processes and facilitating access. This will support appropriate attachment to health providers (primary care and specialists) for patients that require care management support for complex needs.

Incorporation of primary care resources within the model will allow patients rostered

with the PCCH to receive joined-up support from both medical and social service providers. Such models have the greatest potential to reduce the reliance on emergency services for care that should be obtained in the community. This approach will also support proactive health promotion, chronic disease management, and illness prevention.

Specialists who can address prevalent comorbid diagnoses will also be embedded into the PCCH model. These specialists will support both the population, through direct service, and the health care team through capacity building activities.

4.Inclusion of Social and Economic Determinants
According to Health Canada, “primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury”.

The Durham OHT has approached system redesign through a primary health care lens. This is consistent with our definition of complexity, which recognizes that individuals often have medical and social needs that are difficult to address in isolation. These needs interact and anappropriate support for either health or social need significantly affects the benefits of the other. As such, assessment approaches used within the Durham OHT will consider the needs of both individuals and their caregivers and will include social and economic determinants that are known to have influence on the health outcomes. PCCHs will incorporate alliance partners with the skilled resources needed to support patient’s health and social care needs and play an advocacy role with respect to economic supports.

5.Co-designed Pathways
Durham OHT members will collaborate with patients, families, and caregivers to reorganize service pathways to improve coordination, patient transitions, and knowledge sharing, with the aim of meeting identified performance targets. These pathways will enable the integration of the best available evidence, to systemize its application to care throughout the Durham OHT.

Patients receiving care through PCCHs will have a comprehensive plan of care that reflects their unique needs. These plans of care will identify treatments, interventions and services that are required to address the patient’s unique care needs and circumstances. The plans of care will serve as a documented communication tool and service utilization profiles that will identify all medical and social services attached to the patient. Shared access by patients, their chosen caregivers, and their care team will support seamless transition of patients between providers within the circle of care.

6.Care Management
Patients will be actively supported to implement, follow-through, and follow-up their

plans of care by Care Coordinators who will be responsible for coordination of care and system navigation, inclusive of the following expectations:

- Clinical triage and screening
- Service identification and knowledge sharing
- Coordinating access to appropriate care provider
- Follow-up and follow-through support
- Monitoring the effect of clinical and social interventions

Care Coordinators will utilize standardized screening processes to identify services required by the patient and will serve as the one point-of-contact for providers, patients and caregivers. Care Coordinators will have knowledge of the services of all Durham OHT members and health and social services provided throughout Durham Region. Care Coordinators will be responsible for coordinating required medical and social care and support through relevant communication strategies and information sharing among providers. Care Coordinators will actively support patient navigation through the recommended care pathways, providing direct, follow-up, and follow-through assistance.

In addition, Care Coordinators will support the seamless transition of patients between and among services and monitor the interventions and the patient and care giver experiences. As the first point-of-contact for participants and families, the Care Coordinators will help to prevent unnecessary and avoidable service delays, support appropriate attachment to primary care, and contribute to the reduced use of unnecessary emergency services.

7.Digital Tools

PCCHs will leverage digital health technology to facilitate access to care, support efficient consults with specialized service providers and knowledge sharing with providers within the circle of care. Use of virtual care will increase the service capacity within the system. In addition, technology solutions will also be used to monitor and evaluate outcomes from the redesigned system. Please refer to Appendix B: Digital Health.

8.Key Metrics

At maturity, the Durham OHT will establish a core set of indicators in collaboration with its partners, patients and caregivers, and the MOH.

In Year One, the Durham OHT will focus on the following key metrics:

- Number of people in hallway health care beds
- 30-day readmission rate
- Alternate level of care (ALC rate)
- Avoidable ED Visits for selected conditions
- Wait time for first home care service from community
- Wait time for first home care service from hospital
- Patient and Caregiver Reported Experience Measures (including QoL)
- Timely access to primary care

In addition, patient's progress toward their goals will be tracked (e.g. goal attainment scaling) and reviewed by the clinical team. Evaluation of outcomes and results achieved will be a core responsibility of the Durham OHT with outcome measures collected centrally through the Project Management Office (PMO) and reported by the Steering Committee. Cost of services and intangible benefits will be documented to support return on investment (ROI) evaluation. Durham OHT members will have shared accountability for the services provided at the PCCH, which will operate through a collaborative governance model (see Section 4.2). The Durham OHT approach will foster a learning culture that encourages collaborative thinking and transparency.

In addition to identified patient outcomes, system outcomes anticipated from implementing the PCCH model will include appropriate use of system resources, which is supported by:

- Increased system access
- Reduced health system costs
- Increased system learnings (e.g. how best to shift from high-acuity resources to appropriate community resources)

The Durham OHT anticipates a 10% reduction in the unnecessary utilization of emergency services and readmission rates for the Year One target population with the implementation of the change ideas described above.

### 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.

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In Year One, the focus of care coordination will be for the target populations of OALWF and PLWC. Individuals will be identified and recommended to receive service from PCCHs at point of discharge from the ED, by primary care or community providers, through self-identification, or recommendation by caregivers.

In Year One, the Durham OHT will focus on care coordination activities that include:

- Participant identification (or self-identification)
- Triage and assignment to relevant interagency teams
- Service coordination, referral, follow-up, and follow-through
- Tracking of key performance metrics
- Digital information sharing

Care coordination activities will not include procurement, the management of existing service level agreements, or the integration of existing partners electronic health records systems.

Care coordination functions will be included in the case management roles envisioned for the Durham OHT. These roles will be integrated in the PCCHs as core team members, and function similarly to other embedded case management roles, with which we have prior experiences. Care Coordinators (i.e. key workers) may be any member of the interagency team and will function according to a set of core competencies that will be developed by the Durham OHT. Care Coordinators may include resources reallocated from existing LHIN human resources, which will be further articulated within the first 30 days through a detailed human resources

framework and workforce plan.

Successful care coordination within the new redesigned service model will require support from, but not limited to, the following key components:

Participant Identification

In the first year, patients will be identified to PCCH either at point of discharge from the ED, from primary care providers, community providers, or through self-referrals from patients and caregivers.

Service Providers

At the PCCH, Care Coordinators will be responsible for the patient's ongoing care needs and supporting knowledge sharing at discharge and/or transition from acute care to/from other community providers. Within the multi-disciplinary team, coordination of care will be supported through:

- Patient triage and intake for medical and social service needs
- Multi-disciplinary comprehensive assessment, identifying all aspects of the patient's care needs, including influence of social determinants on the patient's health and burden on the caregivers
- Durham OHT members pooling additional specific resources, to deliver physical or virtual care, ensuring enhancement of service capacity through additional resources within their organizations
- Integration of primary care providers and specialists, as per patient's unique care needs, within the PCCH structure to ensure services are delivered within the community
- Connecting unattached patients to primary care providers within the Durham OHT network (e.g. primary care partner and/or CHCs)
- Identifying and supporting resolution for issues that are barriers to care for patients (e.g. financial)
- Digitally enabled information sharing between Durham OHT members and beyond to ensure comprehensive clinical information

Provider Relationships and Shared Accountability Agreements

Many Durham OHT members have MOUs and service level agreements that have been in place for many years and have proven to be successful in providing coordinated care. For example, services delivered by the Geriatric Assessment Intervention Network (GAIN) are a joint venture between specialized geriatric services, CHCs, Alzheimer Society, CSS and Home and Community Care, while diabetes services are delivered in partnership with Lakeridge Health and solo-practitioners in Durham. In Year One, the integration of partners existing electronic health records systems will be out-of-scope, however, increasing digital information sharing will be an in-scope focus.

Within the new service model, appropriately skilled service partners will provide 24/7 service through providers that can complete a needs assessment of the patient. These providers will be skilled and knowledgeable in providing point-of-care assessment and determining where the patient should be directed for the best suited services based on their identified needs. In the early phases of the initiative, these providers will include ED personnel, while at full maturity having addressed any relevant medical/legal issues the responsibility for service coordination and system navigation will be expanded to include paramedic service providers.

Leveraging resources that can direct patients to the appropriate providers will reduce the inappropriate utilization of paramedics and emergency medicine services, often resulting from the patient's assumption of having to utilize emergency services as the only viable options for their care needs after traditional service hours. Instead patients will be connected to appropriate community-based providers at the PCCH that are suitably skilled to accept and manage the care of the referred patients.

As part of the network providers, coordination of care will be supported through:

- Consolidating information and knowledge sharing of care plans, service utilization and progress to ensure comprehensive care
- Early identification of patients' conditions to support timely care
- Formalized shared accountability agreements among providers
- Development of a shared quality improvement plan that focuses on the patient segment

Information Sharing Tools and Processes

To ensure service providers, patient and caregivers receive coordinated care, the redesigned model of care will leverage digital health tools. Electronic applications will be leveraged to share relevant information among the providers within the patient's circle-of-care. In addition, electronic capturing of key performance metrics and service utilization will support the reporting, evaluation and refinement of service delivery pathways and service agreements resulting in improvements to the service model.

Several Durham OHT members also have experience coordinating care across multiple providers. For example, local GAIN teams already include dedicated nurse care coordinators who support plans of care across multiple agencies to meet patient needs. Grandview Children's Centre has a long history of assisting families to coordinate care across health, social and educational sectors, among others.

### *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 success of the PCCH model in supporting patient navigation will be grounded in a comprehensive change management framework utilized across Durham OHT members. The change management framework will focus on patients being at the center of how they will access services as needed throughout the service continuum.

Care navigation will focus on connecting patients to services that support prevention, management and treatment of patient's medical conditions, and in addition, will support connections to services that address social determinants of health.

Care Coordinators within the PCCH will be well trained and knowledgeable on the redesigned model and services offered by the Durham OHT, to ensure full understanding of all services patients can leverage and corresponding pathways for seamless navigation. Care Coordinators will function as patient navigators, responsible for organizing and sharing information with providers within the circle-of-care on the care needs of the patient. This will require Care Coordinators to collects and share clinical information, contact service providers to schedule care, share information with patient, caregivers and providers, provide educational support to patients and caregivers as required, and function as the centralized point-of-contact for care management. Care Coordinators will ensure service navigation is patient centered and individualized to support the needs of each patient. In addition, Care Coordinators will also facilitate knowledge sharing of service options and benefits to patients and their caregivers, identifying any barriers to navigation, to ensure continuity and compliance issues are addressed.

Information on health system navigations will be provided through education programs, coordinated by the Patient Partnering Office, focused on facilitating knowledge sharing and building stronger network partnerships with other organizational key support contacts. Education will be offered to patients on an individualized (in-person or virtual) and/or in group settings throughout their continuum of care. Patient and caregivers will receive support in planning, coordinating and understanding services, through interaction opportunities with peers and care providers. Improved communication will support better understanding of care recommendations and will ensure health care services are effectively and efficiently utilized by providers, patients and the caregivers. Resources to support health system navigation will be made available to patients and caregivers. These

educational programs and supports will be coordinated and available through the Patient Partnering Office as well as through the PCCHs.

The system will embed the valuable roles of peer support and family and caregiver advisory groups that will provide an additional form of navigational support to patients and caregivers. Through centralized coordination of the Patient Partnering Office, these resources can provide input and feedback along with co-design support to improve services and raise awareness of challenges in service equity, specifically supporting racial and ethnic minorities and other underserved populations, thus supporting narrowing of health disparities. Through supporting a patients' care journey, peer support groups and family and caregiver advisors can inform and influence solutions and resolutions to deep-rooted issues related to distrust in providers and the health system, which often leads to avoidance in addressing health problems and compliance with care recommendations.

Implementation of digital health applications will allow an evidence-based repository of clinical information and a formalized channel of communicating with peer support resources. Currently patients and caregivers often search information through informal and insecure channels (e.g. Facebook) that can be misleading and inaccurate. By implementing secure knowledge exchange platforms, providers can also understand and address system barriers and solutions to ensure quality and effective integration of navigation services.

The targeted patient population is often challenged to receive services in person. As such, the redesigned model of care will leverage opportunities to support patient care navigation from alternative locations (e.g. supportive facilities). Options to access care remotely may require additional navigational support which will be accommodated through the team-based approach.

In Year One, the system navigation will be limited to service providers who deliver care within Durham Region. As the Durham OHT matures, patients care can be navigated beyond the boundaries of Durham Region.

### *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*
The proposed redesigned service model is focused on improving care transitions of

PLWC and OALWF from/to acute care and from/to other community providers. The model is founded on a provider network framework that collaboratively supports the patient's care needs with a common goal of improving their health outcome. A significant component of the patient's health outcome is influenced by the quality of provider interaction and knowledge transfer at stages of care transition.

The Durham OHT membership includes teams within the ED and PCCH that can collaboratively work together to achieve shared goals for improved health outcomes and improved value in the health system. Appropriate care transitions will support reduction in unnecessary utilization of ED services, reduction in readmission rate, improved knowledge that eliminates service redundancies, higher participation of self-management, greater patient and provider satisfaction, and overall reduction in health system expenditure.

In the current system, patients and caregivers are required to share their clinical details multiple times when transitioning to other providers. This has been identified as a significant pressure on the patients themselves or their care providers, both of whom are often not in the capacity to understand and translate the clinical information. As a result, lack of a strategic approach in managing care transitions can create a burden of inappropriate care expectations on the provider and the patient, variation in system utilization based on individual understanding, and unnecessary service costs.

Within the Durham OHT's redesigned model of care, a strategic focus will be on transition planning between service providers and care delivery locations leveraging the care coordinators and digital health applications. These resources will ensure appropriate information is collected from each service provider, consolidated to support the patient's care plans, and shared with other providers involved with the care delivery. Standardizing the format of information collection and knowledge sharing will support adoption, compliance, and consistency in utilization.

Care Coordinators will be a key driver of efficient and effective care transitions and are responsible for ensuring patients and their families experience smooth transitions from one care provider or sector to another based on care needs and recommendations with the plan of care. These resources will support navigating the patients through their care journey and serving the function as the patients designated care navigator. In addition, Care Coordinators will be utilized to provide "warm handoffs" between providers, encouraging clear communication and knowledge sharing. Patient and caregivers will work closely with Care Coordinators within an environment of shared-care planning, which will increase the desire to participate in self-management. The relationship with Care Coordinators, peer support, and family and caregiver advisors will also support care transition through enforcing the importance of compliance in follow up, monitoring and managing care to prevent health status deterioration.

Appropriate care transition also requires not only information sharing, but also

evidence-based decisions on what are the appropriate care pathway decisions and transition timelines for each patient's unique circumstances. The redesigned framework will incorporate knowledge sharing, collaboration, and education within the multi-disciplinary and multi-agency teams to facilitate improvements in care transitions. In addition, the model will support mechanisms to allow consistency in provider involvements, especially for care providers involved in paediatric services to ensure skill-based care provider relationships are stabilized and maintained over the continuum of care.

The Durham OHT members will deliver care transitions through service level agreements and memorandum of understanding agreements between partners. Current partners benefit from already existing partnership agreements in delivering care to complex patients who frequently utilize the services. There are existing community support services for adults focusing on mental health services, geriatric intervention services, diabetes community education programs and smoking cessation programs that engage in care transitioning processes. In Year One, these existing programs can be scaled to address gaps and increase capacity to service the attributed population. As Care Coordinators will be under the umbrella of the Durham OHT, they will therefore be able to direct patients to the resources that exist within any of the Durham OHT members and partnering organizations rather than being limited to a specific organization. Decisions around directing patients to a particular service will be made based on specific patient need rather than which qualifications they may or may not meet. In addition, during Year One, reporting and evaluation of the programs and services will be developed to measure success and early learnings.

### 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*

Currently across the Durham OHT members, programs and services offered adhere to evidence informed health literacy levels. Some are offered under frameworks utilized in Community Health Sectors and this work will continue as programs and services are scaled up. Currently, some programs are offered using the Stanford self-management model; these include smoking cessation, diabetes education, and pain management programs.

The utilization and engagement of Care Coordinators, key workers and peer supports workers will further support patients through self-management practices.

PLWC and their families/caregiver will be involved in the establishment of a current plan of care with goals based on the needs of the PLWC and the family/caregiver. Being involved in the establishment and agreement to the execution of the plan supports the family/caregiver and PLWC to be true partners with the care team in achieving the outcomes in the care plan expected.

Further, there are a variety of options that can be utilized to improve patient self-management and health literacy including:

- Development of Personal Health Care plans, supported through the use of technology
- Helpline – 24/7 monitored
- Health literacy 101 programming
- Patient education including disease specific education
- Personalized Information prescriptions
- Existing self-management tools (e.g. Taking Control of our Lives – dementia specific training)
- Caring for Myself: Client-Self Assessment: A process aimed at improving discharge planning though evaluation of patient engagement in self-care, knowledge, and efficacy for self-care at the beginning of each admission, at any point in time during an admission, and then again prior to discharge to determine improvement
- Chronic Disease Self-Management Program: A collective approach to chronic disease self-management including better coaching and teaching to facilitate patient/caregiver empowerment in managing chronic disease from a functional perspective

• Education for front-line staff on preparing patients for self-care and discharge readiness: Implementation of annual education for self-care as part of our annual education plans for front-line staff
• A virtual portal for patients and their caregivers with a telemonitoring application that allows for just in time education by comparing patient outcomes with self-care behaviours
• A virtual platform which provides support and resources to families and caregivers

A health coaching and navigator Centre of Excellence will be designed as part of the Patient Partnering Office to provide training, mentorship, continuing education, and digital health supports.

### *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*

Caregivers are an integral part of the healthcare team. The Durham OHT will recognize and support caregivers in order to improve the overall patient experience and create an environment where the highest quality of care is provided to both the patient and their caregivers. The PCCH will design services that are inclusive of the needs of the patient and caregivers. The interplay of the family, including living environment, financial situation, and caregiver capabilities, will be included as part of an initial assessment. Recommended care plans will be customized for patient's unique circumstances, and where required and possible, additional services will be included for successful implementation.

The Durham OHT will use a number of avenues to support caregivers through education/support and monitoring their health status in order to be able to continue to care for their loved one including:

• Engaging Primary Care physicians to begin asking the caregiver a simple question "And how are you doing today" as a means of early detection of caregiver stress
• Standardized and systematic caregiver assessment to be used by all OHT
• Central repository of caregiver services and educational materials –
• Caregiver education - general and disease specific will be delivered by the Durham OHT. Virtual delivery of education will be developed.
• Caregiver counselling and support (e.g. peer support groups, 1:1 counselling)
• Virtual connections to support groups when caregivers cannot leave their home
• Self-management tools for caregivers (e.g. Power Tools for Caregivers, CARERS/TEACH)
• Navigation to respite supports such as Adult Day services and community in-home respite
• Elizz – launched in 2015, a virtual platform providing support and resources to

caregivers in the form of blogs, 250+ original articles, caregiver chatbot, and a caregiver coach is available 24/7/365 for conversation and advice

• Caregiver channel – a single 1-800 phone number provides caregivers access to information and services 24/7, family-centered care and goal setting

• Caregiver involvement in care delivery

In Health Quality Ontario's yearly report, Measuring Up 2015, evidence showed a doubling of distress among family members, friends, and neighbours who act as caregivers for long-stay home care patients, especially those that receive publically funded home care services for a long or indefinite period of time due to diability, frailty or chronic conditions, such as dementia. The data, from 2013/14, showed that the more cognitively impaired and functionally disabled and frail the patient was, the more distressed the caregiver was likely to be, with 54.5% of caregivers distressed amongst patients with moderately severe to very severe cognitive impairment, and 56.1% of caregivers distressed amongst patients who were at the two most severe levels of health instability. Overall, the research found that one third of all unpaid caregivers experienced distress, anger or depression from their supporting role.

Caregivers education and training will be further scaled to address caregivers' burnout. In the region a number of partners are already delivering supports to caregivers through established frameworks e.g. GAIN teams and caregivers advisory groups.

Respite for families is a key component of being able to successfully care for PLWC in the home. Ensuring adequate respite for caregivers is built into the plan of care will be important.

#### *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*

For older adults living with frailty (OALWF), the identification and follow through will include the following:

Identification: Using the algorithm proposed by Seitz (2019, p. 24*), and a proportionate value of the Durham OHT 65+ population (34% of the Central East LHIN population), there are approximately 6,000 people living with frailty in the Durham OHT with one ED visit. As this number is not attached to specific individuals, the Durham OHT will further refine this estimate by replicating the Frailty Case Ascertainment Algorithm. The frailty cases (as identified in the algorithm), population 65+ who have had:

- One visit to the ED in 2018/19, or
- Two visits to the ED in 2018/19, or
- Three visits to the ED in 2018/19 or
- Greater than three visits to the ED in 2018/19.

Following: The Durham OHT will collaborate as partners and with patients and families to utilize coordinated care plans to track interventions, follow-up, follow-through and effect, and to follow patients through their care journey. This will be facilitated by dedicated nurse case managers embedded in primary care and will require reallocation of existing LHIN home and community care coordinator staff to the employment of local FHTs/CHCs in new roles. Additionally, tracking of trips to ED will inform us of effectiveness of our integrated 24/7 care model.

For people living with complexity (PLWC) – Paediatrics, the identification and follow through of the Year One, 15- 25 families will include the following:

Identification: The Durham OHT will collaborate with The Hospital for Sick Children's Complex Care Team to determine children living in Durham that are waiting for services from the Sick Kids Complex Care Team. These children would be ideal candidates to receive care services within their local community. In addition, the Durham OHT will review the current 75- 100 families with children living with complexity at Grandview Children's Centre who have consented to having their name on a list for contact. The Durham OHT will continue to work with families to obtain consent to ensure there is a current listing of all families in Durham who are seeking care intervention.

Recent data from the Institute for Clinical Evaluative Studies suggests that close to 300 families living in Durham are supporting children living with complexity who meet the Complex Care for Kids Ontario (CCCKO) definition. When the data review is expanded to include adjustment to the definition beyond the CCKO definition the number grows to close to 800 families.

Following: The database created by consolidating information on all the PLWC patients will allow the identification of patient's care needs for service coordination. These patients will be attached to a Care Coordinator to support coordination of

medical and social care services for the patients and their care givers.

### 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*

Carea CHC, as one of the Durham OHT members, has expertise and is a leader in the region delivering programs and services to Indigenous communities across Durham with partnerships with DRAAC. The programs are collaboratively delivered by Carea CHC and Indigenous community leaders. There are current existing collaborative agreements supported by Durham College and Ontario Tech University in building capacity within the community. Carea CHC delivers more than four Indigenous programs annually through cultural safe traditional approved methodologies.

MAPP and the NDFHT currently provide primary care services at the facilities of an Indigenous community. A family physician provides a weekly clinic to meet the needs of this community. The Durham OHT will leverage this relationship and existing activity to further enhance services delivered to this community. This could be supported by the continued active involvement of primary care.

SE Health has invested in a dedicated First Nations, Inuit and Métis (FNIM) Program

for nearly twenty years. Through partnership and collaboration, the program works to enhance and support the capacity of FNIM communities across Canada to understand and solve complex health care issues, improve access, and address barriers to care.

The FNIM Program is a shining example of social innovation that has delivered meaningful and sustainable results. A leading model of collaborative partnership, the program leverages knowledge and technology to support community-led approaches to health and wellbeing and provide virtual education at no cost to community health care providers. The program has been offered on a national level since 2011 and now reaches 70% of First Nation, Inuit and Métis communities across Canada. The FNIM Program is firmly fixed on creating and maintaining meaningful community partnerships, which requires a high level of mutual trust, respect and collaboration. All content is developed in full partnership with First Nation communities to ensure it is relevant and culturally rich. In addition, an Elder Network provides insight and advice to the program team as appropriate, as well as guidance in areas of tradition and culture.

Over the last several years, the Central East Regional Cancer Program's (CE RCP) Indigenous Cancer Team, located at Lakeridge Health, has visited all four First Nation communities in the Central East region, in partnership with the Indigenous Cancer Control Unit (ICCU) at Cancer Care Ontario. These sessions are designed to provide an overview of the past and current Indigenous work being completed as part of our Indigenous Cancer Plan, and to receive community feedback and direction regarding the unique needs of each of the First Nation communities in the Central East. The partnership between members of Lakeridge Health (e.g., CE RCP Indigenous Navigator, Kathy MacLeod Beaver) and the Missississaugas of Scugog Island First Nation represents a unique and important opportunity to continue to collaborate in the development of the Durham OHT.

Indigenous peoples face unique health challenges and substantially poorer health outcomes than the general Ontario population. In a geography as diverse as Durham Region, Lakeridge Health and the CE RCP must do everything we can to meet the diverse needs of everyone who comes through our doors. This past year, Lakeridge Health hosted an open house for the Indigenous communities, celebrated National Indigenous Peoples Day, have created a smudge ceremony policy and developed an Inclusion, Diversity and Equity (IDE) Council. This Council recently hosted Dr. Jason, Pennington, Regional Indigenous Cancer Lead, who presented on the Indigenous history and the path to well-being.

### *3.7.2. How will you work with Francophone populations?*

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

Describe whether the members of your team **currently** engage Francophone

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

*Max word count: 500*

The Durham OHT will continue to collaborate with FLS HSPs and Entité 4, the local French Language Health Planning Entity, through community consultations to ensure engagement with the wider Francophone community.

The Durham OHT will seek to address issues specific to Francophone patients. An important first step is to clearly demonstrate the availability of FLS. It is critical for FLS to be offered actively, to be communicated clearly, visibly, and be readily accessible and equivalent to the quality of services offered in English. The Durham OHT will seek to take measures related to communications, including but not limited to signage, notices, social media, as well as the time of initial contact with Francophone patients.

To continue to enhance FLS capacity, it is important to ensure the continuum of FLHS. The Durham OHT hopes to actively offer services in French, including navigation and care coordination to services, to increase integrated access to services for the Francophone population. Furthermore, the Durham OHT will collaborate and liaise with Francophone Care Coordinators from Home and Community Care to work towards an equitable continuum of care for Francophones.

The Durham OHT will use the FLS designation criteria to help with the structuring of FLS. Examples include developing and working towards an OHT FLS capacity recruitment strategy with support from Entité 4, as well as an FLS policy and appropriate communication standards. We will additionally seek to systematically capture patients' linguistic identities.

The Durham OHT will also encourage staff and partners to complete the FLS Active Offer training to better serve Francophone patients, their caregivers and families. Furthermore, the Durham OHT will continue to collaborate with Entité 4 for innovative advice and support when engaging and caring with the Francophone population.

Carea CHC provides translation services for Francophone populations through professional interpretation services for patients requesting services in the language and many other languages. Additionally, the Alzheimer Society Durham Region (ASDR) provides French language services to caregivers of those living with dementia. Educational support and resources, as well as family/caregiver support (1:1 and group) is provided by staff who are fully bilingual. ASDR is a member of the Durham Francophone table, a network of cross sectoral service providers who all provide services to the Francophone community in Durham Region.

Lakeridge Health offers interpretation services, free of cost to patients for patients/families with limited proficiency in English and/or deaf/Hard of Hearing. Services are provided by Access Alliance and Canadian Hearing Services and also available 24/7, both emergency (real-time) and by appointment. Access Alliance provides interpretation in over 180 languages and can be accessed over the phone, face-to-face in person and face-to face virtually.

Providing services in the official language that is most comfortable for the patient has many benefits:

- Improved access to health care services, particularly disease prevention and health promotion
- Improved disease prevention
- Decreased demand for health care and decreased waiting time
- Better communication and improvement of the therapeutic relationship
- Better assessment of health status
- Quicker and more precise diagnoses by improving the efficiency of primary, secondary, and tertiary health care providers
- Better compliance to prescribed treatments
- More positive clinical outcomes
- Increased understanding of and adherence to prescribed treatment
- Greater patients' satisfaction
- Better health care
- Reduced incidences of risk management issues of service delivery
- Francophone populations will benefit from digital services that will be offered in both English and French.

### *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*

The Durham OHT will strive to work as allies with the Indigenous populations and Indigenous service providers to ensure there are programs and services that appropriately meet the needs of the Indigenous populations. The Durham OHT will look for Indigenous leadership to guide this development and will engage the current Aboriginal Patient Navigator and MRP for Scugog. The Durham OHT will utilize current resources such as the First Nations consultations for the Dementia Capacity Plan.

The Durham OHT will engage with Entite 4 to ensure a coordinated effort to address

the Francophone population needs. Plans will be coordinated with Les Centre d/Accueil Heritage.

The Durham OHT will engage on the rural part of Durham Region (North Durham) to ensure they are represented in planning as they experience significant barriers to accessing services in Durham Region (geographic isolation, transportation, availability of resources).

Current regional statistics, as described in Section 1.3, have identified further populations experiencing equity challenges. The Durham OHT will continue to gain knowledge, implement action plans, and evaluate impact on quality of life for all populations at maturity.

The Durham OHT will collaborate to service children and youth who meet the standard operational definition for Children with Medical Complexity as per Complex Care for Kids Ontario (CCKO) with the expanded inclusion of other elements. These will include:

- Technology Dependent and /or user of high intensity care
- Fragility
- Chronicity
- Complexity

AND

- Have a caregiver with a high caregiver burden score
- Isolated/No supports
- Experience low socioeconomic status (that impedes access to needed resources)
- Long stay in hospital

In addition, Carea CHC, as one of the Durham OHT members, recognizes many populations face discrimination that harms their health and wellbeing. The priority will be to provide appropriate access to everyone, no matter who they are or where they live. Accessibility requires breaking down all racial, cultural, linguistic, physical, social, economic, legal and geographic barriers that prevent people from accessing health services.

The Durham OHT will work together to address the homeless population as homelessness can impact people's ability to respond to life's challenges. The most pressing health conditions for the homeless population are tied to our target population of PLWC, such as mental illness, chronic condition and addictions or substance abuse.

The Durham OHT will serve people facing socio-economic challenges and provide additional supports, such as transit tickets to get to health appointments, counselling on how to secure employment or access to additional social services and peer support groups.

### 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*

Engagement of the diverse populations (Indigenous, Francophone, Rural, Ethnocultural) in planning will be targeted but will remain sensitive and outreach in nature. Examples of engagement include outreach focus groups, surveys, and telephone town halls. The Durham OHT will utilize existing networks and contacts to ensure representation is appropriate.

The Durham OHT will utilize existing PFACs, Client Advisory Committees, existing caregiver/patient groups to connect and collaborate with patients, families and caregivers as we develop services, programs and processes.

A Patient Partnering Office (PPO) is planned to ensure collaboration efforts exist, are inclusive, sensitive, appropriate and that the consumer voice is incorporated. The following aspects are proposed in the design of the office:

- It will be a centralized office led by a regional Patient Partnering Officer with a mandate to develop, enforce and champion the OHT's Patient Declaration of Values
- Supported by a Regional Patient, Family, Caregiver Advisory Council/Patient Family Advisors (PFCAC/PFA) to help coordinate the stronger and broader input of all PFAC/PFA participants from the OHT and to ensure that patients and caregivers are able to share their voices as part of the decision-making process
- The PPO team will gain from the deep understanding, knowledge and information given by the Patient Family and Caregiver Advisory Council members
- A health coaching and navigator Centre of Excellence will be designed as part of the PPO to provide training, mentorship, continuing education and digital health supports
- Also responsible for the activities such as:
  - Co-designing ways to enhance patient navigation improve transitions and enhance equity
  - Engage patients, families and caregivers with the intent to collect and share best practices, lived experiences, recommendations on how to improve our health care system and assist in helping to identify gaps in the system
  - Leading overall performance improvement activities
  - Coordinating performance and outcomes measurement across the entire region
  - Coordinating complaint and review functions
  - Leading implementation of real-time Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs)

| |
|---|
| Throughout care redesign, Durham OHT members will utilize patient and family feedback tools to ensure alignment with patient, family and care giver wishes. |

# 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*

Durham OHT members have much in common as collectively demonstrated though the organizations' goals, values, and operating practices and reflecting a shared commitment to deliver integrated, high quality services to people. This collective commitment is centred on a shared value of quality of care and service, and is grounded in the work completed to-date in planning for the future system of integrated care and service in Durham Region.

Included in the shared values and foundational to the Durham OHT is the integration of patient, family, and caregiver advisors' involvement. Patient, family and caregivers are and have been full partners and decision-makers in the development of the full submission and active participants in the co-design of the Year One action plans.

As good stewards of public funds, the Durham OHT will explore innovative models of care, novel partnerships, and new ways of delivering service that will lead to better outcomes for people living in Durham, while providing the most effective and efficient model of care to achieve better outcomes for defined patient populations. The Durham OHT's mission is to provide integrated care through delivery of safe, quality, connected care to people when and where they need it. The words trust, respect, supportive, compassion and advocacy are found throughout members' mission and value statements.

Grounded in the Quadruple Aim and the principles of the Institute for Healthcare Improvement, all members of the Durham OHT are focused on improving population health within the region by partnering to improve health equity and access at a lower cost with a focus on quality, innovation, partnership, and patient service while improving the provider experience.

The Durham OHT's shared belief is that through partnership, best practice, and effective use of digital tools, that system improvements, including how we as providers support our teams, will result in more connected, more appropriate care and service, which supports best outcomes for people and reduces caregiver burnout. Members of the Durham OHT have different financial models (for profit and not-for-

profit) and operate in different environments (unionized and non-unionized), yet it is the collective desire and commitment to provide accessible and equitable health care and service across all of Durham Region. It is recognized that there are potential operational, legislative, and regulatory barriers created by differences in how funding is obtained and allocated within individual organizations. The Durham OHT will work with Ministry partners and funding bodies to eliminate barriers so as to maximize the return on investment by creating value for patients, improved outcomes, and better connected services.

The Durham OHT is focused on implementing best practices to guide future delivery systems. Given the broad range of health and social services currently offered throughout the Durham OHT collaborative, there is an opportunity to leverage existing services and utilize expertise on a go forward basis. Alignment of existing and best practices is currently being shared amongst the Durham OHT collaborative, and will continue to build on the momentum as we continue to plan.

The Durham OHT is committed to equity and is actively pursuing it. Going forward, the Durham OHT is dedicated to collectively:

- Measure and improve patient outcomes
- Use resources more effectively and efficiently
- Further the use and availability of digital tools
- Collaborate with our partners throughout Durham Region to enhance health and wellness

Further, the Durham OHT is committed to the fundamental philosophy of providing the best care and the delivery of services grounded in the Quadruple Aim and focused on system building.

The overarching goal is to build upon our shared commitment and success of working together to meet the needs of Year One priority populations to create a fully integrated system for the future.

### 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 Durham OHT has agreed to a Governance Structure to support decision making for Year One initiatives.

The transitional Governance Structure in Year One will include establishing a Steering Committee with equal sector representation. The Steering Committee will notionally include: primary care, acute and sub-acute, home and community care, along with patient, family and caregiver representation. Each sector will have equal voting members on the Steering Committee, and it will have no more than 15 members.

Steering Committee membership is limited to employees of the Durham OHT with each member having a single vote, and with equal votes distributed between the various sectors (e.g. Primary Care – three representatives; Acute and Subacute – three representatives; Home and Community Care – three representatives; Patient, Family and Caregivers – three representatives).

The Steering Committee mandate is coordination and decision making to support delivery and achievement of Year One initiatives.

The Steering Committee will be responsible to report on progress of Year One initiatives to the full Durham OHT membership on a regular basis (e.g. quarterly).

Further, the Steering Committee will lead activities to:

- Develop an MOU outlining how partners will work together to deliver Year One initiatives, including (examples) commitments of partners, performance reporting, process for procuring services; resourcing of initiatives
- Establish a Year One workplan and operations plan
- Adopt a conflict resolution framework to support Durham OHT and Committee function
- Develop a performance monitoring framework to measure progress, inform decisions and guide quality improvement
- Establish a standards working group to implement agreed upon care pathways
- Establish a governance liaison
- Establish Patient, Family and Caregiver Table/Committee

The Durham OHT is committed to utilizing and implementing best practice approaches to ensure and enable achievement of Year One goals and deliverables. A Project Management Office (PMO) will be created using existing Durham OHT resources to support Year One initiatives. The PMO will report progress to the Steering Committee.

The Mandate of the Steering Committee is based on:

- Existing funding agreement including Service Accountability Agreements remain in place
- Individual Member's Governing Bodies remain in place and delivery the fiduciary duties associated with their individual organizations
- Funding decisions of the Steering Committee are focused on net new funding.

Project Management Office

The Durham OHT is committed to ensure financial resources are focused on providing patient care. To that end, it will leverage existing resources to assist with the day to day management of Year One obligations. The Durham OHT is committed to work towards a dedicated resource to coordinate and lead project plans in Year Two. There will be no change to the existing employment contracts of PMO resources in Year One.

Building the Durham OHT

Along with the day to day delivery of Year One initiatives, the Steering Committee will support the strategic growth and development of the Durham OHT by supporting ongoing awareness, education and engagement of health and social service providers across the Region.

In additional to the 17 Formal Alliance members in the Durham OHT, there are an additional 40 Affiliate partners that have not yet formally signed onto the Durham OHT as well as dozens of other Supporter organizations who are connected and not involved. It is the intention of the Durham OHT to continue to build capacity through a strategic and phased-in process beginning with reaching out to Affiliate partners who meet an identified care or service gap. Over time those Supporter group members

who are ready to join will be added to the Durham OHT.

While important to bring members onside as soon as possible, it will be important to continue to support stabilization of the Durham OHT through a measured approach to growth.

The Durham OHT has agreed to continue to provide opportunities for broader participation. A path to membership will be created to allow supporters and other interested organizations to participate at an appropriate level.

The Durham OHT will be a standalone partnership created through the MOH. Durham OHT members will continue to have various agreements, formal and informal, with other health and social services providers, outside of their Durham OHT membership to fulfil legal and volume agreements. See Appendix F for the Durham OHT's Year One Transitional Governance model.

### 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*

• In Year One, the Durham OHT will expand existing tools and capabilities to enable the safe (consider privacy and security) and meaningful sharing of data. As the Durham OHT matures, new functionality will be introduced to provide improved capabilities and capacity to share patient informationand to improve the overall experience of care for patients utilizing the services provided.

• Expansion of toolsets will include extending access to Durham OHT members to contribute and consume/access information from common data repositories. This approach includes:

o Expanding the use of existing tools to share patient information
- CHRIS
- Connecting Ontario
- Remote access to Hospital Information System (HIS)

o Providing new capabilities
- The creation of defined common data sets and population of a shared data lake to act as a Health Information Exchange
- Patients to contribute to the data lake with their own data. For example, data through Internet of Things (IoT) devices, patient diary, etc.

The Durham OHT data lake will be populated with clinical content from all members, matching a data standard shared by each contributor. Data will be submitted in near real-time allowing for active decision making and meaningful coordination of services.

• Full agreement across partners, specific to Clinical Data, to not tolerate any form of "Data Blocking" (data blocking would be where a partner withholds information form another partner, this can be seen at times where there may be a competitive advance to hoard the data).

• There are a number of safeguards in place to support sharing of share patient information across the Durham OHT including:
- Data sharing agreements
-Technical limitations to require valid authentication and authorization
- Data in transit will be encrypted
- Data to be stored in secure location, protected by firewalls and active monitoring
- Data interchanges will support and adhere to patient consent directives
- Communication to patient populations – privacy notices will need to be updated

•There are also a number of barriers:
o Current legislation – allow open access and an opt-out process
o Only hospitals are able to contribute to Connecting Ontario
o Lack of provincial standards for minimum data sets - while the Durham OHT could create and define our own standards, each OHT will also create their own standard and we will exasperate the inability to interconnect systems across the province. To enable localized use and also satisfy the need to scale, a provincial standard for health data sets is required.
oLack of Patient Identification Authentication and Authorization System (IAAS) – in order to provide patients with digital access to their health records, they must be authenticated. There is no set of unique identifiers that is universally captured by the health providers that will enable patient authentication. Therefore, a per organization identification process is setup, this leads to a patient have multiple sign-ins to a variety of online tools. An IAAS will allow a patient to have a single set of digital credentials to access their records across a variety of platforms and support multiple systems feeding a single portal.

•In addition, there are supports/enablers that are needed including:
o Data Sharing Agreements
- Communication to patients
- Consent directives (opt out only)

See Appendix G for Data and Information Sharing Models.

#### *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*

All Durham OHT members have confirmed that their organization has no performance or compliance issues with governance, financial management, legislation, or regulation. All Durham OHT members agree to work in good faith towards a formal Governance Model. As such, partners are committed to signing a Memorandum of Understanding (MOU) that encompasses due diligence of compliance obligations.

All Durham OHT members (both current and future) are required to commit and adhere to clear performance management guidelines focused on attaining Durham OHT goals. Where an organization indicates moderate challenges with performance, it is incumbent upon the organization to develop a reasonable action plan and detailed implementation strategy to address such challenges. Durham OHT members are expected to actively contribute to support one another in an effort to improve overall team performance. A commitment to mutual accountability consists of offering support, shifting resources as needed to ensure team success (i.e. educational tools and/or guidance) and providing training or other resources should they be available within the Durham OHT membership.

There are eight key performance indicators that the Durham OHT has prioritized in Year One:

- Patient Satisfaction;
- ALC rates;
- Improvement of avoidable ED visits;
- Patients in hallway beds;
- 30-Day Readmission Rate for Selected Conditions
- Wait Time for First Home Care Service (from Hospital)
- Wait Time for First Home Care Service (from Community); and
- Timely access to primary care.

Durham OHT members will support each other to improve overall patient satisfaction and access throughout the continuum of care. Creation of a Patient Partnering Office

which is focused on supporting people to navigate the system, standardizing assessments and care pathways where it makes sense, providing patient/client focused communications and promoting health literacy among the population is a key enabler to shared success.

Further, the Durham OHT will develop metrics and reporting guidelines to support proactive monitoring and measuring success to inform decision making as well as result in early identification of performance concerns. Metrics will be reported and reviewed quarterly against a set of annual targets.

A shared Durham OHT Scorecard/Performance Report/Dashboard focused on Year One initiatives will be developed by the Steering Committee. Common indicator definitions will be developed by the Steering Committee to enable Durham OHT members to collect a standardized data set where applicable and appropriate. Durham OHT members will be responsible for ensuring that data can be retrieved in a timely manner and can confidently withstand reliability and validity measures, optimized through digital enablement.

As the scope of the Durham OHT matures to serve the entire population of the region, the governance structure will shift and evolve to ensure enhanced performance measurement, reporting, and performance management.

As outlined by the MOH, the intention at an OHT's maturity is to move towards a single accountability agreement with Ontario Health. Also evident for team performance enhancement is that a duplication of services may need to be eliminated. Not all organizations may have the capacity to meet benchmarks and the KPIs are an opportunity to find out and realize anticipated efficiencies. The Durham OHT anticipates combining back end office functions (i.e. administrative work), to ensure efficiencies as an OHT are realized. A single agreement will ensure accountability amongst team members to ensure performance or compliance issues are addressed.

### 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*

The Durham OHT is built on a strong foundation of quality and performance improvement initiatives. Many of the Durham OHT members and broader Affiliates and Supporters have formal quality and performance improvement plans. Further, many organizations are committed through their values to continuous improvement and learning as a core component of their organizational strategy including conducting regular Quality Improvement meetings, reviews, and training/education/learning sessions within their organizations (employees, physicians, partners).

Several organizations track historical data that support quality and performance improvement initiatives and decision-making processes. A few organizations have established programs for staff and front-line education to promote continuous learning, and identify ideas that drive quality and performance.

Most Durham OHT members have a history of partnerships on quality and performance improvement and continuous learning, grounded in the Triple and Quadruple Aim. The Durham OHT is committed to developing and reporting on joint performance indicators and data to inform continuous improvements in quality, outcomes and patient experience while lowering cost as demonstrated through existing partnerships and projects:

- Durham OHT members have co-designed standards, process improvement, performance measurement and evaluation processes for programs including GAIN and the Carriage House Reactivation Program (Lakeridge Health, SE Health, and Carriage House). This experience provides a foundation of shared performance measures that may be used for Year One focus areas.
- Critical to the success of the Carriage House Reactivation Program has been the

joint effort to design patient eligibility, dedication to having patients articulate, and commit to their own care goals, and open and consistent lines of communication for all partners. Metrics are tracked and reported including, Lakeridge Health inpatient and Carriage House LOS, ALC days, Number of Care Goals met, Functional Improvement Measures, Discharge Destination, ED Visits and Patient Experience.

• SE Health's research team conducts co-design to optimize patient and caregivers' experience used in the Putting the Patient at the Heart (PPATH) program. As a result, educational materials were redesigned to reduce anxiety and improve self-management (which are currently being implemented and impact is being measured).

Strong representation of Patient, Family and Caregiver Advisors and clinical expertise is recognized as essential to successful performance improvement plans. The central Durham Patient Partnering Office (PPO) will have the mandate to collect feedback from patients and families, support and co-design performance improvement plans with clinical partners, support and provide guidance on system navigation, support implementation of real-time PREMs/PROMs including functional impact to patients and caregivers, and host education and learning opportunities.

Durham OHT partners are committed to creating synergies by utilizing the best information and resources of each organization to improve care delivery and outcomes. Each Durham OHT member is committed to continuous development and innovation through supporting research and education.

Quality improvement across all partners will be aligned with the desired outcomes of the Quadruple Aim including enhanced outcomes for a defined patient population, improved patient experience of care (including quality and patient, family & caregiver satisfaction); better provider satisfaction (reduced burnout) and lower cost and better value for funders.

In an effort of good faith and mutual accountability, all Durham OHT members will commit to continuous performance improvement and learning through collaboration and mentorship. Partners will have a minimum number of professional development hours annually and are committed to host workshops to enhance the quality delivery of service, support best practice updates and improve the overall health literacy of the community. Through these sessions, Durham OHT members can leverage their individual strengths in order to enhance the performance within the region. For example, indicators and an evaluation of the PCCTs are new learnings that can be leveraged by the Durham OHT members in development of the Year One performance measurement program.

Durham OHT partners are committed to creating synergies by utilizing the best information and resources of each organization to improve care. Each member is committed to continuous development and innovation through investing in research and education. Quality improvement across all partners will be aligned with the desired outcomes of the Quadruple Aim to create a better patient, caregiver, and provider experience, better value and efficiency, and better patient and population

health outcomes.

Working directly with hospital partners, SE Health has been at the forefront of multiple programs created to tailor better population health management. Two examples include:

• Putting Patients at the Heart (PPATH): An example of a transitions of care program, PPATH is a program for patients and their caregivers undergoing cardiac surgery. Working in partnership with Trillium Health Partners, patients and caregivers, an improvement opportunity was identified with respect to both acute post-operative length of stay and the experience of transitioning home following cardiac surgery that led to the design of the PPATH program. The program aims to improve the patient and caregiver experience as well as add system value through improved used of acute care resources

• The North York Central Collaborative for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) Patients: The North York Central Collaborative for COPD and CHF Patients is a partnership in care between SE Health, North York General Hospital, the Central Local Health Integration Network Pro Resp., and Circle of Care to implement a bundled care initiative for patients with mid to late stage COPD and CHF. This Transitions of Care program was focused on both monitoring recovery from an acute exacerbation and education to improve self-care and self-management. As an established in-home/facility care provider, our teams engage in formal industry partnerships, including working collaboratively with other community service providers, hospitals/clinics, pharmacies, and medical supply companies

As a Best Practice Spotlight Organization (BPSO) for 15 years, SE Health has implemented a number of best practice guidelines over the years such as patient centered care; dementia, delirium, and depression; and end-of-life care. This work continues to make a great impact on care outcomes and continues to ground their approach to improvement, continuous learning and organizational growth. As a founding BPSO, SE Health has provided mentorship to many organizations over the past 15 years as they have initiated their evidence-informed practice journey. Lakeridge Health has the following examples of experience with quality and performance improvement:

• Patient Directory – this initiative developed as a result of hearing feedback from patients and families about lack of information and communication about hospital processes, services and general information about being a patient at the hospital.

• ED Wait Experience Enhancements – this initiative stemmed from feedback about the wait experience in the ED, particularly at LHO. In the Spring, a group of Advisors and staff came together to strategize and discuss how the wait experience could be enhanced.

See Appendix H for Durham OHT Accreditation of signatory members.

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

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

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

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

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

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

*Max word count: 500*

The Durham OHT recognizes the importance of system co-design with the voice of the patient, caregiver and family members actively participating in system planning. The majority of Durham OHT partners identified patient/client surveys as a primary source of patient input. Some organizations use the information collected via survey to inform their strategy, policy and operations. Methods utilized by Durham OHT partners to engage patient, family, and caregivers as partners to enhance practice include:

- Co-design sessions on care plans and service delivery i.e. patient journey mapping;
- Participation in courses related to health care innovations;
- Patient committees that participate in quality improvement through policy development; and
- Focus groups, community advisory committees, and workshops.

Durham OHT members have demonstrated a history of meaningful patient, family, caregiver and community engagement through previous initiatives, including sub-region planning tables with Patient and Family Advisors (PFAs). Providers are reporting standardized outcomes and leveraging patient-reported measures to transform quality-based initiatives into value-based outcomes. It is the intention of the Durham OHT to scale these capabilities to measure patient experience through a Durham Patient Partnering Office (PPO). The PPO will be committed to co-design enhanced navigation of the system, improve transitions (e.g. dedicated navigators) between providers, enhance equity across the region, manage the central brand and coordinate a collaborative patient, family and caregiver advisory function.

We are committed to evaluating and refining existing patient and family engagement principles (e.g., HQO's Patient Engagement Framework) to address the community's needs and meaningfully engage with patients, families and caregivers. The Durham PPO will champion the Durham OHT's Patient Declaration of Values, monitor patient reported outcomes and experience data, and connect with existing Patient and Family, Client or Caregiver Advisory Committees to develop a regional PFA. This network of advisors will support a PFA function to provide input, feedback and advice to the Durham OHT governance and leadership structure. The Durham OHT digital health platform will gather feedback from all stakeholders to further inform this work. The intent of the team will ensure that organizations identified to have limited patient engagement in quality improvement and practice change, will adhere to minimal standards developed by the team as a whole.

Through creation of this regional PFA, the Durham OHT through the PPO will ensure that organizations identified to have limited patient engagement in quality improvement and practice change will be empowered and enabled to meet a set of standards developed for implementation across the region.

The creation of the PPO has broad support amongst the Durham OHT membership and was co-developed by members and the patient, family and caregiver advisors of the Durham OHT. Patient, family and caregiver advisors sit as decision makers to inform and influence the work of the Durham OHT and are involved at all stages of planning, implementation, and continuous quality improvement of the Durham OHT. Their contribution brings invaluable insight to the enhancement of the patient experience, and the OHT is committed to continuing in this co-design process. PFAs are active and committed members of the Durham OHT.

PICN is actively rolling out a Partnership Care Plan that is co-developed with the caregiver, patient and family upon admission. The intention of the plan is to ensure alignment of patient input when developing goals and outcomes. The Partnership Care Plan is reviewed ongoing and adapts as needed concluding with a signature to solidify engagement and accountability by both parties to achieve goals.

### 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*

Most Durham OHT partners gather broader community input and identified a few examples of community engagements including partnerships, formal agreements and informal programs and projects focused on: community health, engagement activities, and high involvement in ensuring evidence-based decision making at all levels.

Collecting input from the broader community has resulted in Durham OHT member organizations within Durham Region being able to deliver leading practices in culturally safe care for First Nations, Inuit and Métis communities.

By collaborating with municipalities and regional organizations, Durham OHT members have been able to increase the level of support in community housing initiatives. Working with the target community will identify services that would reduce the need for hospital care. For example, basic foot care prevents infections that if left uncared for can lead to serious health issues. This same community is often unable to keep primary care appointments due to transportation challenges. Collaboration with the Community Support Services sector created a referral program that helps get people to their appointment.

Recent community engagement at Lakeridge Health led to >20,000 points of input and highlighted broad community support for an integrated delivery system in Durham. In a poll during that process, 70% of respondents identified seniors living with frailty and transitions as the most critical challenges.

The Durham OHT received letters of support from Indigenous and Francophone communities in the region.The Durham OHT also recognizes the need to ensure equitable access to services for these communities. The Durham OHT will continue to work closely with Entité 4, the French Language Health Planning Entity, to put in place mechanisms to identify Francophone clients and refer them to services available in French.

### 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 Durham OHT has a demonstrated track record of previous experiences and initiatives managing cross-provider funding for integrated care. A few of the Durham OHT organizations have developed a patient level cost tracking method that ensures their data is connected with the hospital data to get an overall picture for a patient's episode of care.

Most organizations identified previous experiences and initiatives where they have managed cross-provider funding for integrated care:

- Regional programs for the Community Support Services, such as the Home at Last (HAL) program
- Administration of the York Simcoe Brain Injury Program (nearly 30 years): This includes case management, neurosciences and personal rehab
- Transitions in care programs supported by innovative funding models, including bundled care funding:
- PPATH at Trillium
- Lakeridge Health – Carriage House Reactivation
- Michael Garron Reactivation
- SSW Trillium and Halton – Hip and Knee Bundled Care Services
- Mackenzie Health

In order to enhance access to nursing services for complex needs children, PICN collaborates with private, and third-party coverage agencies to augment funding provided by the LHIN. For example, Catulpa and Resources for Exceptional Children are funding sources that optimize quality for our patients and their families by increasing available nursing hours.

# 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 proposed system transformation is designed to achieve key health system improvement goals, specifically focusing on improving the care, experience and value received by People Living with Complexity (PLWC) and Older Adults Living with Frailty (OALWF) patient populations. The implementation plan highlights key activities that will support achievement of Year One performance improvement targets for both population groups. Key change initiatives will focus on:

- Establishing a Primary and Community Care Hub (PCCH) model and implementing care coordinators to support the care coordination and management, system navigation and service transition needs of identified patient populations
- Developing and scaling distributed interprofessional/inter-service models in primary care
- Utilizing Quality of Life (QoL), Family Quality of Life (FQoL) and Wellbeing as standard measures to support care planning

These key initiatives will require significant implementation processes that have been indicated below in time categories:

30 days:

The following work will be concurrent to the Durham OHT Steering Committee development and creation of a MOU between Durham OHT members.

- In order to initiate the system redesign planning, a thorough current state analysis will be completed to evaluate the existing health system services delivered by Durham OHT members and to develop a defined scope of service redesign. The primary focus of the analysis will be to build detailed service profiles, which will identify resources, capacity, SWOT and patient care pathways. Through these profiles, partners will be able to identify unique strengths, service redundancies, alignment opportunities and service gaps. This step will include identification and exploration of interprofessional service models (e.g. FHTs, GAIN, CHC), standards of practice and competencies.
- Develop baseline trends of service utilization, including patient volumes, acuity and services utilized within each alliance partner's environment. In addition, high ED utilizers resulting in new visits and 30-day readmissions will be identified. These data elements will help develop organizational specific improvement metrics in later stages. As part of this work, a lead partner will be selected to lead data collection of new performance indicators and report ongoing performance.
- Developing a methodology and initiate the identification of patients that meet the definitions of PLWC and OALWF. The identified patients will be noted in a system (e.g. patient registry, EMR) and tracked for future service attachments.

• Build knowledge and agreements among partners to develop an integrated system of interprofessional primary and community care that will serve as the hub and spoke model for delivering care. This initiative will identify, at an operational level, the service delivery structure and the resources that will be needed to deliver effective and efficient care to the identified population.

• Partners will identify evidence-based literature review and tool identification for best practices (e.g. for backlog reduction and quality of life instruments). In addition, a HumanResource framework and workforce planning (e.g. transfer of Home and Community Care (HCC) staff) will be completed.

• Assess all participant groups to determine if they have a Patient, Family and Caregiver Advisory Committee

These key deliverables will be initiated to support and improve current service offerings in advance of OHT implementation.

60 days:

• Facilitate the development of targeted interventions that are designed to meet specific health goals of the targeted population. This will include the delivery of comprehensive assessments for target population. The paediatric population, more advanced with existing processes, will merge initiation of patient intake and delivery of comprehensive assessment at this stage.

• Develop service agreements, data sharing agreements and MOUs within the Durham OHT Transitional Governance Model and coordinated through the Project Management Office

• A Data Sharing Committee will explore digital information exchange processes and/or other processes that will enable indicator collection across multiple systems.

• Key resources will be identified, such as the care coordinators/key workers required to deliver care under the redesigned approach. A plan for training and education will be developed through the PMO and all resources identified as part of the Durham OHT redesigned service model will begin receiving training for interprofessional team-based service delivery.

• Develop a common terms of reference for the Durham Patient, Family and Caregivers Partnering Councils

90 days:

At this milestone, the Durham OHT will be in the position to select and implement the model of care that redesigns the system for greater service coordination and system navigation. The Durham OHT will focus on training resources and supporting the implementation of the comprehensive assessments to the targeted population. Plan of care development and knowledge translation will be a key focus during this phase.

As this stage, the Durham OHT through the Steering Committee (Transitional Governance Model) will continue to develop service and data sharing agreements, formalizing the agreed relationships in MOUs within the guiding principles of OHT

governance.

6 months:

At this stage, the redesigned service model will be fully implemented and growing in service capacity. Early outcome results will provide opportunities for the Durham OHT to collaboratively evaluate the initial progress and recommend changes for improvement. The Steering Committee will have completed the required MOU agreement for all members and any other service agreements required to support service advancement.

### 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*

Recognizing the scale of the anticipated change to partners and the region and drawing from formal change management approaches (e.g. HQO's SWITCH Framework, CHSRF, NHS), the Durham OHT will embrace a systematic approach to change management. The change management processes and activities will be approached in four general stages, highlighted as follows and as seen in Appendix I:

Stage 1: Getting Ready for Change
Steps to include: Understanding the context and dynamics of change; determining the readiness and capacity for change
Durham OHT Current Status: Becoming versed in the expectations of OHT, and gathering information, evaluating current state, building on prior collaboration

Stage 2: Implementing Change
Steps to include: Setting direction to improve effectiveness; setting direction for efficiency, accountability and financial sustainability
Durham OHT Current Status: Setting common vision, mission, goals and objectives; working collaborative to build out OHT application and plan; focused literature reviews identified in implementation plan

Stage 3: Spreading Change
Steps to include: Strategies and tactics to transform models, approaches and organizations; strategies and tactics to influence organizational culture (and build a new culture)
Durham OHT Current Status: Further development of plan, once OHT is confirmed

Stage 4: Sustaining change
Steps to include: Monitoring and assessing change effectiveness and success across:

•Process
•Staff
•Organization
•Patient Experience

Durham OHT Current Status: To be developed

Change Management with Primary Care Providers:

Work is already underway to partner with local primary care providers. In addition to the primary practices already committed, and those indicating support (see Section 2.5), the Durham OHT has hosted two sessions with primary care representatives from across Durham Region. Communiques have been distributed through formal and informal networks, and the identification of the Year One desired outcomes was completed by the OHT's Clinical Working Group, which included several primary care leaders. Primary care providers have signaled a willingness to participate fully in the development of the Durham OHT and to lead where appropriate.

Clinician Leaders

Several clinical leaders have been part of the development of the Durham OHT Self-Assessment and Full Application and will be instrumental in helping their peers to embrace and embed change. These leaders include the leads for Palliative Care, Specialized Geriatrics, Complex Paediatrics, and Primary Care.

### 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*

The Durham OHT has expressed that current care levels for OALWF and PLWC are not sufficient due to unmitigated service demand, brought about by dramatic population increases across the region (e.g. 54% increase in the population aged 65+ over the past 10 year). Despite these concerns, the Durham OHT members have pledged to make every effort to maintain current service levels for patients who are not part of the Year One population. At the same time, the Year One population overlaps almost entirely with the total population of OALWF and PLWC, and the Durham OHT believes collaborative efforts may result in improvements that will serve all OALWH and PLWC.

The partners have identified several strategies to assist the Durham OHT to maintain existing service levels and mount new strategies in Year One. These include:

• Engagement of New Specialists

Two geriatricians have recently been recruited to the Durham Region and are not yet at full capacity. The Durham OHT intends to discuss opportunities to assist with the

target population with these new specialists.

• Exploration of Time Limited Staff Release
With the assistance of staff temporarily released from usual duties (e.g. nurses, OTs etc.), there is an opportunity to escalate comprehensive assessment process for a short duration, to help identify patient needs and establish plans of care for the target population in Year One.

• Recruitment of Care of the Elderly Primary Care Physicians
Across Ontario, there are 143 Primary Care Physicians who hold certification in Care of the Elderly (COE), and additional primary care physicians who hold focused practice designation. Only 30 COE physicians currently practice in collaboration with specialized geriatric services. This suggest an untapped resource pool that might be engaged to support the Durham OHT. Such recruitment efforts would be enhanced by the development of an Alternate Funding Plan (AFP) with the Durham OHT, which is a known facilitator for COE Physician practice.

In the PLWC paediatric population, access to coordinated complex care services does not currently exist in Durham. The children and families requiring these services, who will not be part of the Year One cohort, will continue to access the care they need from multiple and often disconnected sources. Grandview Children's Centre provides access to three full time Developmental Paediatricians who work to collaborate across Grandview and the community to ensure families with the highest needs receive the required care.

### 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*

Health system related factors that can create barriers to change within the proposed system redesign include fragmented management of health service providers, lack of communication between allied resources, restricted access to patient's health records, unconsolidated funding structures and limited reinvestment of system-based savings to sustain the service model. Further, there is limited understanding and support mechanisms in place to address the correlation between health services and the impact of social determinants that often prevents the patient's from receiving full benefits of the health services available to them. Investments in the health system need to be appropriately distributed to support the intersection of health and social determinants.

The proposed model of care is designed to address the medical and social needs of the referred patients as part of a comprehensive and wrap-around service delivery approach. To effectively deliver these services, dedicated

resources will need to be positioned within the PCCH structure that can support the intake, triage, assessment, and service coordination needs of the referred patients. These resources will support the ongoing service coordination and navigational needs of the patient. As the model is designed to support patients with multiple complexities these centralized resources need to be scaled to support the patient volumes and must have diversified and specialized skills to manage the complex care needs appropriately, improving outcomes through increased efficiencies.

Thus, limited access to and/or the absence of centrally controlled resources (human, capital and supplies) can create challenges in implementing a well-coordinated and integrated health system. With different organizations controlling the release of centralized resources, the system can be challenged to execute a population health focused system redesign. In addition, the system must also have the capacity to address the unmitigated volumes within the system.

Within the redesigned model of care, once the patients have been assessed and provided recommendations, the care management will also require support from additional resources within the partnering organizations to deliver the care, manage the patient and to share the clinical health information with other relevant providers within the circle of care. In the current system, there are significant barriers in connecting circle of care providers in an efficient and effectively design that creates strong communication and collaboration channels. Barriers exist due to the current privacy legislations that limit the access and sharing of patient's health information. In order to facilitate care coordination, the system will need to be responsive to the needs of knowledge sharing among the partners within the care network. Through a resolution of the barriers to sharing patient's health information, the proposed redesigned model will facilitate collaboration among the partners to develop a network framework that allows supporting services to be connected as required without access barriers. These networks will be built to uniquely service each population group and will be organized as specialized clusters of relevantly skilled service providers partnering together to address the unique needs of each selected target population group. The reorganized partnership connections will provide transparency of the available resources, unique expertise, and accountability of partners, all of which will begin to organize and structure resources around the patients care needs. This approach will allow a clear identification of capacity and expertise required to support patient's health outcomes.

To support the establishment of this model, partners will also have to address the issue of employee contracts, including union and collective agreement issues. As a result, the successful implementation of the model is dependent on the resource participation agreements and approvals to share clinical information among partnering providers.

### 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*

Centralized resources that would support the success of the Year One implementation plans include reporting and evaluation resources that can consolidate information and report on the key performance metrics of each partnering organization. These resources will provide information that reflects the collective impact of the new model of care, allowing the offsetting changes within partnering organizations to be captured. Access to information on the key performance indicators will also support revising components of the model of care based on actual performance results.

Another non-financial support that would provide significant benefits is communication and promotion services. These resources would be instrumental in supporting the changes in service utilization pathways by making patients, caregivers, and providers knowledgeable of the new redesigned service model. Information sharing would encourage the uptake of the model and will also result in greater collaboration.

The option to have resources that support the IT application available to patient, caregivers, and providers would increase utilization of the available applications. Often the primary reason for low uptake of technology-based resources is the perceived difficulty due to the lack of familiarity with the applications. By providing greater support, the utilization and compliance levels are expected to be higher.

### 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<br>• Quality/patient safety | • Human resources<br>• Financial<br>• Information & technology |

| | |
|---|---|
| • Other | • Other |
| **Compliance Risks**<br>• Legislative (including privacy)<br>• Regulatory<br>• Other | **Partnership Risks**<br>• Governance<br>• Community support<br>• Patient engagement<br>• 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*<br>A scenario describing how the interventions outlined can work following implementation can be seen in Appendix J. |

## 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*<br>This appendix is based on information available at the time of drafting. Notwithstanding that this application is non-binding, we submit this appendix without prejudice and acknowledge our reliance on the Ministry to work with all OHTs to |

resolve the issues noted below in order to maximize our commitment to deliver population-based health care.

In developing new models, there are key issues for the Ministry of Health to take into consideration, providing both guidance and direction to OHT candidates. These include: labour relations strategy, including a plan to manage compensation equity issues across sectors (compensation includes total rewards (e.g. wages, benefits); provincial standards that allow for local OHT delivery, but set consistency across the province; and procurement strategies that enable OHT agility for service design and delivery, removing historical barriers.

Full integration of home and community care service is essential to the success of the Durham OHT. Outlined below is a proposed plan for how home and community care could be improved and fully integrated into the Durham OHT. Members of the Durham OHT look forward to working with the Ministry on the future model of home and community care, including alignment to a provincial framework to ensure all Ontarians receive equitable care, and implementing this next phase of transformation.

Durham OHT's future vision for delivery of home and community care is guided by the following design principles:

1. One patient – which includes an individual (patient) and their support system
2. One comprehensive care plan – a triaged assessment with early identification in the community
3. One accessible 'go to' contact – whether a care plan navigator or care coordinator
4. One I.D. and shared record
5. An informed patient/caregiver with a focus on self-management and health promotion
6. Durham OHT - one stop shop, one high quality brand, no wrong door, reduce doors, no individual agency mandate
7.Patient choice about where to live (and die), how to communicate with the care team (phone, text, video, patient portal or in person)

Additional key enablers of the future vision include:

- 24/7 access to care and service
- Centralized scheduling system to facilitate continuity and stability for care support services
- Innovative funding models and outcome-driven metrics (i.e. bundled care)
- Increased use of digital enablers for in-home virtual care delivery, i.e. use of apps for self-management

The Durham OHT will implement a delivery model that enhances the experience of patients/caregivers and providers. Some key elements of our vision are described below.

Quality of Life Teams

To support better integration with home and community care, the Durham OHT will enhance and expand the traditional view of primary health care and implement quality of life (QoL) teams with a Primary Lead for both patient navigation and care delivery. In this model funding dollars will follow the patient and it will not matter which organization the team lead is from. The QoL team will be trained to support health care needs and wellness using a holistic view and work with patients and their families to form a multi-disciplinary team to address health care and social issues as well as identify pathways to wellness.

The Primary Lead will manage a set of standardized assessment tools and have access to a comprehensive database of community specific programs and services available in Durham Region. Care coordination will go hand in hand with care delivery versus being a standalone activity.

QoL teams will maximize wellness of patients by incorporating social service agencies, nutritional needs, and community support services into patient care plans while also addressing the patient's medical needs. A standardized process for connection will be established and available from various points of contact to ensure the needs of both hidden and visible complex cases of care are addressed. Selection of community specific providers will be established, and this team will remain with the patient through the development and follow through of the QoL care plan. Critically reviewing progress and providing direction and cueing for the wellness team will support sustainable and effective health care for patients throughout Durham Region.

The QoL teams will include the patient (and family where appropriate), primary care providers, medical and therapy professionals and social service providers necessary to support the specific needs of the patient and located in patient's community (where possible). The strengths, challenges and needs of the patient will be assessed through standardized testing and assessment. This information will be used to develop a comprehensive acute treatment, wellness and QoL plan specific to the patient's individual needs. Each member of the QoL team will share responsibility for follow through of the care and wellness plan as directed by the patient.

Milestones and accomplishments will be identified and measure progress toward the identified care plan goals. Processes and goals will be critically reviewed to understand barriers to, or indicators of success to support building of best practice methods to maintain a sustainable and working home and community system. In Year One, QoL teams will address the targeted patient populations including people with complex conditions and seniors with frailty or at risk of frailty. The work of the QoL teams will extend at maturity to all residents requiring this service within Durham Region.

Key Elements of the Vision

Team Based Care

In Year One, Formal Alliance members supporting the Primary Community Care Hub (PCCH) will collaboratively deliver care to patients with complex conditions/medical needs through a team-based approach. This coordinated approach will increase access to timely care, interactions between patients and providers, and participation and shared-care responsibility.

One Assessment
A common assessment tool will be implemented with a focus on:

- Baseline assessment for all individuals at 75 years of age
- Comprehensive geriatric assessment by interprofessional team when issues escalate
- Continuous cycle of assess + re-assess, as situation changes
- Documented advanced directives, wishes, goals – accessible to all team members
- Model follows the frail senior irrespective of where they are in the Durham OHT
- Full participation of the patient, family and caregivers.

One Quality of Life Plan
The team will receive the request for service (from the patient/hospital/community) and develop the QoL Plan in collaboration with patients and families. The QoL Plan will document and update as needed the patient's health care needs, requirements and activities to ensure the best possible quality of life. As modifications are required, all parties involved in the wellbeing of the patient will update/add to the QoL Plan to support a continuous cycle of assess and re-assess, as a patient's situation changes.

### 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 Durham OHT has identified Older Adults Living with Frailty (OALWF) and People Living with Complexity (PLWC) as the focus of Year One initiatives.

There are approximately 1,700 individuals who demonstrate key indicators of frailty within Durham Region and who used the ED more than three times in 2018/19. Seniors included in the Year One population are typically 65-years-old or older, with varying abilities to manage daily living activities within a home setting. These people may or may not be attached to a family physician and will have had experience with varying types and intensity of home care services.

For people living with complexity (PLWC), the Durham OHT will target individuals within select patient populations (Complex Paeds, COPD, CHF, diabetes and mental health). This would include people of all ages with high-need complex conditions. Supporting these individuals is a Year One focus due the high needs' nature of the care these patients receive.

Potentially 100 per cent of Durham OHT's Year One target population will require comprehensive home care support following initial assessment and planning.

Specific home and community resources that may be required to manage the care needs of Year One patient populations include:

- COPD and CHF: Respiratory Therapist, Dietician and RN care in the home
- Diabetes: Registered Dietician, RN, Registered Social Worker care in the home
- Mental Health: NP, RN care in the home
- Paediatrics: NP and administrative scheduling supports for clinics and team reviews

Support teams, which will encompass home and community resources will be developed with the intent to decrease the presence of frailty and complex conditions to achieve a state of independent function.

The Durham OHT will innovate the delivery of home and community by developing and mobilizing Primary Community Care Hubs (PCCH) that will provide appropriate comprehensive care and wrap-around services for people with multiple complex conditions, addressing both medical and social needs.

In Year One, home and community care will be enhanced through:

1.Creating an inventory of all current integrated community services as a means to develop programs to support the PCCHs which will support building Quality of Life (QoL) and Wellness Plans

2.Developing and utilizing a standardized assessment tool that identifies housing, nutritional, emotional, physical, cognitive, environmental and social strengths, challenges, and relevant support needs and priorities. This standardized assessment will be used in consultation with the patient, primary care providers and intake team to develop a QoL Care Plan which will follow both the family and the service providers throughout treatment and support. Reassessment will be completed as needed and will be determined by the changing conditions of the patient. The voice of the patient and families will be embedded throughout the intake, care plan development, treatment and ongoing monitoring of wellness building processes

3.Creating communication and feedback systems to ensure accountability and co-design in quality improvements of service options

4.Creation of new pathways for:
- o Older adults living with frailty
- o Individuals living with complex conditions (including people of all ages including Paediatric)

5.Using innovative health technology to support communication and feedback

Managing Intake

In Year One, patients will be referred to PCCH either at the point of discharge from the ED, from primary care providers, community providers or through self-referrals from patients and caregivers. Referred patients will receive a response within 24 hours and a standardized assessment. A QoL team will also be developed, based on the patient's specific needs.

Care Coordinators will be responsible for managing the patient's ongoing care needs and supporting knowledge sharing at discharge and/or transition from acute care to/from other community providers. Care Coordinators, directly connected to care

delivery will have knowledge of all Formal Alliance and Affiliates partners in the Durham OHT, responsibility for coordinating required medical and social care through relevant information sharing among providers and actively support patient's navigation through recommended care pathways. As the care team lead for patients with complexities and their families, these resources will ensure elimination of unnecessary and avoidable service delays through processes of continuous care delivery and case care management to support the reduction of unnecessary utilization of emergency medicine services.

Assessing Patient Needs

When assessing a patient's needs, we will develop a clinical treatment/care program which will consider the needs, strengths, and challenges of the patient and the availability of community care both in and outside of Durham Region. A multi-disciplinary comprehensive assessment will be used (see Year One priorities) to identify all aspects of the patient's care needs, including influence of social determinants on the patient's health and burden on their caregivers.

Within the new service model, appropriately skilled service partners will provide 24/7 service through providers that can complete a needs assessment of the patient. These providers will be skilled and knowledgeable in providing point-of-care assessment and determining where the patient should be directed for the most appropriate services based on identified patient needs. The delivery model will include referrals to social service agents and the QoL team if required.

The PCCH will design services (see Year One Priorities) that are inclusive of the needs of the patient, families and caregivers. The interplay of the family, including living environment, financial situation and caregiver capabilities, will be included as part of the standardized assessment. Recommended Quality of Life care plans will be customized for patient's unique circumstances, and where required and possible, additional services will be included for successful implementation. In addition, patient assessments from alternative locations (i.e. virtual, community based) will be possible when a patient is unable to attend in person.

The patient, family/caregiver and QoL teams – occupational therapist, RN, PN, Personal Support Worker, physiotherapist, rehabilitation therapist, kinesiologist, community volunteers, social workers, etc. – will be involved in the assessment.

Delivery of Services

The new model of care as identified in the future, will deliver services to patients within organized PCCH strategically placed in high need Durham neighborhoods. In Year One, Durham OHT members supporting the PCCH will collaboratively deliver medical and social services to people with multiple complex conditions using a team-based approach. This will allow for increased access to timely care and increased

interactions between patients and providers to increase participation and shared-care responsibility.

A visioning session took place with a wide range of stakeholders to design the future of home and community from a patient lens. Please refer to Appendix K for the outputs of that session.

### 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*

As mentioned previously, full integration of home and community care services is essential to the success of the Durham OHT. Members of the Durham OHT look forward to working with the Ministry on the future model of home and community care and implementing this next phase of transformation. Outlined below is a proposed plan for how home and community care could be improved and fully integrated into the Durham OHT.

The transition of home and community care responsibilities are necessary to support the new model of care and Year One patient populations. Transitioning of care coordination resources will require education and awareness of what is available in Durham Region to support the comprehensive wrap-around services for the target populations in order to address both the medical and social needs of the patients and families.

Planning for a new model of care will require dedicated resources along with local knowledge and expertise to leverage services and identify and address gaps in care and services. The relocation of current Central East LHIN Home and Community Care funding and services (formally CCAC services) will be essential to support this transformation process and to address capacity to ensure coordinated services are available along the full continuum of care. The Durham OHT suggests that the Central East LHIN allocate these services to the lead agency while the MOH determines a transition plan for resources.

The lead agency will manage the resources, coordinate human resource issues with the Central East LHIN, and assignment of home and community care services (formerly CCAC) will have oversight from the Durham OHT Steering Committee through the Project Management Office to seamlessly transition services without disruption to people receiving services. The Durham OHT lead agency will ensure that these services are well integrated with primary, home and community and acute care providers. Patients and caregivers will benefit by dealing with one organization for all care and services which will support seamless and coordinated care.

Full access to digital assets and common system-wide data collection will support system planning and evaluation. Clinical information systems such as CHRIS will be important for the Durham OHT to enable information sharing to ensure integrated care delivery and planning.

Provision of integrated wraparound care during transition of services as well as post transition will be planned, monitored and achieved by a single point of care, Care Coordinator. Upon referral from hospital, primary care or family, assessment will be performed by the most appropriate service (social or health) in the home. Service(s) and coordination will be managed ongoing from point of care delivery by the Care Coordinator. Ultimately, fully integrated care is the responsibility of the care provider in the community who knows the patient best.

As stated earlier, the Durham OHT looks forward to working with the Ministry on the future model of home and community care and implementing this next phase of transformation.

Please find below an example of a patient receiving fully integrated care through the new model of care:

During a regularly scheduled home visit with his primary care provider, Mike mentions he has been experiencing pain near his spine. Initial diagnostic testing using remote diagnostic equipment reveals lesions near Mike's spine. Mike's primary care provider is able to schedule an appointment for him with an oncology specialist at his local hospital, and further testing reveals a diagnosis of multiple myeloma. As a result of Mike's diagnosis, he expresses that he is experiencing anxiety and depression to his primary care team.

Mike has surgery and an inpatient stay at his local hospital where his circle of care team includes a homecare nurse, who will support Mike when he is discharged.

The home care nurse is a member of the circle of care team throughout Mike's inpatient stay and has full understanding of Mike's health and social needs, his home environment, his discharge orders and his medication needs. She is also fully aware that Mike lives alone in a rural setting. After Mike returns to home, he is able to be supported with health and social needs including accessing services to support ongoing outpatient care and transportation to his radiation appointments.

All of the health care providers on his care team are able to access real-time information through a shared electronic patient record. Health coaching and virtual monitoring help Mike manage remotely the side effects he is experiencing.

He is also connected with a virtual support group for seniors living with multiple myeloma. In addition, his primary care nurse connects Mike with a mental health counsellor early in his journey to support him during this time.

To ensure he keeps up his strength during his cancer treatments including radiation therapy and chemotherapy, a nutrition support plan is established. Despite the best efforts of his primary care team, he is deemed palliative due to the aggressive nature of his cancer. Early conversations regarding advanced care planning have occurred with Mike and his primary care team and oncology specialists. Mike's primary care

team has direct access to palliative care specialists in the region to ensure Mike receives palliative care support via nursing and physician home visits.

Mike and his visiting family members receive palliative care support in his home, and he passes away peacefully in his location of choice.

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

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

*Max word count: 1000*

In considering new models for home and community care modernization, there are several barriers and considerations for the MOH and OHTs:

- Change Management
  - oThe ability and willingness of the Central East LHIN Home and Community to participate in the relocation of resources aligned with the Durham OHT future delivery model of Home and Community Care
- Patient access to primary care providers
- Availability of appropriate health human resources. There are a lack of care providers available to support the new model of care (i.e. more PSW hours are required to fill the hours allocated). Access to funding/services of Home and Community Care LHIN resources will be required for planning, program development and clinical care to support the Year One target population.
- Wage inequities between service providers and sectors and potential impacts of the Public Sector Labour Relations Transition Act (PSLRTA)
- Health equity and the diverse needs of the Durham OHT population including the need to plan and deliver care and social services considering:
  - Transportation costs
  - Housing limitations
  - Language considerations
  - Access of services close to home for isolated and rural settings
- Access to regional broadband services to support communications and availability of innovative health communication technology needed to be developed and accepted for use within communities between hospital, clinics and community partners.
- Technology, digital and virtual tools and connected networks to support more efficient access to health care services.
- Privacy policies can create barriers to information sharing and inhibit holistic and effective health care strategy development. Access to personal health information and integrated care plans will support system navigation for patients and providers.

| |
|---|
| • Limitations of regulations put on EMS regarding assessing needs of patient and determining appropriate location/support for patient.<br>• Agency partners standards of practices need to include the integration of interprofessional, collaborative, team-based care approaches. |

# 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*

Year One plan to build off of the team's existing digital capabilities to expand virtual care offerings:
The Durham OHT envisions virtual care as a key enabler to achieving its outcomes of reduced time spent in hospital, improved access to primary care providers and increased patient, family and caregiver satisfaction, while at the same time increasing efficiency and value-for-money.

Durham OHT Formal Alliance members currently provide virtual care through the following digital channels:
- Synchronous channels: voice and video calling
- Asynchronous channels: secure text or e-mail; voice-mail, and remote health data monitors (e.g. WiFi enabled Blood Pressure cuffs)

Several Durham OHT partners have experience in providing virtual care including:
- SE Health provides a comprehensive digital platform called Medocity. This tool allows teams to collaborate digitally on care plans, integrate wearable information, monitor clinical status in real time, record PROMs, secure message, and conduct eVisits;
- Lakeridge Health has provided 16796 OTN/Voice Virtual Visits (Jan-Dec 2018);
- Medical Associates of Port Perry (MAPP) offered 1633 OTN eVisits and 10,00 Ocean (CognizantMD) visits (Jan-Dec 2018)

- At MAPP, 9.8% of patients have had a virtual visit (Jan-Dec 2018);
- Brock Community Health Care, Carea CHC, Region of Durham-Long Term Care Homes and Victoria Order of Nurses Canada also provide OTN eVisit/eConsult options.

In Year One, the Durham OHT will deploy the existing capabilities towards the target populations with prioritization of expanding virtual visit capabilities that support the new clinical models of care (such as an expanded Interprofessional Care Team to provide coordination and system navigation). The Durham OHT will utilize internet-enabled home monitoring devices to support complex care patients which will drive key performance measures for these patients.

Further, the Durham OHT will expand existing virtual care channels across all partners. This will target capabilities that are best suited to address the identified high-needs target population and increase assets to applicable delivery partners to support seamless transitions. Education and support will be provided to front line staff to enable them will tools and knowledge so they may leverage virtual care services to support patient access.

The Durham OHT will leverage existing incentives for physicians in the telemedicine program and further with collaborate with Ontario Health and the MOHLTC to explore sustainable funding models that encourage adoption of virtual care channels by all OHT partners.

Year One plans for expansion of virtual care capacity to the full Durham OHT team:

Most Durham OHT Formal Alliance members have already incorporated some aspect of virtual care into their models of care and are committed to expanding these platforms to all partners to ensure that the target populations have access to these digital channels.
The Durham OHT will leverage clinical teams that are already familiar with delivering virtual care to successfully expedite change management for partners who are new to adopting virtual care channels. A plan will also be developed to harmonize the virtual care patient experience whenever possible, augmented by purpose-specific apps (enabled by the Digital Health Service Catalogue).

Provide an assessment of how difficult it will be for your team to meet the target of 2-5% of virtual care encounters in year one:

As the majority of the Durham OHT Formal Alliance Members have already incorporated some aspect of virtual care into their models of care, the Durham OHT will leverage those partners and their experience to ensure that this target is achieved for our targeted populations.
Gaps/Barriers exist which are outlined in 2.2

How will the Durham OHT determine whether the provision of virtual care is successful (e.g., measures of efficacy or efficiency):
Virtual care will be an integral part of the new care models intended for the targeted populations, and therefore evaluation of benefits realization will consider the role of virtual care. The Durham OHT will integrate with PREMS and PROMS to assess patient satisfaction for a virtual care experience and will monitor the direct impact of virtual care on the Durham OHT identified eight (8) indicators for improvement outlined below:

1. Avoidable ED Visits
2. Patients in Hallway Beds
3. Alternate Level of Care Rate
4. 30-Day Readmission Rate for Selected Conditions
5. Wait Time for First Home Care Service (from Hospitals)
6. Wait Time for First Home Care Service (from Community)
7. Timely Access to Primary Care
8. Patient Satisfaction

Efficiency will be measured through the following:
- A series of process metrics related to virtual care utilization, duration of virtual service, dropped calls, etc.
- Cost-saving metrics such as Emergency Department diversion and Home visit diversion
- Measure impact on rates of “no-show” rates at physical and virtual visits

### *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*

Three patient access portals currently exist within the Durham OHT:

- MyChart at Lakeridge Health
- Medocity at SE Health
- AlayaCare at Partners in Community Nursing

In addition, lab service providers in the Durham Region (LifeLabs, GammaDynacare) provide proprietary portals to review lab results; however, some of these come at a cost to the patient.

The uptake and utilization of these portals have been low to date. Only 6,366 out of 214,333 unique patients who visited Lakeridge Health between April and December 2018 utilized the MyChart service, which represents only three (3%) of potential users.

The Durham OHT is confident that a 10-15% utilization rate in our target population is achievable by promoting the adoption and utilization of existing portals. Expansion of health literacy will be a key driver to support this goal and we will focus on the following so that individuals can better understand digitally accessed health information:

- Proactive onboarding with focused education to patients & their caregivers.
- Providing extensive training materials in multiple formats and languages
- Augmenting training & utilization through in-home one-on-one training with patients/caregivers.

Online appointment booking will be made available for the services provided for targeted populations through digital appointment booking applications and where possible, the Durham OHT partners will integrate with patient portals that have existing online booking capabilities to simplify access and increase adoption.

At maturity, the focus will be on providing more content and less complexity. The Durham OHT will expand the breadth of content within patient-accessible portals and further enhance the educational value of the portal through personalized information prescriptions. The Durham OHT will leverage the Ministry of Health objectives to increase the integration of Hospital Information Systems (HIS) and Electronic Medical Records (EMR) through patient identity systems, open API's, and standard data sets to include complete patient results, notes, and continuous patient profiles. It will be important to integrate with regional pharmacies to augment DHDR information and directly integrate with provincial information assets (OLIS, ConnectingOntario, CHRIS) to include more information, including outside the Durham OHT. An important aspect of this work will be to promote patient participation to contribute to and validate their personal health information (e.g. Medication Reconciliation).

Consolidation of all portals to provide one comprehensive portal will alleviate the need for the patient access information and digital health services in multiple products. Online booking services will also be consolidated across the Durham OHT Formal Alliance members to simplify transition of care for patients.

The Durham OHT is confident that through a concerted effort of the strategies listed above, that this target can be reached for Year One populations.

A number of barriers have been identified to successfully reach our goals at maturity for virtual care services and digital access to care. The list below (and table in Appendix L) summarizes the identified barriers, along with mitigations and identified supports required from the MOH or delivery organizations. This applies to both Section 2.1 and 2.2 of this appendix.

Barrier: Language, Literacy, and Accessibility Barriers

Mitigation and Support Required: Creation of training material in different languages and formats to increase accessibility (e.g. AODA, Integrated standards compliant)

Mitigation and Support Required: Ensure digital assets can be presented in multiple languages

Barrier: Digital Proficiency of Patients and Staff

Mitigation and Support Required:

- Targeted change management strategies
- Increased on-boarding support at time of registration
- Caregiver engagement and support
- In-home one-on-one training with patient/caregiver

Mitigation and Support Required: Will require Direct IT/Admin support for patients

Barrier: Accessibility of Broadband Internet, especially in rural areas

Mitigation and Support Required: The Durham OHT will advocate for advancement of the Durham Regional Broadband Strategies

Mitigation and Support Required: Utilize cellular hotspots, OTN local sites

Mitigation and Support Required: OHT support for patients with financial barriers

Barrier: Lack of Appropriate Internet enabled devices
Mitigation and Support Required: Lending library of appropriate technology for patients in financial need

Barrier: Concerns about Privacy of information
Mitigation and Support Required: Ensure privacy standards are met and clearly communicated to patient during onboarding

### *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 Durham OHT is committed to digitally enable information sharing for the purposes of integrated care delivery and planning while prioritizing the privacy and security of health information that is stored and exchanged in electronic form.

Information sharing is a key enabler of many components of our service redesign. Care coordinators will require comprehensive clinical information to appropriately plan and prioritize services.

Currently a patchwork of applications are being used among Durham OHT members:

- Client Health and Related Information System (CHRIS)
- Connecting Ontario (cON)
- Remote desktop access to the Hospital HIS

The Durham OHT is confident that a number of quick wins are possible within existing regulations, to enable further information sharing while ensuring patient information is shared securely and digitally across providers

In Year One, the Durham OHT will dedicate resources to building on existing assets which will support the expansion of remote access to the full Hospital HIS to all OHT members; increase adoption of CHRIS and Connecting Ontario for all relevant health information by all members and increase use cases for Health Report Manager (HRM). By way of the Provincial eCommunications Gateway interfaces, CHRIS has integration with Sunnybrook's MyChart and Connecting

Ontario to ingest CDR and ADT datasets. Increasing the scope of this integration to additional clinical datasets will provide enhanced functionality for the Durham OHT.

A data governance committee will be established in Year One to develop data standards and establish a timeline for adoption of standards among all Durham OHT members and report into the Steering Committee. This is intended to be in collaboration with other Ontario OHT's and the province. We will also conduct a data cleansing analysis to identify and subsequently remove corrupt or inaccurate records from current systems to ensure quality data is being collected to drive integrated care delivery and planning; and a privacy and security policy and framework will be developed for information sharing within the Durham OHT.

At maturity, all Durham OHT members will understand and commit to data governance expectations and have the knowledge and training to utilize the tools necessary to facilitate data information sharing. Comprehensive data sharing agreements, and privacy and security safeguards will exist between all members to establish a common data warehouse for use within the Durham OHT with the OHT will fully participating in any provincial Health Information Exchange and adhering to the common datasets, and a provincial Identity, Access and Authorization (IAA) service.

To achieve this, we will require the following supports from the Ministry:

- Logistical, technical, and governance support in expanding CHRIS and Connecting Ontario to Durham OHT members, including mechanism to include non-Health Information Custodians
- Advisory services on the development of data sharing agreements, privacy and security standards within existing and anticipated legal frameworks
- Legal framework to prevent "data blocking"
- Support work of the Durham OHT to align with data standards of existing and anticipated provincial Health Information Exchanges
- Provide an Identity, Access and Authorization (IAA) service

### *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*

All Durham OHT partners currently track and analyze key performance indicators independently to determine areas of quality improvement and strategic opportunities at each organization. This combined data set includes a combination of outcome and process driven indicators; some government mandated and others in-house custom metrics. Data is pulled from various sources including; electronic health care records, digitized patient/caregiver satisfaction surveys, and formal data tracking software systems. Many team members collect government mandated metrics, that can be compared to provincially set benchmarks and targets which helps identify gaps and drive quality improvement initiatives.

Data is currently collected and housed via various sources including: within eHR vendor software, PowerBI, eForms, AlayaCare, MoD Quatro Process. Quality Improvement Plans are created and submitted annually to Health Quality Ontario by a number our members.

In Year One, the Durham OHT will create a standard set of indicators that can be captured along the continuum of care for our target populations. These would include specific key performance indicators, as well as patient-oriented outcome and process measures.

Patient-oriented outcome metrics will be monitored by the Patient Partnering Office to address both clinical and social determinants of health which will inform the development of a unified annual Durham Ontario Health Team Scorecard and Quality Improvement Plan. Lakeridge Health will host a central data warehouse for these indicators and develop reports and visualizations via the Microsoft PowerBI tool and provide the Durham OHT partners with remote digital access.

There are four barriers identified by Durham OHT partners to achieve the desired outcomes related to Digitally Enabled Quality Improvement. Below (and in Appendix M) is a summary of these barriers along with proposed mitigations and required supports.

Barrier: Lack of established Quality Outcome metrics for community services
Mitigation and Required Support: Durham OHT to develop with guidance from MOH

Barrier: Infrastructure / Resources to capture data
Mitigation and Required Support: Durham OHT members to support
Mitigation and Required Support: Utilize point-of-care opportunities for data collection

Barrier: Lack of defined minimum data set for Quality Improvement measurement
Mitigation and Required Support: Durham OHT to establish standards with guidance from MOH
Mitigation and Required Support: Durham OHT to enforce as a requirement for membership

Barrier: Data sharing agreements that enable combined data sets
Mitigation and Required Support: MOH support and guidance to establish these

### *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*

Secure communication will be established between Durham OHT members to allow for improved coordination of care, and enhanced ability for providers to share sensitive information when arranging transfers of accountability. Secure channels for information sharing will assist in timely and seamless transitions of care.

Strategies include:

- Expand use of secure email within the Durham OHT and integrate with the OneMail System to allow for inclusion of contacts outside the Durham OHT
- Use of single platform for secure chat & video conferencing between Durham OHT members
- Use of single, secure, cloud-based platform for secure document sharing
- At maturity, evolve to patient-linked communication via Provider portals, embedded within the clinical record

Artificial Intelligence (AI) supported Digital Health

- Expand existing partnerships with Durham College AI Lab to innovate on quality improvement and patient experience. (e.g. AI enabled Quality Improvement analytics & inferences applied to our metrics as well as Voice assistants and chat "bots" to support patient care at home (i.e. PROM, Medication reminders) and increase accessibility.

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

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

for your team.

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|---|---|
| **Name:** | Ilan Lenga |
| **Title & Organization:** | CIO and CMIO, Lakeridge Health, |
| **Email:** | ilenga@lh.ca |
| **Phone:** | 905-576-8711 x 34601 |