Ontario Health Team: Full Application

Introduction

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

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

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

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

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

OHT Implementation & COVID-19

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

Information to Support the Application Completion

At maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents and will be accountable for the health outcomes and health care costs of that population. This is the foundation of a population health model, as such (at maturity) Ontario Health Teams need be sufficiently sized to deliver the full continuum of care, enable effective performance measurement, and realize cost containment.

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

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

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

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

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

Participation in Central Program Evaluation

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

Submission and Approval Timelines

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

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

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

Additional Notes

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

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Joseph Lee MD, CCFP, FCFP, MClSc(FM)
	Title: Chair & Lead Physician, The Centre for Family Medicine, Waterloo Region Clinical Lead, KW4 Subregion, Waterloo Wellington LHIN Chair, Kitchener-Waterloo-Wellesley- Wilmot-Woolwich (KW4) Leadership Table Clinical Associate Professor and Assessment Director, Dept. of Family Medicine, McMaster University
	Organization: Centre For Family Medicine
	Email: joe.lee@family-medicine.ca
	Phone: 519-783-0021
Contact for central program evaluation	Name: Ingrid Pregel
	Title: KW4 Transformation Lead

Please indicate an individual who the Central Program Evaluation team can contact for follow up	Organization: KW4 OHT
	Email: ingrid.pregel@rogers.com
	Phone: 226-989-2736

1. About Your Population

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

1.1. Who will you be accountable for at maturity?

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

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

Maximum word count: 500

The MOH has provided two data sets including population and provider network information, to enhance our understanding of the KW4 population. The insights derived from the data sets have been supplemented with other local data sources to inform the application.

Size and Demographics

At maturity the KW4 OHT will be responsible for approximately 400,000 residents (397,627 in FY18) covering a wide geographic region of Kitchener, Waterloo, Wilmot, Woolwich, and Wellesley. Geographically our attributed population spans across both urban cities (80%) and rural townships (20%) with close ties to partner OHT's in Guelph-Wellington and Cambridge North Dumfries. 14% of our attributed population lives outside of KW4 geographic boundaries (i).

Given this mobility and KW4 hosting a number of critical regional programs (i.e. Oncology, Stroke, Renal and Cardiac) KW4 will work closely with our partners in the neighbouring regions as well as Ontario Health West for broader alignment. By

[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.

localizing the approach to working with the KW4 priority populations as well as executing on regional and provincial priorities the KW4 OHT we will work to improve care for the region as a whole.

In many ways the KW4 population is similar to the broader Ontario population in terms of demographics and health conditions. The KW4 population has a slightly younger age than Ontario (39.5 vs. 41.0) and is predominately located in the KW4 geographic region (86%). Looking at the Health Conditions KW4 and Ontario are very comparable in the types of conditions patients have, sharing 9 of the top 10 (i).

In most performance metrics (use of emergency services, hospital wait times, and wait time to access home care) KW4 has exceeded the broader Ontario network and our community has grown to expect a high-level quality of care. There are opportunities to improrve care. Examples include access and transition of care as measured by % of patients who were able to schedule same day/next day appointments (KW4 34.9% vs. Ontario 44.7%) and acute care follow up within 7 days (41% vs. 44.8) (i).

In order to care for this diverse population, the KW4 OHT has, and will continue to engage organizations from across the health spectrum. These partners will align under the priority populations and work to maintain the momentum achieved during the COVID-19 efforts to improve upon care. Within KW4 there is a very diverse set of care providers that the OHT will be accountable for engaging and working with as we work to transform care into a patient-centric approach (Appendix A).

As an example of the decentralized care providers KW4 is home to:
- 2 large community hospitals
- 21 primary care provider groups (including FHT's, CHC's, NPLC)
- Over 150 solo practitioners
- A large number of community supports integral to our population's well being

The result of this many primary care providers is a community where patients receive care outside of hospitals (lower rate of ED visits and lower percentage of CTAS 4 and 5 visits) (i) and the KW4 design framework (Appendix B) continues to put improved access to primary care as one of the drivers of success.

1.2. Who will you focus on in Year 1?

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

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

If this Year 1 population differs from previously submitted documentation, please provide a brief explanation (for example, many teams have seen changes to their priority populations as a result of COVID-19).

Maximum word count: 500

KW4 will continue to focus on the three previously identified patient populations: refugees; frail elderly; and those who are homeless. The priority populations will be reviewed through the overarching lenses of Urban-Rural, Mental Health, Home and Community Care, and Digital Enablement.

Refugee Population

• KW4 is home to more refugees than any Ontario community outside Greater Toronto and Hamilton areas, the highest numbers being from Syria, Somalia and Eritrea (ii).
• The volume of refugees to Waterloo region has increased by 87% from 2008 to 2017 (ii).
  ○ We receive the highest number of secondary migrants in Canada, and approximately 350 Government Assisted Refugees annually who often arrive with acute and complex health and mental health needs requiring immediate coordination across health and community services.
  ○ Newer immigrants (including Refugees) report much less access to a regular health care provider than those established/Canadian born (73% vs. 95%/90%) (iii).
• 95% of refugees' interactions with healthcare require some sort of interpretation (iii).
• Four primary care member organizations serve the majority of KW4 refugees (5,500), but are currently operating over capacity and with waitlists.
  ○ Underserved patients tend to end up using the ED services as they are accessible.
• Both hospital member organizations serve refugees, often through emergency departments for issues better dealt with elsewhere, including primary care.

People who are Homeless and Precariously Housed

• Homelessness is difficult to gauge due to stigmatization and system barriers, however it is estimated that 450-500 people are currently homeless in Waterloo Region, 39% who are under age of 30, facing mental health and addiction issues (iv).
• 4,849 households are waitlisted for community housing, resulting in people staying longer in shelters (v).

• Those who are homeless present frequently to hospital due to limited access to brain injury services, mental health and addictions services, or primary care, and sometimes remain in hospital settings due to capacity constraints within the shelter system or a lack of viable housing options.
• The Inner City Health Alliance (ICHA), comprised of six member organizations, delivers primary care through a network of fixed and outreach services including a mobile van, however sustainable resourcing, including healthcare staffing, is an ongoing challenge.
• Grand River Hospital and St. Mary's General Hospital provide service and track clients through their emergency and specialized services.

Frail Elderly Patient Population

• 15.8 % of the attributed population is over 65 years (i).
• This patient population is more likely than others to experience chronic illness in the form of Dementia, COPD, CHF in addition to more concurrent or episodic care needs.
• Waterloo region is projected to have over 100% growth in seniors over 2018-2046 (viii).
• As of September 2020, 2,929 patients in KW4 are 75+ and are receiving home care supports through the LHIN Home and Community Care.
• Palliative and Dementia care costs are the largest of all HPG's accounting for 20% of all KW4 costs (i).
• Behavioural concerns and dementia are the top barrier to hospital discharges.
• Seniors diagnosed with CHF, COPD or dementia draw on a multitude of healthcare and community services that would benefit from improved integration.

1.3. Are there specific equity considerations within your population?

Certain population groups (e.g., Indigenous peoples, Franco-Ontarians, newcomers, low income, racialized communities, other marginalized or vulnerable populations, etc.) may experience health inequities due to socio-demographic factors. This has become particularly apparent in the context of the COVID-19 pandemic response and proactive planning for ongoing population health supports in the coming weeks and months. Please describe whether there are any population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

Maximum word count: 1000
Where known, provide information (e.g., demographics, health status) about the following populations within your Year 1 and attributed populations. Note that this information is not

provided in your data support package. LHIN Sub-Region data is an acceptable proxy.[3] *Other information sources may also be used if cited.*

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

Addressing health equity is central to the KW4 OHT. This is reflected in our year one priority populations whose healthcare has been characterized by barriers to access, integration and transition challenges, and/or limitations in social determinants of health.

The COVID-19 pandemic has re-emphasized the importance of a health equity lens for our initial priority populations as well as the broader KW4 population.

• Across Canada, 80 % of COVID-19 deaths occurred in long-term care, while 80% of long-term residents have dementia (ix).
• The biggest barrier to healthcare access identified by those working with refugees throughout the pandemic continues to be language.
• While the KW4 sub-region developed a range of COVID-19 assessment and testing options in the first months of the pandemic, there are ongoing access challenges including:
  ○ Patients without transportation to assessment or testing centres.
  ○ Patients without internet that impedes their ability to access test results.
  ○ Patients without primary care may have difficulty accessing testing initially; including adults with physical or cognitive disabilities.
  ○ A lack of culturally appropriate testing and assessment options for indigenous peoples.
  ○ Limited information about assessment and testing services and follow up available in French and other languages.
• A “Lessons Learned” survey conducted by the KW4 OHT in June 2020 identified additional equity gaps and challenges, many tied to de-prioritizing a range of programs and services through the initial COVID-19 response. These include:
  ○ Patient challenges accessing face-to-face primary care, mental health services, and maternal and newborn care (post-delivery).
  ○ Suspended immunization programs and other services for vulnerable populations including those living with HIV/AIDs.
  ○ Discrepancies between face-to-face service offerings available in rural versus urban areas.
  ○ Postponement of surgical and diagnostic services at hospitals.
  ○ Rising caregiver burnout across the community due to significantly reduced healthcare services and community programs.

Although we face equity challenges, the KW4 OHT is characterized by a diverse set of partners representing the spectrum of healthcare, community services, municipalities and academia. This gives us broad scope for problem-solving, planning and addressing healthcare and social determinants of health concurrently, and we have

[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.

had some successes through the first seven months of the COVID-19 pandemic. These include:

1. Initiation of the voluntary integration of Sanctuary Refugee Health Clinic and (SRHC) and Kitchener Downtown Community Health Centre (KDCHC) to ensure sustainable, integrated, team-based primary care services for the 5,100 and growing refugee patients of SRHC.

• In addition to ensuring long-term sustainability of SRHC, this integration is the center-piece of our move to better integrate health and community services for refugees in their first two years of settlement with an initial (current) focus on the work of Reception House (settlement services), Centre for Family-Medicine Family Health Team (primary care) and Carizon Family and Community Services (mental health) to be followed by other member organizations.

2. The ongoing, cross-sectoral response to COVID -19 of over 45 different organizations working together to ensure that those who are homeless in the downtown cores of Kitchener and Waterloo:

• Are sheltered during the pandemic and hopefully into the future.
• Have ongoing access to mobile primary care.
• Are supported through population level infection-control strategies such as testing and assessment via a mobile primary care van, an isolation ward for individuals with COVID-like symptoms, face-to-face support services that endeavour to adhere to social distancing requirements, and coordinated and standardized PPE and IPAC standards across the outreach services, fixed health clinics and associated congregate care settings working with the same clients.

3. Piloting culturally appropriate assessment and testing in partnership with two indigenous cultural organizations and using the COVID response to test extending primary care access to indigenous populations.

4. Establishing a KW4 Evaluation and Research Committee to support KW4-level research and to support the KW4 OHT in implementing its draft evaluation framework.
    ○ This committee is to support KW4 level research on equitable access as well as other topics important to KW4 (ie. COVID)

5. Encouraging our community and Region to collect race-based and disaggregated data to better understand the longer-term and ongoing consequences of the COVID-19 pandemic on vulnerable peoples and to support future OHT planning.

So, as KW4 OHT moves toward its first official year of activity, we will build on our current work and successes to continually tackle health equity – a long term, community–wide issue.

2. About Your Team

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

are able to provide.

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

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

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

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

Keeping the above partnership stipulations in mind, **please complete sections 2.1.1 and 2.1.2 in the Full Application supplementary template.**

2.2. Confirming Partnership Requirements

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

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

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

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

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

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KW4 has a rich history of collaboration around initiatives that have been successful in improving the health and wellbeing of our community. Supported by strong community partners these initiatives span the continuum of care both pre and during COVID-19. Examples highlighting the nature and success of the work are outlined below.

Counselling Collaborative

The Counselling Collaborative is a community-based partnership between six community counselling service providers within Waterloo-Wellington Region to ensure access to counselling services for those in need in the community. Over the last year, the Counselling Collaborative has been working with primary care in KW4, including the Centre for Family Medicine that provides mental health services to rostered patients and patients of 52 other physicians in the community, to ensure that patients of all primary care providers in KW4 have access to short-term counselling (8-10 sessions). This supports one of the KW4 OHT's integration themes of enhancing primary care capacity.

Continued COVID-19 Response

Given that many of the relationships between signatory organizations are longstanding, it is no surprise that organizations supporting our three year-one priority populations are well-connected and preparing together for a second COVID-19 wave. Partners at congregate care huddles to support long term care homes and retirement homes are readying themselves to extend their support to other congregate settings where vulnerable populations reside. Long Term Care partners are also being engaged and integrated into the OHT system in more intentional ways through partnered models of support with hospitals, primary care and other signatories.

Refugee health partners spanning settlement services, primary care and hospital have continued to welcome newcomers to our community and are offering support in an integrated system of care with modifications to service delivery to increase safety and reduce COVID-19 spread.

The 45+ partners involved in the tactical response to support patients who are homeless are prepared to rally their resources again to respond to subsequent COVID waves, including pivoting the mobile COVID testing bus towards other vulnerable populations, using population health data to guide where poorer outcomes have/may be experienced.

Inner City Health Alliance (ICHA)

Launched in 2018, the ICHA was formed as the needs of those living in vulnerable conditions in our community were surpassing the capacity of any one individual organization. The ICHA is made up of six OHT partner organizations (The Working Centre, Sanguen, Ray of Hope, Kitchener Downtown CHC, House of Friendship and Centre for Family Medicine Family Health Team) and works closely with many other OHT partners. During COVID, the ICHA has been working alongside almost 40 additional organizations to coordinate a downtown response to support the homeless populations in Kitchener and Waterloo.

In 2020, the ICHA partners identified their 2020-2021 priorities, some of which are informing KW4 OHT planning:
• Sustain existing COVID Homeless/Health Tactical Response
• Continue pilot to integrate health care into emergency shelters (Sheltercare)
• Support the creation of permanent housing where possible
• Pilot an extended-hours (24-7) outreach team with nursing support
• Participate in and lead, if necessary, a tactical response for those who are unsheltered in winter
• Advance new ways of providing people safe drugs in our community

KW4 Primary Care Council

Kicked off in 2019 and launched formally January 2020, the KW4 Primary Care Council aims to bring primary care institutions together to support and inform the application to be an OHT. Currently there are 19 individuals representing the majority of primary care FHTs, FHOs, CHCs and NPLCs in KW4.

With the emergence of the COVID-19 pandemic, the purpose of the council transitioned to focus on: launching a community assessment and testing centre, sharing information and best practices with KW4's 300+ primary care practitioners,

responding to community practitioners' needs for PPE and IPAC supplies/equipment, and generally supporting one another during this time. The Primary Care Council continues to support the ongoing COVID-19 response including a sub-regional approach to flu immunizations in fall 2020.

Older Adult Strategy (OAS)

Lead by the Research Institute for Aging in partnership with the Waterloo Wellington LHIN, the OAS is a comprehensive ten-year strategy focused on helping older adults in our region stay healthy and remain independent as they age. This work is guided by an advisory committee and informed by the experiences and perspectives of older adults, families and care partners. With a strong partnership between WW CMHA, long term care, community services, primary care and post-secondary institutions, this cross sectoral group is bringing research to practice.

Sanctuary - KDCHC Integration

Previously two distinct organizations, the Kitchener Downtown Community Health Clinic and Sanctuary Refugee Health Centre have integrated to stabilize clinical operations and enhance team-based primary care for over 5100 refugee patients.

This was done voluntarily by both organizations to reduce gaps in the care provided to our refugee population and is a key foundation of our proposed plans for better integrated care for refugee health in KW4 (See section 5.3 for more information)

Shared EMR between Hospitals
In 2016 Grand River Hospital and St. Mary's General Hospital began working towards a shared EMR in a project branded as PRISM. This $80M Cerner implementation went live in the fall of 2019 and created a single patient record shared between the 2 hospitals.

Wellbeing Waterloo Region

Wellbeing Waterloo Region is a multi-year community initiative that brings together local collaboratives, non-profit organizations, multiple sectors (e.g., business), local residents, philanthropic organizations and governments. The collaboration's mission is to create a diverse and connected network that works differently to make transformational change in wellbeing across the region.

The KW4 OHT has rooted its design framework (Appendix B) in the community's vision as articulated by Wellbeing Waterloo Region: "A Community where everyone thrives, and no one is left behind." Much of the work of the KW4 OHT intersects with

the three big ideas identified as part of Wellbeing Waterloo's multi-year plan: social inclusion; affordable housing; and healthy children and youth.

3.0. Leveraging Lessons Learned from COVID-19

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

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

Max Word Count: 500

3.1

Digital Care

• Hospitals deployed virtual health appointments for some ambulatory services utilizing primarily OTN and telephone consults.

• A survey of 48 KW4 primary care practices found all respondents implemented some kind of digital care during the first five months of pandemic.

○ Between March and June, eHealth Centre of Excellence tracked a 17% increase in primary care registrations, 40% increase in patient registrations for VirtualCare, and LTC VirtualCare adoption achievement of 33% LTC homes in WW region (i).

Cross-sectorial Collaboration

• Over 45 organizations collaborated to provide a tactical response for those experiencing homeless.

○ There were no positive COVID-19 cases among those experiencing homelessness.

○ A mobile primary care bus and walk-in clinic were enhanced to enable community-based COVID assessment and testing.

○ The Men's Shelter was relocated to a hotel and a pilot of ShelterCare launched to integrate emergency housing and healthcare, demonstrating quick wins, including:

• Overdose rates decreased by 50%, reduction in EMS calls decreased by 75%, and ED transports reduced by 85% despite a doubling of people served.

• Connections to virtual psychiatry consults and other mental health supports for approximately 50% of individuals experiencing active psychosis.

• 30 individuals transitioned to permanent housing, none of whom have returned to shelter (ii).

• A cross-sectoral huddle met daily to coordinate assistance for LTCs and RHs in need, including providing operational advice, IPAC expertise, emergency staffing, and accepting and caring for their residents in hospitals.

• The Primary Care Council (PCC) mobilized to create a community assessment centre with mobile testing spokes and met weekly to communicate and problem-solve around COVID.

Testing
• GRH opened a drive-thru testing clinic with a peak daily volume of 650 tests and implemented a new platform for COVID detection with a capacity of 1,500 tests daily.

Bed Capacity
• During the pandemic GRH increased internal bed capacity and on behalf of hospitals in Waterloo Wellington planned for the use of temporary non-traditional facilities (i.e. hotels, student residence, field hospitals). Robust plans are in place to open these spaces with 2-3 weeks notice.

Supply Chain
• Regional warehouse was established at GRH to coordinate supply amongst 106 locations (hospitals, LTC, shelters, congregate settings, primary care, etc.)
• PCC coordinated collection and distribution of PPE for community healthcare providers

3.2
• Closer alignment between OHT Steering Committee, signatories, and Regional COVID Response Triad.
• Creating centralized communication service to coordinate OHT communications related to COVID and year one.
• Coordinating primary care efforts around flu immunizations, mental health access and other capacity issues.
• Coordinating with the Ontario West, Waterloo Wellington area, and sister OHTs to operationalize provincial and regional strategies at the KW4 OHT level.
• Addressing interpretation gaps and limitations with healthcare providers treating non-English speakers.
• Supporting integration of long-term care with the rest of the health system by leveraging existing cross-sectoral work supporting older adults; ongoing vulnerability screening (e.g., COVID-vulnerability screener and C5-75); supporting LTC communities of practice in planning and problem solving; and exploring non-traditional caregiver respite/supports.
• Continuing virtual care, testing and swab processing, coordinated supply chain efforts and activating additional bed capacity

4.0. How will you transform care?

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

coordinated response to COVID-19 in the future.

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

- Number of people in hallway health care beds
- Percentage of Ontarians who had a virtual health care encounter in the last 12 months
- Percentage of Ontarians who digitally accessed their health information in the last 12 months
- 30-day inpatient readmission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions
- Patient reported experience and outcome measures and provider experience measures (under development)
- ED physician initial assessment
- Median time to long-term care placement
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready
- Caregiver distress
- Time to inpatient bed
- Potentially avoidable emergency department visits for long-term care residents

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

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

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

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

5.		

4.2. How will your team provide virtual and digitally enabled care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care and other digital health solutions enable patients to have more choice in how they interact with the health care system, providing alternatives to face-to-face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging, websites and apps that provide patients with easy access to their health records, innovative programs and apps that help patients manage their condition from their homes, and tools that allow patients to book appointments online and connect with the care they need from a distance. At maturity, teams are expected to be providing patients with a complete range of digital services. Please specify how virtual care will be provided to Indigenous populations, Francophones and other vulnerable populations in your Year 1 population and/or sub-group.

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

Max word count: 500

To support the response to COVID-19, virtual care was implemented as follows:

Primary Care:

• There was a 17% increase in PCPs registered for ThinkResearch VirutalCare in the first three months of the pandemic and a 40% increase in the patient registration.(i)
To date 15% of PCPs have registered for VirtualCare, enabling secure video, audio and asynchronous messaging. (i)
• Approximately 17% of PCP have newly adopted OTN eVisits. (ii)
• Other primary care providers used telephone visits to connect with patients

[4] By completing this section the members of your team consent that the relevant delivery organizations (i.e., Ontario Health and OntarioMD), may support the Ministry of Health's (Ministry) validation of claims made in this section by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

Hospitals:

• Virtual care implemented using telephone and OTN eVisits across a range of clinics.
• GRH and SMGH's shared single HIS instance enabled integration of virtual visits into clinician and clerical workflow accounting for initial contact, scheduling and conducting the visit.
• ED virtual visits program implemented, diverting 58% of those visits from the ED. (iii)

LTC and RH:
• Virtual care implemented supporting primary care access for residents, reducing avoidable ED visits and enhancing quality of life for residents.

Other:
• Service delivery changes including digitally enabled solutions enthusiastically championed by practitioners initially reluctant to attempt virtual services.
• Moving forward, we will continue to encourage and enable virtual care. The eHealth Centre of Excellence (a KW4 Signatory organization and a provincial leader in digital health) will continue supporting adoption of virtual care solutions (i.e. ThinkResearch, Novari, OTN eVisits).

The following provides an overview of digital health solutions in place or planned for imminent implementation to support equitable access to health services:
• Over 65% of PCP in KW4 have adopted eReferral with 120 receiving sites live on eReferral across Waterloo-Wellington. (iv)
• Over 79% of PCPs in KW4 use eConsult, supporting equitable access to specialist advice. We plan to expand the use eConsult particularly for Refugee Health and Frail Elderly patient populations. (v)
• eReferral and eConsult integration proof of concept currently underway within KW4, to enable provision of specialist advice, where appropriate, through the eReferral solution.
• Over 2500 registered users for ClinicalConnect (acute care, primary care, LTCs, Community, Pharmacy and Public Health). (vi)
• Remote patient monitoring initiative underway to establish monitoring of COVID-19 positive patients.
• Chronic Disease Management Decision Support Tools for EMRs (i.e. palliative care toolbar) will continue to be offered to primary care.

To ensure information is shared securely and digitally across providers in KW4 for the purpose of integrated care delivery, we will:
• Continue encouraging the use of ClinicalConnect across the continuum of care.

• Integrate HIS with ClinicalConnect supporting easy access to information.
• Continue Implementation of HyperCare (a secure, mobile-first collaboration platform that allows provider-to-provider & provider-to-care team communication).
• Use robotic process automation to share coordinated care plans, updating patient information from one organization's chart to another, as required.
• Privacy and security working group will leverage regional privacy work and assess KW4-specific privacy needs.

Our plans are aligned and consistent with the digital health playbook as they:
• Leverage current assets and explore opportunities for greater integration and expansion while considering infrastructure requirements (i.e. resources, privacy).
• Leverage digital health solutions to support continuous quality improvements and attainment of quadruple aim.
• Leverage the OH-West Digital Health Advisory to align with regional work.

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Lirije Hyseni
	Title: Quality Improvement and Knowledge Transition Practice Lead
	Organization: The eHealth Centre of Excellence
	Email: lirije.hyseni@ehealthce.ca
	Phone: 519-722-3411

4.3. How will you address diverse population health needs?

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

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

4.3.1. How will you work with Indigenous populations?

Describe how the members of your team currently engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and

maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term.

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

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

Max word count: 1000

Many KW4 OHT partners and signatories have working relationships and partnerships with indigenous organizations and communities. For example:

- The former WWLHIN (now part of Ontario Health West) has a strong history of patient engagement with 6,270 KW4 residents who identify as indigenous and has shared summaries of key themes with the KW4 OHT.
- Both the City of Kitchener and the City of Waterloo have strategic plans that recognize and support calls to action around truth and reconciliation.
- Wellbeing Waterloo Region has an indigenous working group and works with an Elder from Missanbie Cree First Nation who supports the WWR community in their shared responsibility to ensure everyone is welcome and can belong in Waterloo Region.
- The WW LHIN/Ontario Health West facilitates access to cultural training for healthcare providers across KW4 in which frontline and administrative staff from signatory organizations have participated.
- The University of Waterloo is building an indigenization strategy with five active working groups: curriculum and academic programming (including health sciences); research; student experience; community engagement; and policy and procedures.
    - In addition, the University of Waterloo School of Optometry & Vision Science is partnered with the Vision Institute of Canada and the Wikwemikong First Nation to provide a comprehensive eye clinic with the Wikwemikong Unceded Indian Reserve (WUIR), Manitoulin Island. In addition to vision care, a goal of this initiative is to develop collaborative vision loss prevention strategies with an indigenous community.
- Both hospitals have been creating the culture and space for indigenous healing practices such as smudging. Tobacco-Free Hospital policies also account for the

traditions and spiritual needs of First Nations peoples by ensuring an exemption that permits the use of tobacco for traditional Aboriginal cultural or spiritual purposes.
• The First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy 2019 –2023 provides a road map for Ontario Health (Cancer Care Ontario), Indigenous communities and individuals, and health system partners, to work together to improve health equity and reduce the unique burden of cancer and other chronic diseases on Indigenous people. Under the guidance of this Strategy and colleagues in the Indigenous Cancer Control Unit at Cancer Care Ontario, the Waterloo Wellington Regional Cancer Program (WWRCP) at Grand River Hospital has embarked on a path to create partnerships based on trust and mutual respect with Indigenous peoples of this region. WWRCP is working to better engage and address cancer control needs of First Nations, Inuit and Métis and Urban Indigenous peoples in the region by: building productive relationships with indigenous communities and organizations; conducting research and surveillance to better understand regional Aboriginal demographics, cancer control needs, and access and use of regional cancer services by the Aboriginal population; and creating opportunities for increasing cancer awareness amongst local Aboriginal communities and organizations and indigenous patients' needs amongst WW RCP staff.
• The Inner City Health Alliance continues to work collaboratively with indigenous elders and organizations to explore ways to align traditional healing practices and traditional health care, particularly as it relates to addiction and recovery.

The KW4 OHT is highly conscious that consultation and partnership with indigenous communities cannot be quick or de-contextualized, and is working hard to understand past and current engagement strategies and build on them as the OHT matures. However, the COVID-19 pandemic has brought about an opportunity for the OHT to forge more immediate connections with indigenous communities who have historically experienced inequities in healthcare access and treatment. Recognizing this legacy, the Inner City Health Alliance is working with the Region to support indigenous led COVID-19 testing and assessment. Using the mobile primary care bus, in July 2020, they worked with a local organization to pilot locating the bus at a culturally safe environment for Indigenous residents to come out for COVID-19 assessment and testing, and to seek primary care as needed.

The COVID-19 testing pilot is an important initial step in starting to build meaningful and trusting relationships with the many Indigenous residents in the region. The KW4 OHT will use it as an opportunity to keep building relationships with the Indigenous Communities in the subregion and look at sustainable solutions to provide culturally safe health care, e.g., identifying a network of primary care clinicians that have received Indigenous cultural safety training; and working towards understanding the importance of a wholistic approach to health and wellbeing that includes both traditional and western medicine and can support the community in the long term.

4.3.2. How will you work with Francophone populations?

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

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

Max word count: 500

French speaking residents comprise 3.3% of our population. Our OHT leadership includes bilingual members at the Steering Committee and Operations team. Currently, the following providers offer FLS in KW4.

• The Alzheimer Society Waterloo Wellington is identified under the French Language Services Act. It offers education, social work counselling and support and First Link Care Navigator (case management) services in French.

• CMHA Waterloo Wellington is also identified under the French Language Services Act. The website outlines the FLS available for our residents and includes a full range of counselling and mental health supports and services, available for children, adults and seniors.

• All Health Service Providers contracted through Home and Community at the WWLHIN are contractually obligated to provide services in French.

Since the fall of 2019 we have worked with representatives of the French Language Health Planning Entity to understand the recent research and analysis that has been done in our community to understand the needs of our Francophone residents and the gaps in service they experience.

Existing Needs and Issues

• The provider's perception of the patient's ability to speak and/or understand English does not always mean that it is the client's preferred language of service. The missed identification of such a barrier, especially when health matters are at play, may affect the patient's experience and subsequent care.

• Data collection around FLS is inconsistent. Not all providers are actively identifying their Francophone patients. Comparatively, users of the system may not self-identify for a variety of reasons (assume the service doesn't exist, not wanting to be a bother, worried it'll take longer to access care, etc.) Providers misinterpret the lack of demand as a lack of need for FLS, and the community does not request services due to lack of active offer.

• Given that our region falls below the 5% threshold for FLS, little data is captured about the availability of French speaking health human resources in KW4. This means it is not possible to pool or share French speaking service providers on a predetermined basis among the many health and community service organizations.
• Although interpretation services exist, patient experiences reveal that these services are often not offered to clients or are not well understood by staff members. There is opportunity to better equip the system to use this as a way to access linguistically appropriate care.
• There is no care pathway or navigation often leaving access to FLS random and a matter of happenstance. The responsibility for FLS often falls on the shoulders of a single employee at a given HSP and the capacity is then lost when that person moves on. There is opportunity for a more concerted approach regarding FLS within the OHT.

Our Year One Strategy
• Reach out to OHTs in northern Ontario communities with larger French speaking populations to leverage their experience and services.
• Integrate the need for French language interpretation services with the translation services strategy already identified for target populations in year one.
• Collaborate with sister OHTs and Health Force Ontario on HHR recruitment standards to ensure our desire for French speaking health providers is known.
• Investigate current processes for capturing demand and supply for French language services in KW4 to identify gaps in data integrity to enable setting of priorities for year two and beyond.

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

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

Max word count: 500
Within and across our priority populations and the subregion, the KW4 OHT is planning targeted activities with several sub-populations.

1. As noted in the previous section, we are working with the region to support Indigenous-led COVID assessment and testing, and to begin establishing relationships to support better primary care access for Indigenous peoples.

2. We have an immediate focus on supporting an anticipated 76 Government Assisted Refugees (GARs) expected to arrive in our community during the last months of 2020 (the first 16 having arrived at the end of August); and approximately 350 newborns of refugees expected in the next 12 months.

3. The KW4 OHT includes three rural municipalities (who account for 14% of our population) that have been uniquely impacted by the COVID pandemic. The OHT's rural health and community service partners continue to support their community in innovative ways with fewer resources. For example, through a cross-sectoral group that has been meeting monthly throughout the pandemic to plan and problem solve as issues arrive.

• An important program to keep frail elderly out of hospitals and in their homes, reduce wait times and lower costs is the Regional (MINT) Memory Clinics. Approximately 11% of Regional Memory Clinic patients are referred by rural primary care practitioners and plans are already underway to expand the WW Regional Memory Clinics to rural locations in our OHT.

4. Pervasive across all three priority populations are challenges related to mental health and addictions and/or brain injury, and this has been exacerbated by the COVID-19 pandemic. The KW4 OHT continues to coordinate with relevant integration work occurring in this sector; and we are seeking to augment access to mental health services through primary care in our first year of work. Examples of our work with the sector include:

• Liaising with the Addictions and Mental Health Program Council comprised of 15 providers throughout Waterloo Wellington, which since the time of our original self-assessment has transitioned into an advisory group for the newly formed Centre of Excellence for Mental Health and Addictions.

• OHT partners connected to the Connectivity (situation) and Specialized Outreach Tables that work collectively to provide health and community interventions, including mental health and addictions and/or brain injury services for vulnerable residents.

Examples of our plans to support mental health access through primary care include:

• Liaising with the Counselling Collaborative, a community-based partnership between six counselling providers within Waterloo-Wellington that is coordinating with primary care to ensure residents who otherwise do not have access to short term counselling, can be referred to counselling through their primary care practitioners.

• The Refugee Health working group has mapped mental health services currently available to refugee patients and has identified gaps and opportunities for additional mental health resources.

• We are considering a pilot to create an interprofessional team with care coordination/system navigation, mental health and pharmacy that would support non-team-based primary care practitioners as they care for complex patients with mental, cognitive and/or physician health needs.

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

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

Max word count: 500

The KW4 OHT plans to maintain a focus on the three vulnerable populations identified in the expression of interest, homeless and precariously housed, frail elderly and refugees. However, with an immediate and ongoing priority on supporting the COVID-19 response, the OHT will remain flexible to the care needs of other populations that may be at increased risk for COVID-19 and influenza.

The KW4 OHT, in development through Wave 1, participated robustly on health system response tables led by Waterloo Wellington COVID-19 Command Triad members. To ensure the COVID-19 response is sustained, the KW4 OHT Steering Committee and WW Triad are collaborating on an agreement of roles and responsibilities. The Triad and representatives of OH West, will continue to act as an enabler, support and means for escalation of the pandemic preparedness and response activities that the KW4 and sister OHTs are operationalizing.

A Wave 2 preparedness plan has been developed, identifying key actions that the OHT can take in their respective community. The major areas of planning and implementation include testing, IPAC, congregate care settings, vulnerable populations, service resumption, health human resources, supplies, virtual care, communication, and supporting a sub-regional approach to supporting primary care and Public Health in delivering flu immunizations. As noted in Section Three, this work will be supported by several active KW4 OHT working groups.

The strategies employed during Wave 1 of COVID will all be maintained and expanded with a focus on enhanced partner communication, capacity for the continuation of essential services like primary care and mental health and addictions,

and the delivery of linguistically appropriate care. Much of the coordination and response in Wave 1 of COVID was to extend supports to settings where these individuals congregate. Congregate care huddles took a risk-based approach to offering COVID-related supports (IPAC, testing, staffing, PPE) to LTCs and RHs where frail elderly patients were at higher risk for exposure and infection.

We will continue to integrate LTC/RH into the broader system through communities of practice, interprofessional outreach teams, and enhanced caregiver respite supports. The KW4 Inner City Health Alliance mobilized to provide mobile testing at shelters and on the streets, relocate shelter beds for greater social distancing, and stand up an isolation unit for homeless/precariously housed individuals. This work will continue with a priority to provide 24/7 clinical outreach, continued mobile testing, and stabilization of health human resources to serve this population.

The KW4 OHT now has a focus on extending support to other congregate care settings such as developmental service, mental health, and supportive housing, collaborating with OH and various Ministries on targeted and risk-based responses. We are also relying heavily on our OHT partners in Public Health, primary health care, and assessment centers to implement respiratory care strategies to make assessment, testing and isolation of COVID and influenza cases safe and efficient.

From a patient flow perspective, hospital, homecare, community support services, LTC and primary care partners are all coordinating a short- term and longer-term strategy to improve the movement of ALC patients from hospital out to community, to ensure capacity for hospital surge and concurrent resumption of scheduled care.

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

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

Max word count: 1000

Patients, families and caregivers have been integral to our work as a group of KW4 health and wellness organizations since our Self Assessment. At that time we built on the experiences of our signatories engagement with clients to bring lived experiences to our tables. Since September 2019 we struck working groups for our planned first year target populations (frail elderly, refugees and homeless/precariously housed) and included persons with lived experience in those working groups.

Our KW4 Steering Committee continues its leadership role; two of ten are persons with lived experience and as family and caregivers and three are leaders in other community sectors. Through the fall we reached out to our community to help create our vision and goals for a KW4 improved model of care experience. Through our WWLHIN's PFAC roster we ensured

those voices were strongly present. As we focused again on preparing for the Full Application, we added additional working groups for Data, Performance Management and Quality Improvement and Home Care and Community Care, each with community representation for the codesign process. These working groups will join the three target population working groups as ongoing implementation planning and subsequently monitoring groups within our OHT.

Our plan for year one includes fulfilling our long held objective of creating and implementing a community engagement strategy, anchored by a “PFAC” for the OHT – what we are now calling a “Community Council”. Our intent is to build on what we have learned through the COVID-19 response period to date to build the design and approach for our Community Council that reaches beyond those who typically volunteer in these roles and reach into traditionally marginalized, vulnerable and at risk populations. Through our consultations we have heard the strong desire to collect racialized and disaggregated data and our OHT has put a fine point on our original health equity lens to be even more inclusive as we reach out to the HIV/Aids community and our Indigenous residents to co-design culturally appropriate COVID testing strategies. We will build lessons learned into our Community Council composition and its approach. We intend to consult further on how people wish to participate with us and the best way we should approach engaging in ongoing co-design. We have no preconceived notions that traditional PFAC structures are most appropriate for all our populations. Our goal is to build a well thought out co-designed Community Council model that will give voice to all the populations in KW4. We fully expect “one size” solutions will be inappropriate, and may end up with a constellation model that brings together a wide variety of engagement approaches under an overall umbrella label – Community Council.

We will begin researching other models of engagement, including successes in other parts of our community such as Wellbeing Waterloo Region, youth engagement approaches championed by UNICEF and the opportunity to work alongside Family Councils at our community’s long term care homes.

Our year one plan is in place. However, our immediate work is preparing for COVID-19 wave 2 and beyond, within the IMS structure established for COVID. The OHT meets weekly with the Non-Hospital Leadership table locally to ensure the voices of our residents are channeled through our Waterloo Wellington Triad to the policy work being done by Ontario Health. Our ongoing facilitation of partner “Huddles” to feed information and concerns up through the Triad and respond to directives coming down through the Triad keeps the voices of our residents ever present. Through our ongoing meetings with Signatories we are learning about “on the ground” experiences of people, families and caregivers being impacted by the province’s pandemic response directives. The unintended consequences being experienced by so many residents are the foundations of many of the initiatives and priorities contained in this Application. Primary Care, Home and Community Care, Community Support Services, Hospitals, Long Term Care Homes, Retirement Homes and Congregate Care Settings all collaborate through the OHT to adjust community processes and plans to support new needs as these arise, monitor outcomes and provide data to ensure evidence informed decision making.

In June the OHT embarked on a Lessons Learned process to ensure we explicitly captured in our planning both the positive outcomes resulting from our COVID work, and just as importantly, the substantial gaps in care so significantly magnified through the COVID experience. We captured stories from front line workers, worked with CMHA WW to monitor mental health services demand and through our colleagues at the Inner City Health Alliance to capture real time homelessness data, monitor trends in overdoses and deaths and create a picture of the life experiences of our residents during this time. Our intent is to repeat this work later this Fall to ensure updated planning as winter approaches. These ad hoc engagement opportunities will continue as we put in place the foundation for our longer term engagement strategy.

We have established an Evaluation and Research Council whose first task has been to put in place and Evaluation Framework to help us understand the full range of questions we need to answer as we move forward. That framework will inform an initial plan for year one to commence a developmental evaluation process. The Community Council development work will dovetail with this evaluation process. Our goal is to make mid course adjustments as we proceed with our various engagement activities.

5.0. Implementation Planning

5.1. What is your implementation plan?

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

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

Max word count: 1000

The OHT Implementation Plan is three pronged: 1) ongoing response to COVID-19; 2) finalizing, prioritizing and implementing year one priorities; and 3) developing OHT internal support structure. Key elements are summarized below, and Appendix C outlines milestones/deliverables.

1. Respond to COVID

The KW4 OHT will collectively respond to COVID needs in community, including planning and coordinating responses in following areas:

Testing:
• Plan and/or participate in targeted, risk-informed testing campaigns
• Ensure stability and enhance testing and assessment capacity, including to rural townships and universities/colleges

IPAC:
• Ensure partners have resources and access to supports through PHO, PHU and OHT partners with IPAC expertise

Congregate Care Settings:
• Develop a partnered support model through phased approach from self-help to guided/onsite help for PPE, IPAC, staffing, testing
• Perform joint pandemic-preparedness exercises

Vulnerable populations:
• Develop and participate in proactive strategies specific to vulnerable patients (for example, mobile testing, isolation and 24/7 access to care for homeless)

Service resumption:
• Ensure sector recovery, system capacity and patient flow
• In preparation for subsequent waves, identify ramp-down triggers and core services that need to be maintained

Health Human Resources:
• Link into provincial and regional staffing strategies, while identifying and pooling local resources for redeployment

Supplies/PPE:
• Explore options for expanded local and diversified PPE distribution

Virtual/digital health:
• Sustain and expand remote and virtual care options

2. Finalize, Prioritize and Implement Year One Priorities

The OHT working groups continue planning year-one for implementation starting April 1, 2021. Work across the three priority populations will fall under five integration themes and drive outcomes for five performance measures (PMs) described in Section 4.1 and Appendix D, along with a balanced scorecard to be developed.

i) Theme one: Increase use of virtual care

• Building on recent increases in virtual care, the OHT continues to support adoption of VirtualCare in primary care and LTC; and to consider other digital tools to enable care.

○ For example, including virtual tools as part of a range of supports to address caregiver distress among home care clients (PM#1); and to provide virtual triage, primary care, and/or health and community care services to ensure residents whose conditions are best managed in community stay out of hospital (PM#2).

ii) Theme two: Increase primary care attachment

• Given ongoing primary care attachment challenges, we are working to increase primary care's capacity through COVID with a sub-regional approach to coordinating flu vaccinations and other COVID-related primary care needs.
• Similarly, we are looking at ways to increase primary care's capacity to take on new patients from year one populations to ensure residents whose conditions are best managed out of hospital are cared for in community (PM#2); and to address frequent emergency room visits for mental health and/or addictions (PM#4).

iii) Theme three: Increase integration across primary care and specialist care

• Lessons-learned through COVID include impacts related to health and community service-closures across KW4. As we resume services in KW4, we are looking at how to address caregiver distress among home care clients (PM#1) and the ALC rate (PM#3) through more integrated care.

iv) Theme four: Increase and coordinate mental health and addiction services

• All three priority populations have identified mental health service gaps and opportunities that pre-exist or have emerged through COVID, some of which we are considering how to address in year one.
• For example, House of Friendship and Inner City Health Alliance (ICHA) continue to pilot Sheltercare initiated during the COVID response; and the Inner City Health Alliance is currently launching a six-month, pilot project with 24-hour nursing support for homeless.

○ We will learn from, and potentially build on both pilots about how socially and medically complex patients whose conditions are best managed out of hospital are cared for in community (PM#2); and to address frequent emergency room visits for mental health and/or addictions (PM#4).

v) Theme five: Increase and systematize care coordination options (system navigation, outreach, access to LHIN services).

• The OHT is exploring ways to employ in-home care coordination and care where needed with a particular focus on frail elderly to address our alternative level of care rate (PM#3) and total expenses for frail elderly (PM#4).

3. Build OHT Internal Support Structure

OHT Leadership

• Operating Model

○ In alignment with Ontario Health's Operating Model, KW4 OHT has created a conceptual structure (Appendix E) with the people needing services and their families at the top.

• CDMA

○ Using the MOH Guidance Checklist, OHT Design Framework and My Journey documents as road maps, we will develop a CDMA that enables OHT leaders to engage in consensus-oriented, collective decision-making to achieve shared goals, accountabilities, and opportunities for improving care.

Stakeholder Engagement

• Change management

○ The OHT will experience significant change as we continue to mature (i.e. governance, strategy, culture and partnerships, technology, Integrated care etc.). Effective change management is a critical success factor.

• Communications

○ Communication is fundamental to relationships built on transparency and trust, for obtaining input and creating awareness, for rallying support, for celebrating successes, for dealing with crisis, etc.

• Community Council

○ Patient partnership, community engagement, and system co-design are important OHT principles. This will involve meaningful engagement and involvement including inclusion on Steering Committee, working groups and creation of a Community Council.

Digital Health

• Strong digital capabilities are critical enablers of system-integration and information-sharing among HSPs. The Digital Health Playbook guides our work and will be augmented with advice from OH West Digital Health Advisory Committee. We will build on local relationships with KW4's vibrant technology sector.

Financial & Performance Management
• Establishing financial and performance measures, identifying a baseline, monitoring progress, seeking opportunities to reduce inappropriate variation, implementing clinical standards and best evidence, pursuing joint quality improvement activities, and engaging in continuous learning will help ensure we are championing integrated care.

Strategic Planning
• Developing a Strategic Plan will enable multi-year goals for the KW4 OHT. It will articulate the 'what' and 'why' of our existence and help us identify longer-term health system priorities and plans for our community. It will not only identify what we want to accomplish but how it will be accomplished. It will also provide a mechanism for oversight of the implementation of OHT deliverables.

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

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

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1. Continue to provide clear communications about government expectations.
• Ensure clear communication about overarching priorities related to OHTs and the ongoing COVID-19 response from provincial bodies such as Ontario Health and Ministry of Health.
• Create single sources of accurate and timely information that can be accessed and referred to by OHTs.

2. Share data and support data analytics.
• Up-to-date data related to the KW4 OHT would assist us in ongoing planning.
• The KW4 OHT would also benefit from accessing data from other OHTs to understand peer performance, identify benchmarks and high performers, and for insight and expertise into the interpretation of centralized data sources.
• We support the idea of the Ministry of Health enabling a centralized repository for close geographical areas (e.g., the previous WW LHIN region) if appropriate. This would include dataset creation / maintenance, hosting, privacy, security, etc.
• As we move forward, KW4 OHT is eager to work with government to identify existing regional and/or community-based resources including those in the former WW LHIN and Homecare that best align to advance the government's model through our OHT approach.

3. Help OHTs navigate privacy legislation and policies to ensure integrated care and better outcomes.

• As the privacy legislation is provincial, ensuring a centralized resource to support questions related to the development of integrated privacy and information security policies, procedures and data governance models is necessary for both success & compliance.
    ○ This includes digital management of patient information, changes to home and community care information management practices, and applying legislation in a manner that supports optimal data sharing amongst KW4 partners and/or with surrounding OHTs (ie. HINP versus prescribed entity versus other).

4. Provide centralized project management and change management support where possible.
• Depending on cascading goals from Ontario Health to Ontario Health West to KW4 OHT, we see value in centralized project management and change management services where relevant to ensure progress, accountability, lack of bias within the management, and efficiencies.

5. Take a provincial approach to managing and navigating labour relations.
• With the proposed changes to the Home and Community Care Act and ideas generated around transfer of resources, there are likely implications to local and provincial collective bargaining agreements.
• Having expertise and support to navigate these changes and engage in a productive dialogue with the provincial bargaining groups would reduce political negativity and help present a unified voice amongst OHTs.

6. Support our population health approach.
• While the local public health units are engaged with the ongoing COVID-19 pandemic, there is room for further expertise in broader population health management approaches and best practices, especially as they relate to our priority populations and performance measures.
• Along with best practices around management given the mobility of our patients (20% access care outside KW4 and 20% from outside KW4 access our services) knowledge and support for technology to enable a broader population health approach would be useful.

7. Continue to share best practices amongst OHTs.
• The KW4 OHT has benefitted from the experiences of its sister OHTs in Waterloo Wellington region; and is learning from other OHTs in Ontario through webinars, publications and on-the-ground relationships.
• Building on knowledge banks such as RISE and other methods of sharing redesign activities, lessons learned and evaluation results, and/or OHT management should be a continued resource.

8. Collaborate and align across Ministries.
• Many of the strategies to address the social determinants of health fall outside the purview of the Ministry of Health.
• Increased collaboration amongst the different ministries, such as Health, Long-term Care, Children, Community and Social Services, and Municipal Affairs and Housing will be required to provide a conducive ministerial policy atmosphere to support our OHT development.
• Encouraging the related ministries to have more communications together at a provincial level to embrace the development of OHTs would be beneficial to mobilizing healthcare, community and social services partners to work collaboratively together.

9. Advocate for timely Clinical Connect and coordinated care planning enhancements.
• Enhance and expand the Clinical Connect modules and coordinated care plan access in CHRIS, in a timely manner to include sharing patient information across the continuum of care, e.g., primary care, and mental health information.

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

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

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BARRIERS

Funding Models
Historical funding models focus on activity rather than outcomes and value and on episodes of care rather than person centred care models across the continuum of care. All OHT partners need the flexibility to move or share funding without the need for multiple layers of approval.

Physician and nurse practitioner funding models impact our ability to deliver innovative care.
• Early in the COVID response, Grand River Hospital and St. Mary's General Hospital Emergency Departments (EDs) piloted virtual visits to allow patients to connect with an ED physician. This pilot was ended when ED physicians were unable to apply a billing code that accurately captures the complexity of these visits.
• The Ministry of Health (Primary Care branch) has yet to approve a business case submitted by WW LHIN to develop alternative funding models for physicians.
  ○ The WW LHIN and Inner City Health Alliance submitted two business cases in 2020 outlining the challenges of providing primary care to those who are homeless when working within a fee-for-service model; and provides alternatives.
  ○Given the complexity and vulnerability of our year one priority populations, being able to fund physicians and Nurse Practitioners (NPs) in alternative ways, e.g.,

salaries for physicians, and additional billing options for NPs, will enable us to fairly compensate primary care practitioners currently working with complex patients; and to recruit additional health human resources to support these populations.

Legislation to Support Workforce Flexibility

• Local and provincial collective bargaining agreements (CBAs) can restrict or delay movement of staff within and outside current roles. This inhibits the flexibility required for an ongoing COVID response, and hinders trialing new models, as experienced by partner OHTs with new models for home and community care delivery. Ongoing considerations to allow for the redeployment/reassignment of staff between organizations, as was permitted through a directive order during the pandemic, would be helpful.
• Provincial decisions related to legislation and policy; and any sharing of resources throughout the KW4 system will require review of all impacted parties' local CBAs and without regional and provincial support has the potential to prevent human resource sharing across the OHT partnership.

KDCHC-SRHC Voluntary Integration

Failure to approve (Ontario Health) and fund (Ministry of Health) the voluntary integration of the Kitchener Downtown Community Health Centre (KDCHC) and Sanctuary Refugee Health Clinic (SRHC) initiated in April 2020 will impact the KW4 OHT refugee year one priority population.
• This planned integration was fast-tracked early in COVID-19 pandemic to ensure sustainability of SRHC and extend team-based care to 5100+ refugee patients since OHIP billings would not sustain SRHC's costs over the pandemic.
• The KDCHC Board of Directors approved implementation of the first phase of integration, by:
    ○ A permanent redistribution of $250,000 annualized funding from KDCHC's budget, and assuming SRHC's payroll (including physicians traditionally paid for via fee-for service).
    ○ Signing an agreement that makes SRHC a satellite of KDCHC.
    ○ Integrating the two EMRs and training all staff new to PS Suites.
    ○ Transitioning resources (e.g., staff COVID-19 screeners) from KDCHC to SRHC as needed.
• These efforts are fundamental to addressing the needs of the year one refugee priority population.

Sustaining an Ongoing COVID-19 Response

The region of Waterloo has a relatively high number of COVID cases compared to other Public Health Units in Ontario. As a result, the significant COVID response has increased provider stress levels and burnout.
• The brief reprise during the summer is giving way to planning for a potential second wave concurrent with influenza season, and a sustained sub-regional effort to resume services and address backlogs caused by health and community service system slowdowns (I.e. surgical and diagnostic back logs).

• New IPAC regulations regarding shared spaces (e.g., reduction of ward beds in LTC/Hospitals, cleaning practices between patients in clinics, social distancing in care settings, etc.) has groups focusing attention, effort, and resources on ensuring core operations can continue.
• The reduction of capacity in the region's LTC (reduction of 5% in the broader WW region) beds due to Directive 3 will cause pressures on patient flow to those homes.

Privacy

With the increase in digital options implemented during the first months of the COVID-19 response, and the plan to increase the number/types of visits and providers using virtual services, there are ongoing questions related to health data and patient information security.
• Direction regarding options or changes to regulations is required to ensure care providers and patients feel secure and supported with digital care.
• Common goals across the OHT are to: ensure patient information can be shared and is accessible; to minimize duplicate information; and to enable longitudinal views of the patient's journey. Secure sharing of patient level data across providers is challenging and the existing mechanism for doing so (i.e. HINP model) is resource-intensive with multi-sector partners. Significant work will be required to design/implement an integrated approach to allow patient data sharing across the continual care journey.

ENABLERS

Collaboration around COVID Response

Despite Waterloo Wellington's relatively high proportion of COVID-19 cases, KW4 quickly united under a shared goal. OHT lessons learned compilation identified numerous new and innovative coalitions and collaborations previously described. Although some fatigue is setting in, the community feels a sense of teamwork and possibility around the KW4 OHT.

Diversity and Expertise Among Community Organizations

The KW4 region has a wide variety of organizations and sectors who bring expertise in many different facets of health care. These organizations include traditional health care services (primary care, hospitals, LTC and other), community organizations a range of services to residents, universities and research centres that bring an academic rigor to improving care, and municipalities in rural and urban areas. Many of these organizations have indicated a desire to be official partners of the OHT, or to otherwise collaborate with KW4 OHT.

The KW4 community is also home to a vibrant and varied technology sector that has connected closely with the healthcare system during COVID through direct outreach or events such as the Hackathon. The OHT will continue to build on these relationships as we work to further enable digital care where appropriate.

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.	