Connected for Care: Lanark, Leeds and Grenville

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.

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.

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 the 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

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 to 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 healthcare-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.

[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.

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 with 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.

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 the 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 the 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: Barry Guppy
	Title: President and CEO
	Organization: Perth and Smiths Falls District Hospital
	Email: barry.guppy@psfdh.on.ca
	Phone: (613) 284-7898
Contact for central program evaluation	Name: Barry Guppy
	Title: President and CEO
Please indicate an individual who the Central Program Evaluation team can contact for follow up	Organization: Perth and Smiths Falls District Hospital
	Email: barry.guppy@psfdh.on.ca
	Phone: (613) 284-7898

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:

[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.

Maximum word count: 500

The Lanark, Leeds and Grenville (LLG) OHT recognizes the challenges in providing health services across a broad geographical area and smaller predominantly rural population. The LLG OHT believes that the provision of high-quality care based on the 6 Health Quality Ontario dimensions of quality must be the focus. These fundamental dimensions of care include: efficient, timely, safe, effective, patient-centred and equitable. The LLG OHT believes that a special emphasis is needed on equity, to ensure that every resident served by the OHT has equitable access to health services with a reasonable expectation of similar health equity and health outcomes regardless of any resident's circumstances.

With this in mind, the OHT aims to build an integrated system of primary care across our area through which all residents have equitable access to a range of services and supports needed to build and maintain health. Without an integrated primary care system and ensuring that all residents have a primary care home, substantive change across many priorities including mental health and addictions (MHA) and improvements in population health will be very difficult. The LLG OHT intends on using the MHA Year 1 priority population as a mechanism to support the strengthening of an integrated primary care network while improving access to care and outcomes for residents with MHA issues. Consequently, the LLG OHT Year 1 population and change initiatives will inform the evolution and maturation of our OHT and how we will care for our full attributable population at maturity.

At this time, the LLG OHT intends on working toward the attributed populations represented by the "Naturally Occurring Networks" (NON) for Network 9 and Network 10 based on the Institute of Clinical Evaluative Sciences (ICES) methodology. These networks are inclusive of populations principally from the United Counties of Leeds and Grenville and from the western, central and southern portions of Lanark County. The population attributed to the LLG OHT is a total of 94,657, with 36,676 from Network 9 and 57,891 from Network 10. The LLG OHT recognizes that the two NON are distinctly different and represent very different contexts, patient populations and health status issues.

The LLG OHT has been developing a cluster or "constellation" model in order to organize the OHT in a manner that recognizes the uniqueness of both NONs but is structured to advance overall population health through the creation of an OHT of sufficient size to be operationally and strategically viable at full maturation.

The LLG OHT team is aware that there are 3 other OHT proposals "in-development" who are geographically adjacent to the LLG OHT and who are generally within the complex NON referred to Network 8 (Ottawa Satellite). These OHTs include the Lanark County OHT, Three Rivers OHT (Arnprior), and the North Rideau Health Alliance (Kemptville). Depending on the direction determined by the Ministry of Health and these OHTs, the LLG OHT team believes that the cluster/constellation model would allow the unique features of the local health systems represented by any interested OHT groups to be successfully incorporated.

Draft guiding principles that will shape how we work together as a group and with the people and communities we serve are included in Appendix A. These principles will be finalized in the coming months as part of the Collaborative Decision-Making Framework.

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 on initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

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

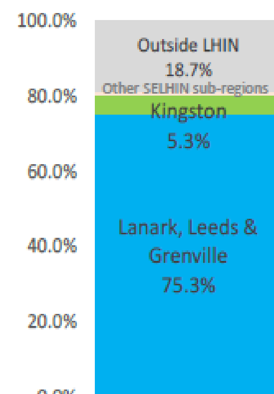
If this Year 1 population differs from previously submitted documentation, please provide a brief explanation (for example, many teams have seen changes to their priority populations as a result of COVID-19).

Maximum word count: 500

In Year 1, the LLG OHT will focus on a subset of the attributed population including: (a) residents who are unattached to a primary care provider and; (b) residents with a diagnosis of a MHA disorder(s) who are challenged with accessing MHA services resulting in (i) being unable to attain care; and/or (ii) have an avoidable Emergency Department (ED) visits.

Unattached Patients:

There are a wide range of primary care models including three CHCs, one NPLC, four FHTs, and two FHOs unaffiliated with an FHT in the LLG region. In 2017, there were approximately 118 family physicians in the LLG sub-region with 78.3% of the attributed population within a Patient Enrolment Model (PEM) while 21.7% attached to a Fee-for-Service provider. The number of unattached patients are unknown.



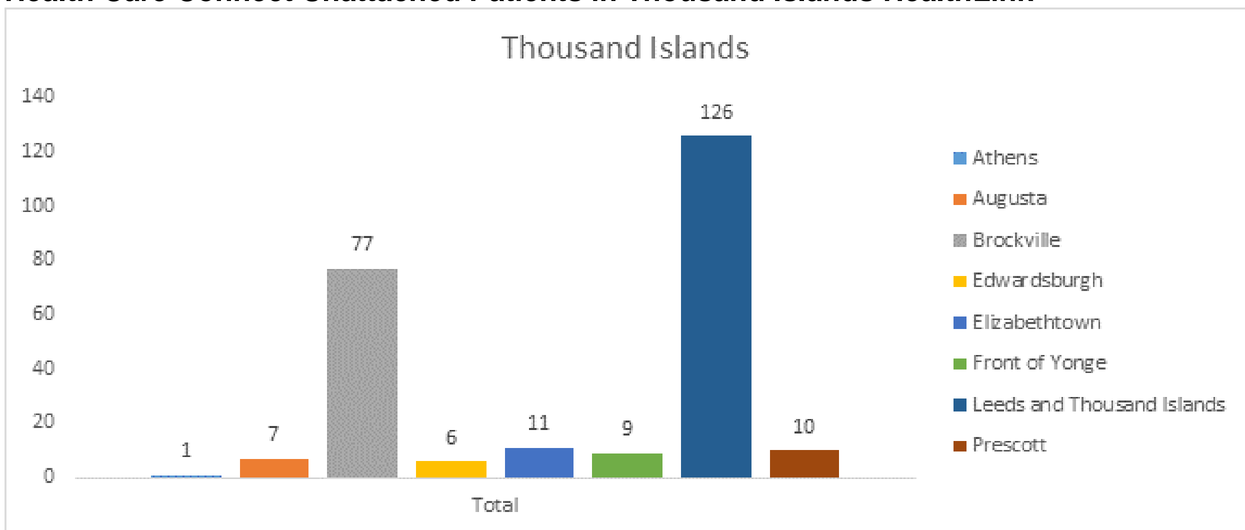
In September 2019, 97.4% of LLG residents reported having a primary care provider[3] although almost 1 in 5 non-CHC residents seek primary care outside of the region.

There are currently 446 unattached patients on the Health Care Connect (HCC) roster, with 247 in the Thousand Islands Health Link and 199 in the Rideau-Tay Health link respectively. It is well recognized that the HCC roster significantly underestimates the number of unattached patients.

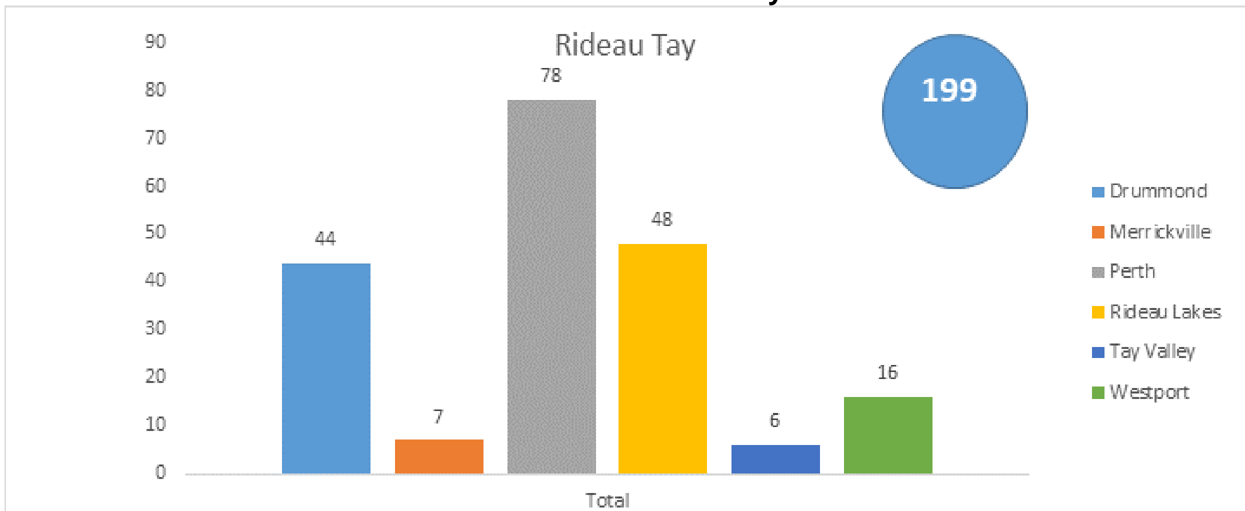
The following tables provide a geographical distribution of unattached patients within the two Health Links in the LLG OHT area as of September 8, 2020:

[3] Health Care Experience Survey, Ontario Ministry of Health

Health Care Connect Unattached Patients in Thousand Islands HealthLink



Health Care Connect Unattached Patients in Rideau-Tay HealthLink



All primary care models throughout the LLG area have agreed to participate in a project aimed at identifying and connecting residents to primary care.

Equitable Access to MHA:

According to the CCHS[4] completed in 2017, 21% of the population in LLG reported being diagnosed with a mood and/or anxiety disorder. Furthermore, NACRS[5] data from 2014/15-2016/17 indicates that LLG has overall higher rates of ED visits for MHA as the main problem (21.0 per 1,000 LLG compared to 19.2 per 1,000 Ontario). Increased ED utilization is higher for all age groups, especially for younger (0-17, 18-44) and older (80+) groups. According to the 2017 LHIN Sub-Region Profile, there were 37.3/1000 ED visits best managed elsewhere in the

[4] Canadian Community Health Survey

[5] National Ambulatory Care Reporting System

LLG sub-region as compared to 16.4/1000 for Ontario. The LLG OHT expects even higher levels of MHA issues over the longer term due to COVID-19[6].

ED visits with Main Problem of MH/SA rate per 1,000 population	Lanark, Leeds & Grenville	Ontario
Age 0-17 years	16.3	9.8
Age 18-44 years	35.7	29.5
Age 45-64 years	16.5	16.2
Age 65-79 years	10.7	10.4
Age 80+ years	23.2	18.6

In Year 1, the LLG OHT plan is to attach MHA counsellors to primary care models throughout the region in a phased approach. This initiative, in association with a strategy to ensure that all residents have a primary care home, will enable:

a. A preventative approach where patients with less severe MHA issues are assisted in primary care reducing the likelihood a patient will require a higher level of care (e.g. hospital EDs, in-patient resources);
b. Enhanced primary care capacity for diagnosis and management of MHA issues;
c. Seamless transitions to higher-level MHA services when needed (e.g. psychiatry, case management, BGH crisis team, Assertive Community Treatment (ACT) outpatient program)

A current state analysis has been started to identify where primary care settings are already directly linked with MHA services and where there are gaps. Various attachment models will be utilized and phased-in based on the community need and the characteristics of the primary care practice including, but not limited to, on-site location (permanent or rotational) and virtual attachment models.

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.

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.[7] Other information sources may also be used if cited.

[6] Mental Health in Canada: Covid-19 and Beyond CAMH Policy Advice July 2020. See: https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/covid-and-mh-policy-paper-pdf.pdf

[7] 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.

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

Maximum word count: 1000

It is recognized by the LLG OHT that a person's mental health is affected by a complex interplay of various factors including social, economic, and physical conditions operating at different stages of life. Some of the many determinants of mental health include income, education, housing, transportation, working conditions, access to appropriate services and level of social and civic participation[8]. These areas are important to recognize and consider as Year 1 strategies and activities are planned as they influence the MHA needs of our community and present opportunities for intervening to reduce the risk.

Furthermore, the LLG OHT serves a population that is aging and has a high level of rurality as compared to Ontario. Both factors present important considerations as the OHT plans for care delivery for MHA services, as well as the population as a whole. Beyond this, additional consideration is needed to address health inequities for specific populations including those with economic disparities, Indigenous populations and Francophone populations.

Aging Population

According to the 2016 Census, 25.7% of the LLG population was age 65 or older, compared to 16.9% for the province overall. Based on population projections, this population is expected to grow to 33.5% by 2026, with the population age 75 and over, in particular, expected to grow by 46% in this short time frame. This is expected to result in an increasing prevalence of aging-related physical and mental health conditions over time. In the context of the LLG OHT, an aging population has difficulty accessing many of the health-related services required, as the services are often located in larger urban centres.

Rurality

The OHT geography spans 4,249km^2, with 57.1% of the population living in a rural area or small town and 24.1% of the population residing in rural or small communities adjacent to urban areas. With less than 20% of the population living in small to medium urban centres and none living in large urban centres, there is a high dependency on private transportation to receive many health services. As a result, many organizations must consider rurality in planning service delivery and adopt virtual care enablers where possible. In particular to the primary care system, there are many types of primary care available but access to inter-professional care is inequitable and based largely on where people live rather than on healthcare needs or level of vulnerability.

[8] World Health Organization 2014. See: https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

Economic Disparities

According to the 2016 Census, the percentage of the population in LLG living below the low-income measure was 14.6%, which is similar to the LHIN (14.6%) and province (14.4%). However, there are higher rates of children (ages <6 and <18) living in low income households than the SE LHIN overall and provincially (21.8% vs 20.8% vs 19.8% for <6, and 19.4% vs 18.5% vs 18.4% for <18, respectively).

The LLG population has slightly higher rates of unemployment at 8.0%, compared to 7.4% provincially. Moreover, there are higher rates of dependency (reflecting those who do not have income from employment) overall across the geography, with the LLG region falling within the highest quintile for dependency relative to other areas of the province. Sub-geographic detail is outlined in the heat map below, with darker colours indicating higher levels of dependency. The high dependency rates are likely due to the higher proportion of older adults in the LLG region.

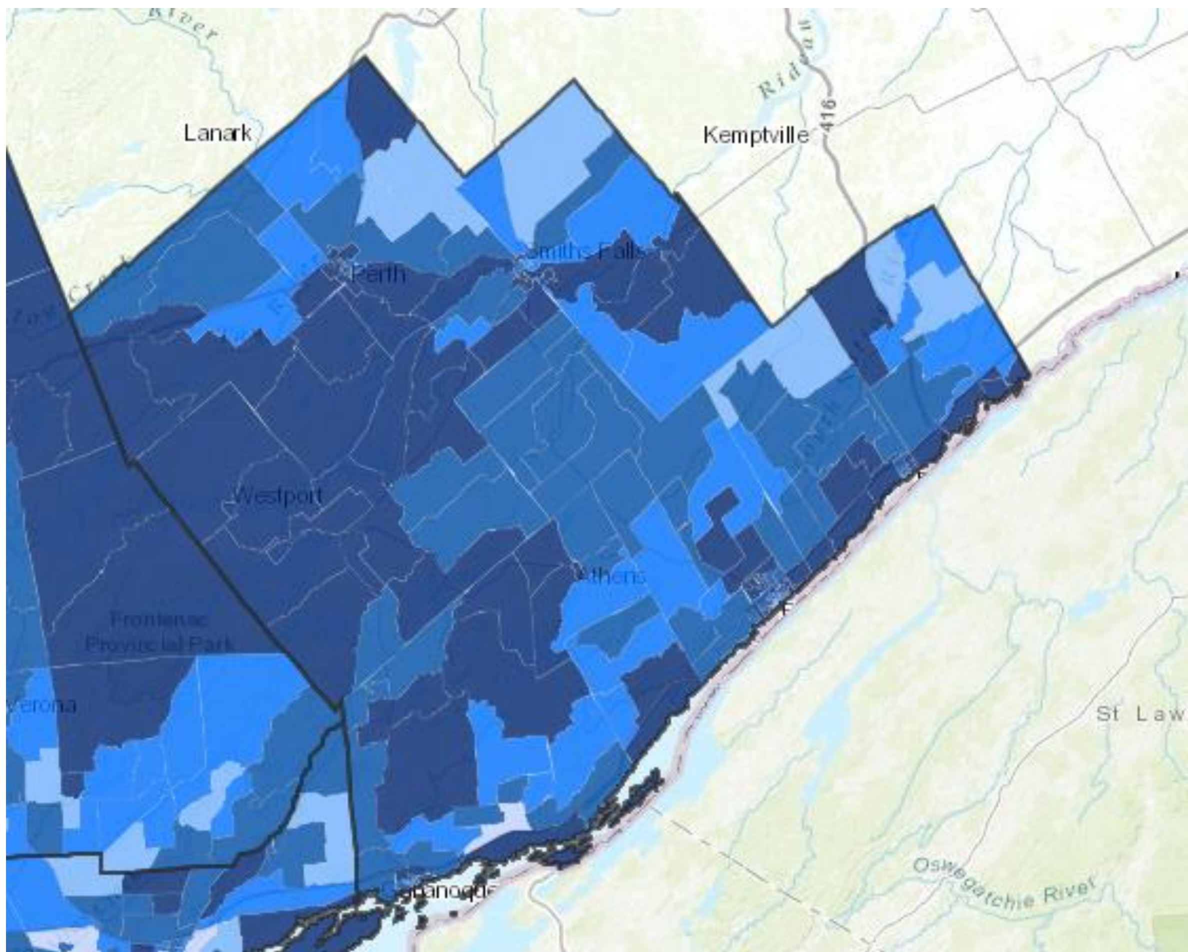


Figure 1: Level of Dependency in Lanark Leeds & Grenville. Data Source: Matheson, FI; Ontario Agency for Health Protection and Promotion (PHO). 2016 Ontario marginalization index. Toronto, ON: Providence St. Joseph's and St. Michael's Healthcare, 2018.

The LLG OHT geography has areas with higher levels of material deprivation (quintile 4 overall), with areas around and within Brockville, Smiths Falls, Prescott, Gananoque and Perth

having the highest levels of material deprivation (quintile 4 and 5) as outlined by the darker colours in the image below. Material deprivation is closely connected to poverty and it refers to the inability for individuals and communities to access and attain basic material needs. This is important to note, as service utilization trends vary based on the level of deprivation. The Health Equity Snapshot by Public Health Ontario (2020) reported that the rates of ED visits for mental health reasons in the LGLDHU (Leeds, Grenville and Lanark District Health Unit) were more than 2 times higher for the least materially advantaged group compared to the most advantaged group in 2016-17. Moreover, rates of alcohol-attributable hospitalizations in LGLDHU were 2.5 times higher for the least materially advantaged group compared to the most advantaged one in 2016-17.

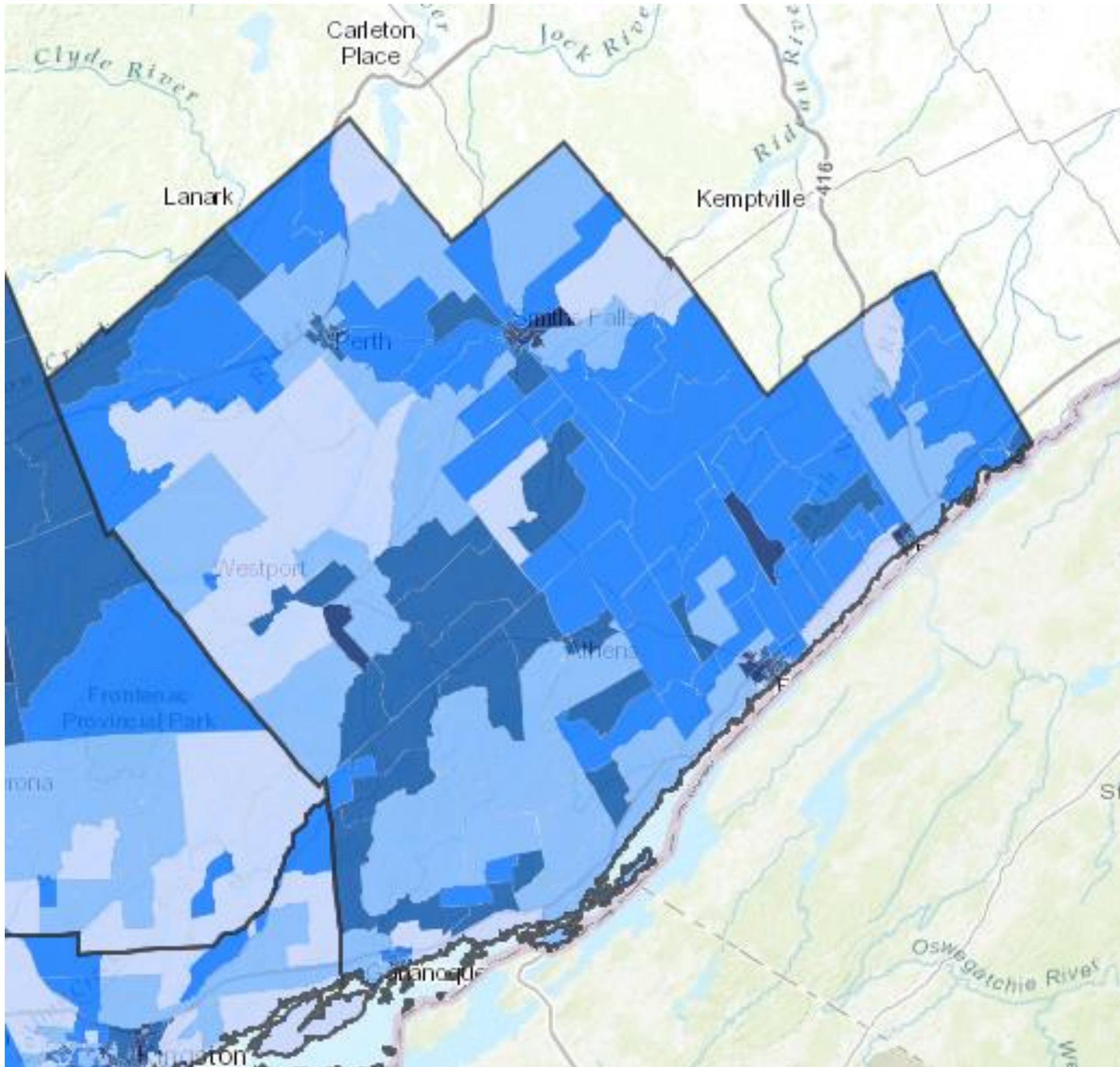


Figure 2: Level of Material Deprivation in Lanark Leeds & Grenville. Data Source: Matheson, FI; Ontario Agency for Health Protection and Promotion (PHO). 2016 Ontario marginalization index. Toronto, ON: Providence St. Joseph's and St. Michael's Healthcare, 2018.

Indigenous Populations

Based on the 2016 Census, there were 3,925 residents in the LLG area who identify as having an Aboriginal identity, representing 3.5% of the population. This was lower than the SE LHIN percentage (4.7%) but slightly higher than Ontario (2.8%). Municipalities with higher proportions of residents reporting an Aboriginal identity include Edwardsburgh-Cardinal (5.8%), Smiths Falls (4.7%), Front of Yonge (4.7%) and Montague (4.6%). According to the Canadian Community Health Survey 2010-2014 (Statistics Canada), there is a significant difference in the rate of individuals that reported not being diagnosed with a mood disorder between the overall population in LGL (90%) in comparison to the Indigenous population (77%).

Francophone Populations

Based on the 2016 Census, there were 3,705 Francophones as per the Inclusive Definition of Francophone Population, representing 3.3% of the LLG population. This was slightly higher than the SE LHIN percentage (3.0%) but lower than the provincial value (4.3%). Municipalities with higher proportions of residents identifying French as their mother tongue include Merrickville-Wolford (5.6%), Edwardsburgh-Cardinal (4.7%) and Montague (4.7%).

Other Populations for Consideration

There are several other populations identified by the OHT that will warrant specific consideration and further discussions such as individuals with developmental disabilities, individuals experiencing homelessness and members of the LGBTQ community.

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.**

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 below

Team Member	**Other Affiliated Team(s)** *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 addictions services)*
Alzheimer Society Lanark Leeds Grenville	● Lanark County OHT	The Alzheimer Society of LLG operates Memory clinics at the Ottawa Valley Health Team and the North Lanark Community Health Centre and receive referrals from these teams for our services.
Athens Family Health Team	● Frontenac Lennox Addington OHT	Athens FHT expressed interest initially in affiliation with the Frontenac Lennox Addington OHT but have not been actively involved in the development of their full application
Bayshore	● Algoma OHT ● Barrie and Area OHT ● Brampton and North OHT ● Etobicoke Area OHT ● Couchiching OHT ● Équipe Santé Sudbury and Districts OHT ● Frontenac Lennox Addington OHT ● Guelph and Area OHT ● Hills of Headwater - Dufferin Caledon OHT ● KW4 OHT	As a service provider organization and due to the uncertain nature of OHTs, we have attached to several OHTs in order to continue providing services for the geographic areas that an OHT represents.

	• Mississauga OHT (Trillium) • North York Central Health System OHT • Ottawa East • Scarborough • Southlake	
Canadian Addiction Treatment Centres (CATC)	• North East OHT • Potentially multiple OHTs	CATC has been selected as an “innovative model” and will be working with any OHT where CATC provides OAT clinics.
Carebridge	• Lanark County OHT • Three RIvers OHT	The main reason for affiliation with all listed OHTs is that the jurisdictions of these OHTs would have overlap with current community support services (CSS) catchment or service area. Carebridge felt it was important to be present at all OHT tables to ensure CSS was represented.
CarePartners	• Hills of Headwaters Collaborative OHT • Couchiching OHT • Mississauga OHT (Mississauga Health) • Brampton/Etobicoke and Area OHT • Peterborough OHT • Northumberland OHT (Ontario Health Team Northumberland) • Huron Perth and Area OHT • Western OHT (London) • Cambridge North Dumfries OHT • Connected Care Halton (Halton Healthcare Corp) OHT • Great Barrie Area OHT • Oxford OHT • Guelph OHT	As a service provider organization across Ontario, CarePartners is working with many OHTs where the organization provides services for the geographic areas that an OHT represents.
Children’s Mental Health of Leeds & Grenville	• North Rideau Alliance OHT • Kids Come First OHT	Children’s Mental Health of Leeds & Grenville (CMHLG) is both a core service provider and a lead agency for system planning for the service area of LLG. As local teams were organizing prior to the first submission of proposals, several teams spanned the communities we are funded to serve. Because CMHLG is the only

		child and youth mental health agency, it was critical to ensure the services we provide were represented in all OHT teams that spanned the service area. CMHLG is not a full signatory of the Kids Come First OHT as we do not provide service in the Ottawa region. The children, youth and families we serve however, may require tertiary services from CHEO. The children, youth and families of LLG may also benefit from the development of regional or specialized resources available through Kids Come First. CMHLG has co-developed a mental health and addictions hub with Kemptville District Hospital. Based on our service provision in the North Grenville area and our partnership to provide the hub services, we have supported the North Rideau Alliance. It is unclear at the time of this application if the Rideau Alliance OHT will move to full application. As such, CMHLG's primary affiliation is the LLG OHT.
Leeds, Grenville and Lanark District Health Unit (LGLDHU)	● Lanark County OHT ● North Rideau Health Alliance (NRHA) OHT The LGLDHU is an affiliate member of the above OHTs	All of the applications where LGLDHU has been an affiliate include part of the area of the Leeds, Grenville and Lanark District Health Unit. LGLDHU is committed to working with each OHT bringing the public health and population perspective.
Perth and Smiths Falls District Hospital (PSFDH)	Lanark County OHT	PSFDH is a medium-sized hospital operating on two hospital sites located in Lanark County. Approximately 80% of the hospital's activity in the ED, Same-Day Surgery and In-patient Days are derived with residents of Lanark County, while the remainder of residents come from the United Counties of Leeds and Grenville (plus a small portion from Frontenac County). PSFDH is participating in both the Lanark County OHT and the LLG OHT until a determination of the future of both OHT proposals is determined to ensure that the hospital's role in serving residents within each OHT proposal are fully captured. PSFDH is the governing sponsor of two community agencies serving Lanark County - Lanark County Mental Health and Lanark County Support Services.

Providence Care	• Frontenac Lennox Addington OHT • Rural Hastings OHT • Belleville and Quinte West OHT	Providence Care provides services across the South East Ontario Region: • In the community - Community Mental Health Services include Adult Mental Health, Dual Diagnosis, Adult Brain Injury and Attendant Care, Behavioural Support Mobile Response Teams and Community Treatment Order programs; • In Providence Care Hospital - Regional short term In-Patient Adult Mental Health Beds, Specialized Mental Health, Rehabilitation, Complex Care and Palliative Care beds; • In Providence Manor long term care home-resident bedrooms and Adult Day programs and Respite Care. The Providence Care Board has committed to continuing these specialized services and working with local OHTs to meet the needs of their population.
March of Dimes	• Durham OHT • Hamilton Health Team • Burlington OHT • Niagara OHT • Chatham Kent OHT • Guelph and Area OHT	March of Dimes Canada is a National organization with services throughout the province of Ontario. We want to ensure we continue to meet the needs of our clients and Ontarians with disabilities throughout our service catchment areas, and to also build relationships with our partners throughout the continuum of care.

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.

Max word count: 1000

Members of the OHT have a successful history of collaboration to advance integrated care, value-based healthcare and population health. Some of the many examples include:

A. The integration of MHA services into other parts of the health system which has been a principle of LLG system development in recent years. We will build on these partnerships and leverage these experiences to deliver better-integrated care more broadly within our population.

- This practice has been evident with MHA workers in the opioid substitution therapy clinics in Brockville, Smiths Falls, Carleton place and Gananoque. In these clinics, MHA counsellors and caseworkers are available on a walk-in basis to provide people who are attending these clinics with immediate MHA services. These MHA workers are integrated with the opioid staff and other service providers, like public health, so that transition is seamless as all health programs focus on client service in these clinics.

- A similar example of health service integration is between MHA services and primary care in both the Athens District FHT and Country Roads CHC. In both of these rural parts of our OHT, there is an embedded MHA counsellor who does this specialized therapy service on-site. This embedded model provides enhancements of the counsellor being able to collaborate directly with the health care personnel in the office. They also have access and can view the electronic medical record (EMR) for any additional information and also communicate with providers through messaging in this modality. This provides a positive experience for the patient in being able to not have to travel outside of their community for this service and the comfort of receiving this care within their primary care office.

- Our region has also had opportunities to link specialty geriatric mental health services to primary care, improving access for frail seniors, through the Primary Integrated Service Model (PRISM). Some of our inter-professional primary care teams including our CHCs have access to memory clinics, geriatric mental health assessments, on-site fitness and seniors support programs. These partnerships represent the true integration that can be achieved by embracing a philosophy of 'your roster is our roster' and highlight the importance of maintaining a quality improvement approach, open communication and a shared vision. This initiative aimed at ensuring all residents have access to an equitable range of supports needed to meet their health needs offers many lessons the OHT can leverage (see Appendix B for further detail).

B. The integration of MHA services into other parts of the system including emergency services.

- Brockville General Hospital (BGH) has partnered with local Ontario Provincial Police (OPP) in a pilot project embedding mental health workers within OPP services to ensure timely and immediate intervention for mental health-related encounters. A similar approach has been taken in Lanark County with a partnership between Lanark County Mental Health and the Lanark County OPP since 2018.

C. Partnerships to address health human resource challenges.

- Many parts of the broader LLG OHT geographical area have had health human resource challenges, particularly in the area of primary care. This has resulted in increased utilization of EDs to obtain primary care and higher rates of Canadian Triage and Acuity Scale (CTAS) 4 and 5 patients in Network 9. Prior to COVID-19, a Health Human Resources Collaborative

was created to address primary care shortages in the Network 9 area. This involved collaboration between the hospital, primary care, municipal, economic development sectors and included community representatives. This has contributed to the recruitment of several new family physicians in the area.

D. Partnerships formed and lessons learned through the Health Links.

- One of our premier learning opportunities for the past 7 years has been those learned through Health Links. The integrated “Health Links Approach " to supporting complex patients to remain in the community serves as a strong foundation for the LLG OHT (see Appendix C and D for further detail). Some of the many lessons learned through this approach and collaboration include:

  - The cost and care implications of coordinated care planning which involves client/caregiver, primary care, specialist care and community supports
  - The need for user-friendly digital health solutions and technological integration in order to effectively support complex patients
  - The crucial role of care coordinators/system navigators to support and advocate for complex patients to obtain support in the community
  - The need for standardization of major business processes as well as roles and responsibilities of organizations and providers who were attempting to operationalize the Health Links model of care
  - The need for consistent use and acceptance of the Coordinated Care Plan (CCP) with aligned interpretations of its purpose and its owner (i.e. Health Information Custodian).

- A community rounds table that provides a venue for communication, resource sharing and brainstorming complex cases among various community agencies. The evolution of this collaborative table that evolved from the work of Rideau Tay Health Link embodies what we would envision our OHT could look like at the front line. This includes partner agencies coming together to support each other in the care of complex clients. Through this community rounds table, we have seen enhanced communication, reduced duplication, improved transitions of care as well as an increase in clinician satisfaction.

- Our region is fortunate to have a number of inter-professional primary care models including 3 CHCs and 1 NPLC. As a result, our region has significant expertise in understanding and addressing health inequities and the social determinants of health. We will leverage experience in community development, system navigation and in understanding population health to identify and support our most vulnerable residents. Our year one focus on MHA will be supported by our experience in Health Links and innovative approaches such as social prescribing, an evidence-based approach to linking individuals who have social and health barriers to a wide range of non-traditional supports in the community.

E. Partnerships to address COVID-19 related needs.

- Since March our local LLG District Health Unit, PSFDH, BGH, paramedic services and primary care groups have been working closely together to organize and contribute to the

staffing of COVID testing/assessment centres in our area. There has been a great collaboration and strengthening of relationships working together during the COVID-19 pandemic. This work is continuing this fall in preparation for a potential second wave of COVID-19 and also planning for the start of influenza season and flu shot clinics.

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

Max Word Count: 500

The strengthening of partnerships between members of the LLG OHT contributed positively to the collective response during the COVID-19 pandemic. In both Network 9 and Network 10, primary care, public health and the hospitals partnered to create and operate the COVID-19 Assessment Centres (CAC). In Network 9, the PSFDH created a new professional staff category to enable nurse practitioners from the local CHCs and NPLC to work in the hospital CAC. In Network 10, Primary Care fully operated the CACs and provided the necessary coordination and staff in partnership with support from public health, BGH and municipal partners. Further details are described below.

Challenge and opportunity - Lessons from COVID-19

As a result of the above collaboration between LLG OHT partners in addressing challenges faced across all organizations, partners were able to:

- Provide safe and effective medical and mental health care
- Efficient use of staff
- Conservation limited Personal Protection Equipment (PPE)
- Increase ability to perform COVID-19 testing
- Plan for the worst-case and best-case scenarios of disease activity and severity
- Keep up to date with local and provincial public health, Ministry of Health and Ontario Health recommendations

One essential opportunity that emerged from the collaboration of partners was the establishment and operation of COVID-19 Assessment Centers (CACs). CACs were set up in Brockville and Smiths Falls, and both continue to function at the time of this application. The initial set-up and dynamic nature of the CAC response and operations allowed Primary Care, Hospitals, Public Health (and in the case of Brockville, the municipality, police and paramedic services) to experience and depend on collaborative decision-making. The 2 CACs in Brockville and Smiths Falls operate differently as each community has found a model that best serves its needs and resources. As in many CACs across the province, the collaborating organizations needed to quickly innovate a solution that worked with the available resources. In the case of

Brockville, primary care (which includes 4 FHTs) is able to redeploy management, administration and nursing support in addition to Primary care providers.

The co-creation model in the CACs also provided a vehicle for more continuous communication. In Brockville, primary care leaders have attended the Brockville General Hospital Incident Command meetings since the onset. The Incident Command meetings were initially daily in addition to regular calls which include the hospital, public health, primary care, paramedics, city hall and police that occurred twice daily initially enabling the consideration of multiple perspectives and rapid communication of decisions and necessary changes.

Links and communication within Primary Care have also been strengthened through the pandemic, with tighter cohesion and collaboration within the 4 FHTs in Brockville and the 2 FHOs in Perth and Smiths Falls.

Another opportunity to come from COVID-19 is the rapid and broad use of adoption of virtual care. This will continue to shape how care is provided where, when and how patients want it.

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)
- 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
- The 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 an inpatient bed

- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- 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 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).

The LLG OHT believes that primary care is the foundation of our local health system. Reliable access to strong primary care is elemental in determining and providing appropriate care and supporting navigation across the health system. This is particularly important as it pertains to the first-year priority population where strengthening access to high-quality MHA services within the local health system is needed.

There are significant differences between Network 9 and Network 10 when it relates to emergency visits best managed elsewhere. Focused efforts will be made to areas where the most impact can be achieved.

Challenges in access to primary care have also contributed to significant alterations in various relevant quadruple aim indicators. For example, the Lanark, Leeds and Grenville area, there is a significant increase in the number of Emergency Visits best managed elsewhere as compared to the rest of Ontario (37.3/1,000 for LLG versus 16.4/1000 for Ontario). Overall Hospitalizations for Ambulatory Sensitive Conditions are also significantly increased as compared to Ontario (7.4/1,000 for LLG versus 4.6/1000 for Ontario). The rate of CTAS 4 and 5 visits to hospital EDs are also significantly increased with 457 visits per 1,000 in LLG as compared to 140 visits per 1,000 in Ontario. In Network 9, almost 10% of all patients attending an ED do not have a primary care provider in the community. Many of these wayward performance indicators are directly related to access to primary care in the community.

Many performance metrics are being collected at the present time by our OHT member organizations. Metrics will be used to measure our priority population and activity of MHA transitions of care across the continuum of care. This includes coordination of care among member organizations but also coordination with community services and social services to maximize benefit. It will include the collection and analysis of process and outcome metrics.

Data governance and data analytics will require significant focus over the first three years of the OHT. The intent is to develop a robust continuous quality improvement plan including data governance. At maturity, the data model will include operational metrics, (e.g. Number of coordinated care plans); results-based metrics (e.g. Reduction in the number of avoidable ED

visits) and; outcome-based metrics (e.g. Overall health system experience). To demonstrate improvements in health outcomes for the priority several performance measures will be collected and analyzed (as noted in the chart).

The overall performance framework for the first year of the OHT development will include:

Phase 1:

A number of performance metrics are already available and reported across the system related to the change initiatives proposed by the LLG OHT. Collection and analysis of metrics that are already in place include:

1. Wait time (referral or self-referral to 1st encounter) across the continuum of care serving the priority population.
2. ED visits by the priority population and some analysis of deferability – primary care and/or mental health and addiction services.
3. Clients provided with care coordination including a Coordinated Care Plan and coordination with Community and Social Services.
5. Client/patient satisfaction including timeliness, system navigation (e.g. OPOC-MHA).
6. Provider satisfaction including communication, system navigation.
7. Virtual care delivery measurement.

Phase 2:

As the second component of the performance monitoring and management, the LLG OHT will focus on the development of a common scorecard including:

1. Inventory of performance indicators currently being captured.
2. Development of a key performance indicator matrix.
3. Identification of common measurement tools to collect the information outlined above.
4. Analysis of cost to implement the common measurement tools.
5. Development of the implementation plan including:
   - Identifying the lead responsible for collecting and analyzing the data
   - Developing a governance data sharing agreement
   - Determining training needs/plans
   - Determining how the data collected is distributed and utilized.

Within the above framework, for each change initiative LLG OHT has proposed a series of performance indicators (including process and outcome indicators as applicable), along with a series of monitoring indicators that are more directly linked to quadruple aim indicators. While the LLG OHT will be assessing impacts on monitoring indicators in Year 1, it is expected that any substantive improvements may not be realized until Year 2 and beyond.

The LLG OHT believes that accountability of the local health system performance requires full public transparency and reporting in addition to reporting to the collaborative decision making table and the governors of member organizations. The LLG OHT will target reporting on a quarterly basis at a minimum.

The proposed metrics are as follows:

<u>Change Initiative #1</u>: Create a Primary Care Network (PCN) for the LLG OHT

Year 1 Performance Indicator(s)	Year 1 Monitoring Indicator(s)	Purpose/Rationale	Method of Collection/ Calculation
Number/proportion of primary care providers (family physicians, nurse practitioners) across all primary care models actively involved in the LLG OHT who are members of the PCN	As per Year 1	Participation rate in the PCN is an indication of the engagement of primary care providers in the OHT and related primary care initiatives	• Reporting by PCN and oversight monitoring by LLG OHT Leadership Committee • PCN Membership
Number of PCN meetings	As per Year 1		
Identification of a PCN "executive" to participate in the LLG OHT leadership committee /collaboration council	As per Year 1	An organized PCN across the OHT will also ensure an appropriate leadership role on the OHT Leadership Committee/ Collaboration Council	
Improved provider experience and satisfaction	As per Year 1	A high functioning PCN with robust engagement processes is expected to improve provider satisfaction	• Provider experience satisfaction using pulse surveys

<u>Change Initiative #2</u>: Work towards ensuring all residents are attached to a primary care home

Year 1 Performance Indicator(s)	Year 1 Monitoring Indicator(s)	Purpose/Rationale	Method of Collection/ Calculation
Overall proportion of residents attached to a primary care provider in the community	• Decrease in the number of patients attending an ED who do not have a primary care provider in the community • Decrease in ED visits for conditions best managed elsewhere • Decrease in hospital admissions for ambulatory care sensitive conditions • Decrease in the proportion of CTAS 4 and 5 ED visits • Decrease in the overall number of avoidable ED visits	Improvements in unattached patients is expected to translate into lower rates of low acuity and avoidable ED visits and a decrease in the rate of admissions for ambulatory care sensitive conditions Unattached patients attending an ED will be targeted	• Local data provided by Brockville General Hospital (BGH) and the Perth and Smiths Falls District Hospital (PSFDH) captured at time of patient registration • ED visit volume, CTAS score and primary care provider in the community tracked and reported through NACRS
Decrease in number of unattached patients on Health Care Connect roster	• As per Year 1	Unattached patents on the Health Care Connect roster will be targeted	• Health Care Connect data provided by SELHIN

Change Initiative #3: **Create a system where mental health and addiction services are attached to all primary care settings**

Year 1 Performance Indicator(s)	Year 1 Monitoring Indicator(s)	Purpose/Rationale	Method of Collection/ Calculation
Number/proportion of primary care teams with attached MHA counselor	• As per Year 1	Reporting on the number of primary care teams with attached MHA counselor is a process indicator related to the success of the change initiative	• Reporting by PCN and oversight monitoring by LLG OHT Leadership Committee
	• Number/proportion of avoidable ED visits for residents presenting with MHA condition Note: Report on MHA population overall and on residents without a primary care provider in the community	Attachment to primary care. Timely access to appropriate community services. This indicator measures access, capacity and effectiveness of primary care and community based MHA services in responding to and managing less urgent MHA conditions.	Numerator = Number of CTAS 4 and 5 unscheduled ED visits for MHA conditions in the previous quarter. Denominator = Total number of unscheduled ED visits for MHA conditions in the previous quarter. Data Source: BGH and PSFDH Clinical Information Systems
	• Number/proportion of residents with Primary Care follow-up within 7 days of hospital inpatient/ED discharge following presentation for MHA condition	Improved transitions related to attachment to a Primary Care Provider. This indicator measures the percentage of MHA discharges that had a follow-up visit to either a primary care physician or psychiatrist, within 7 days of discharge.	Numerator = The number of patients who within 7 days of discharge following index hospitalization had at least one psychiatrist or primary care physician MHA visit. Denominator = The number of acute care discharges from an episode of care in which a MHA condition is diagnosed and is coded as the most responsible diagnosis. Data Source: Ontario Health Insurance Plan (OHIP) Claims History Database

	• Number/proportion of unscheduled repeat ED visits within 30 days following an ED visit for a MHA condition	Reduction in ED visits demonstrates access to community services and attachment to a Primary Care Provider. An increasing trend toward patients visiting the ED for MHA conditions has been observed locally. This indicator was added to better understand this issue and how the system can best support these patients.	Numerator = Number of unscheduled ED visits for MHA conditions in the last 30 days of the previous quarter and the first two months of the reporting quarter followed by another visit within 30 days for a MHA condition. Denominator = Total number of unscheduled ED visits for MHA conditions in the last 30 days of the previous quarter and the first two months of the reporting quarter. Data Source: BGH and PSFDH Clinical Information Systems
Number/proportion of complex/ high-needs patients/clients with coordinated care plans	• Decrease in 30-day readmission rate for MHA condition • Decrease in avoidable ED visits related to MHA condition	Improved patient/client experience. Improved access to services. This indicator measures the percentage of complex/high-needs patients who have a coordinated cross-sectoral plan of care, i.e. Shared Health Integrated Information Portal improving the flow of information between providers and decreasing utilization of hospital resources.	Numerator = Total number of complex/high-needs patients residing within the area enrolled within a FHT or other primary care provider and registered within the Shared Health Integrated Information Portal. Denominator = Total number of complex/high-needs patients residing within the LLG OHT area enrolled within a FHT or other primary care provider. Data Source: Shared Health Integrated Information Portal.
	• The proportion of patients who have a follow-up visit with a primary care provider or primary care MHA provider within 7 days • Decrease in average wait time for initial contact with MHA worker	• Promote the use of advance access and other mechanisms (e.g. Measurement of the 1st and 3rd available appointment)	• Local MHA service provider reporting • Data captured and reported by CIHI through NACRS and DAD • Provider experience satisfaction using pulse survey • Client patient satisfaction using a validated assessment tool (e.g. Ontario Perception of Care Tool for Mental

			Health and Addictions - OPOC-MHA)

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[9].

Max word count: 500

Digital health solutions are the cornerstone to health service delivery and have the ability to improve patient health outcomes, increase accessibility to quality health care, and ensure the effective and efficient delivery of health care services – all in a manner that protects privacy and security. It is understood that technology and particularly digital health solutions are core to improving the quality of care and improving the efficiency and cost-effectiveness of that care. COVID-19 has magnified the need Digital Health requires a strategic approach to introducing new ways to solve complex problems. Within the LLG OHT, digital health must be managed strategically to improve and enable the delivery of high quality care. Within the realm of healthcare, a high-performing health care system invests in digital health assets strategically to improve the delivery of high quality care and to support patients and families in navigating the health system.

[9] 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.

Digital Health and specifically virtual care priorities will represent a balance of provincial, regional and local priorities. A network of hospitals in Southeastern Ontario, including the two hospitals in LLG OHT, are in a process to obtain a Health Information System (HIS) as a standard system across the region. This HIS transformation will drive data standardization that will facilitate information sharing with all partners across our region and will be a powerful lever for enabling a value-based health care.

Direction contained within Ontario's Digital health playbook and related targets for Year 1 virtual and digital deployments will be central to the LLG OHT. The Patient-Facing Digital Health Policy will be leveraged specifically for virtual care implementation to support patients requiring mental health supports (acute and chronic) in Year 1. Virtualized services also to include clinical program outcome measurement. Focus will be on upscaling of mental health virtual care delivery across OHT to support additional hospital and community programs. Currently a number of OHT partners are leveraging a combination of Aetonix and OTN to support mental health workflows. One such project has introduced custom modules that support remote psychotherapy counselling which includes patient-therapist communication, virtual homework and patient surveys. Opportunities to incorporate existing provincial assets endorsed by the former OTN, will also be an important foundation to virtual care support to vulnerable populations. All virtual care and digital health tools will ensure that both content and end-user experience support Indigenous and Francophone cultures.

These tools are intended to be scaled through the introduction of a digital health delivery model that will orient OHT patients and providers to a more service-oriented experience. A virtual care framework for the LLG OHT defines the organizational assets and capabilities required to optimize the delivery of virtual care. Best practices from the following 4 domains will be critical to operationalizing virtual care and digital health deployment:

*__Strategy -__ development of virtual care roadmap; use case creation; defining technology/virtual care strategic and operational priorities.

*__Governance -__ policy assessment and governance (privacy, information management, acceptable use); development or decision-making/risk management structures and processes; management roles/structures.

***Technology Selection -** requirements gathering; procurement; contracting.

***Implementation -** workflow design; project management; patient engagement; change management; evaluation & monitoring.

A Digital Health Centre of Excellence approach will allow for the integration of a standard suite of digital health tools and services to enable alignment of technology participation and streamline what has been uncoordinated services from various digital health service providers. The 4 domains referenced above for virtual care are applicable for all digital health deployments. Technology available to support LLG OHT include:

- Virtual Care Visits
- Virtual mental health/psychotherapy supports
- Digital Yellow Card

- ConnectingOntario
- System Coordinated Access/eReferral
- eConsult
- eNotification
- SHIIP (regional Business Intelligence)
- Regional Collaboration via Business tools (e.g. Sharepoint/MSTeams)
- Computer Maintenance and implementation
- Health Report Manager
- Health Information System Renewal
- Procurement Coaching/Support

The LLG OHT is also developing other opportunities related to advancing virtual care[10].

Contact for digital health	Name: Gina Johar
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	Title: Chief Information Officer
	Organization: Brockville General Hospital
	Email: GJohar@brockvillegeneralhospital.ca
	Phone: 613-243-3427

[10] The LLG OHT recognizes that there are a multitude of opportunities presented to health service providers through Ontario Health and LHINs. LLG OHT is committed to aligning all virtual care and remote patient monitoring opportunities (e.g. community support services, MHA, acute sector) and ensure a standardized approach to product selection, interoperability and overall strategy and governance of such investments.

Through natural partnerships and collaboration, the LLG OHT has made positive progress in developing an ecosystem of tools that streamline the provider experience as well as reduce the number of platforms for patients to potentially access. Although a single solution would be ideal, product and process maturity are required to enable such an approach. As a result, we will initially have a multi-vendor presence in our region and ensure that these tools streamline workflows in respective sectors and support circle-of-care use. We will use standards (as suggested in the application narrative)

Representatives from LLG OHT are currently in the process of submitting business cases to the following virtual care opportunities:

- RPM (Remote Patient Monitoring) Funding to support unattached patients, mental health patients and support COVID Assessment centre processes. Focus will be on strategy development, upscaling of existing successful RPM pilots in LLG OHT, and development of a sustainability model to support continued virtual care service delivery.
- Virtual Care Funding – Community Funding Initiative.

As mentioned above, alignment to LLG OHT priorities will supersede these activities and the overlay of a strong virtual care framework will be instrumental in the success of these initiatives. Copies of the above-mentioned applications will be available upon completion, should further information be required.

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

Although there is not a First Nations community within the LLG OHT, 2016 census data indicates there were 3,925 residents in the LLG area who identify as having an Aboriginal identity, representing 3.5% of the population. Aboriginal identity includes persons who are First Nations, Metis or Inuit and/or those who are Registered or Treaty Indians and/or those who have membership in a First Nation or Indian band. Of this total, over half identify as First Nations (56%) and over a third identify as Metis (38%). In terms of this population's demographics, 38% are between the ages 0 to 24, 54% are between 25 to 64 and only 8% are over the age of 65.

There is variation across the OHT geography in the proportion of residents that identify as Aboriginal, with highest counts in the following municipalities: Edwardsburgh-Cardinal (5.8%), Smiths Falls (4.7%), Front of Yonge (4.7%) and Montague (4.6%).

Members of the LLG OHT are committed to implementing the recommendations from the Truth and Reconciliation Commission (TRC) and providing culturally safe care in year 1 through to maturity. One way the OHT aims to improve care is by engaging in online training including the provincial Indigenous Cultural Safety training (ICS Core Health and ICS Core Mental Health) which was identified by Health Quality Ontario as one of the five quality improvement measures to advance health equity in 2018/19. This online training provides an opportunity for participants to examine the ways in which their own culture, education and history have shaped their practice, especially with regard to stereotypes that impact Indigenous experiences of the health system. Since 2018/19, more than ten LLG OHT members have participated in the ICS Core Health training and more than 5 have participated in the ICS Mental Health training. Engaging additional providers of our year 1 population in this training will contribute to improved patient experiences, access to health services, and health outcomes for Indigenous people. In addition, the LGL District Health Unit has recently formed an Indigenous Engagement Committee. This Committee has developed an internal education plan and aims to promote awareness of Indigenous resources in the community and build on their relationships with key stakeholders including Ottawa Public Health and leaders in the community.

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

Max word count: 500

Based on the 2016 Census, there were 3,705 Francophones as per the Inclusive Definition of Francophone (IDF) Population, representing 3.3% of the LLG population. The IDF includes both persons whose mother tongue is French, as well as persons whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home. The majority of this population (55%) is between the age 25 to 64, followed by 32% aged 65+ years and only 14% under the age of 24.

There is variation across the OHT with more eastern municipalities closer to the Ottawa region generally having higher proportions of individuals who identify French as their mother tongue. Municipalities with higher proportions include Merrickville-Wolford (5.6%), Edwardsburgh-Cardinal (4.7%) and Montague (4.7%). By comparison, municipalities further South and West have lower proportions including Front of Yonge (1.9%), Athens (2.2%), Leeds and the Thousand Islands (2.4%) and Westport (2.5%).

While the LLG OHT does not serve a designated area under the *French Language Services Act*, members recognize the importance of providing Francophone patients and their caregivers with the right care, at the right time, in the right setting. Our two-pronged approach to supporting Francophone patients, clients, caregivers and families across the region will involve a combination of:

1. Harnessing and pooling existing capacity within the LLG OHT members and
2. Enhancing partnerships with health service providers offering French Language Services outside of the OHT.

This approach will ensure we are able to connect patients with services and support a continuum of care for Francophones in French.

In Year 1, the LLG OHT is committed to better understanding the needs of Francophones in our community and mapping existing services through the continuum of care for our Year 1 target population. To further understand our current human resource capacity, we are working in partnership with the French Language Health Services Network of Eastern Ontario to review member's recent OZi submissions. Among 3 CHCs, 2 hospitals and 2 MHA agencies within LLG OHT that serve our year 1 priority population, there are nearly 200 staff that have French Language Service capacity ranging from the elementary level to superior. Further analysis will be done to determine how many of these staff are in patient-facing roles and collaboratively we will develop an FLS plan utilizing the tools and checklists described in the Advancing the Delivery of Health Care Services in French for Non-Identified Health Service Providers report (2019).

Although there are no designated FLS providers in the LLG area, there are several identified within the SE LHIN. These are listed at http://www.southeastlhin.on.ca/Page.aspx?id=4578&HSP&sc_Lang=en. The LLG OHT will explore opportunities to leverage both the skills of staff within LLG OHT who have FLS capacity member organizations and the expertise along with resources available from the SE LHIN and designated FLS partners within the SE LHIN.

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 subgroups (e.g., marginalized or vulnerable populations) who may have unique health status/needs due to socio-demographic factors. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities in Year 1 or longer-term.

Max word count: 500

The LLG OHT has an aging, rural demographic. According to the 2016 Census, 25.7% of the population was age 65 or older, compared to 16.9% for the province overall. There is a growing

understanding that older Canadians face many mental health challenges and that these are often under-reported. Loneliness, depression, grief and loss compound psychogeriatric conditions including dementia. Further information and considerations important to planning and service delivery for rural seniors can be found in the following report by United Way: https://www.unitedwayeo.ca/wp-content/uploads/2020/01/UWEO-Regional-Vulnerable-Senior-Report-EN.pdf.

There are many services within our OHT that seek to address the mental health needs of our older adult population. Services are provided by a wide range of organizations including funded agencies such as community support service agencies, Alzheimer's Society and primary care but also by community groups such as service clubs and churches and municipalities. Many of these supportive services that are available to seniors and their caregivers need to be better understood by primary care so that identified clients can be connected to them. These programs include diners clubs, socio-recreational programming, respite care, friendly visiting, food security programs and transportation.

To support better alignment of senior's mental health services across the South East region, the SE LHIN and Providence Care have engaged Corpus Sanchez International (CSI) Consultancy to deliver two key goals. These include: Completing a current state evaluation of specialized community older adult mental health services to create a regional system of integrated patient and care partner care through existing mental health community supports and inpatient services across the SE LHIN; and delivering clear and actionable recommendations for a comprehensive and integrated mental health "model" for older adults at the primary, secondary and tertiary levels that build on existing assets and strengths, as well as current and new partnerships to support older adults along the continuum of need. The LLG OHT will leverage this work over the coming years to further support the rural psychogeriatric population in our region.

There is also interest within the LLG OHT to explore opportunities for improving outcomes for residents with developmental disabilities. Organizations that serve this population, including Developmental Services of Leeds and Grenville, are active in our OHT and will inform opportunities.

Through our OHT, with service access and coordination as a key goal, primary care teams will have access to the information they need about programs and services available to their clients. Existing programs including system navigators, community health workers and social prescribing will inform our approach to helping identified populations connect with primary care and with mental health and related supports. Where appropriate, these approaches will be expanded so that they are accessible throughout our region. Our OHT will also be able to leverage the new investments and service expansion made by the Ministry of Health at the Brockville General Hospital for inpatient mental health services and inpatient rehabilitation. These enhanced services will be fully operational within the next 18 months.

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 support 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 LLG communities and settings in which social distancing and other infection control practices are a challenge include:

1. Poorly housed people in Brockville, towns, and rural areas - People in our region are living outdoors, including during inclement and extreme weather. People in Brockville are sleeping in Hardy Park during winter. In addition, people who are transient tend to frequent multiple establishments frequently throughout the day increasing the number of contacts. They do not have access to face masks, hand sanitizer, hand washing. Other people are "couch surfing" with a friend or relative. This housing is unstable. While each municipality has emergency housing arrangements, this does not provide long-term housing. In the spring, the United Counties set up a safe housing opportunity in a motel in Brockville that was supported by United Counties Social Service and the LGLDHU. Lanark County arranged a safe site where people with COVID-19 could self-isolate.

   The LGLDHU will continue to work with Social Services of both Counties to develop alternative arrangements for housing should the levels of COVID-19 pose a significant risk to people who don't have stable housing.

2. People using Illicit Drugs - The LGL region has seen an increase in overdoses, deaths, and emergency visits in 2020 due to drug use, mainly linked to fentanyl. This in part because of the change in drug sources with COVID-19 restrictions. In addition, the COVID-19 spring closing of in-person community supports for people with mental health and addiction contributed to increased instability for some people. Stable housing is also a challenge for many. Encouraging social distancing results in people using substance more frequently in isolation, increasing the risk of overdoses. Social distancing is a challenge for this group of people because so much of substance use is wrapped up in using with groups of people so they could have a large number of contacts. Another aspect to consider is that substance use and sex are closely intertwined (sex workers, MSM population) and therefore limiting number of contacts and practicing social distancing and infection prevention and control is very difficult.

The focus of the LLG OHT on mental health and addiction will provide a vehicle to consider the unique needs of people with addictions in light of the risk of COVID-19 and influenza. LLG AMH and the LGLDHU currently collaborate directly with Change Health Care (methadone clinics in Brockville and Smiths Falls) with on-site staff support. The Public Health Nurse provides information and education on safe COVID-19 practices, and influenza immunization.

In the community, the Public Health Unit provides harm reduction services at each of its services sites that includes information and education about safe COVID-19 practices, influenza immunization. Peer support workers connect with the community of people who use illicit drugs to support access to services along with information and education.

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

The LLG OHT has developed Terms of Reference and an information package to support the recruitment of an inaugural Lived Experience Advisory Network (LEAN) consisting of clients, patients, family members and caregivers who have lived experience across the complete continuum of care (see Appendix E).

As the priority population for the first year of the LLG OHT pertains to improving the care of individuals with MHA in the community, the LLG OHT team has been seeking the input of individuals who have lived experience in Mental Health and Addictions as part of preparing this application. This has included a consultation with a Family Advisory Committee from one of the member MHA agencies and a focus group that included participation of patients, clients, family members and caregivers from across LLG OHT member organizations. Participants in both lived advisor sessions were supportive of the change initiatives proposed by the LLG OHT and they highlighted several thematic challenges in their personal journeys within the local health system (see Appendix F). Several participants felt that the Year 1 change initiatives would be very helpful in addressing many of these challenges.

Although the LLG OHT had the objective of including a LEAN advisor on the committee preparing the full application, there was insufficient time to organize participation. The LLG OHT also has a working group to develop the collaborative decision making framework for the OHT and inclusion of a LEAN advisor is planned.

Work is underway to recruit LEAN advisors who have lived experience across the entire continuum of care. The LEAN will be aligned with the Patient Declaration of Values for Ontario, emphasizing respect and dignity, empathy and compassion, accountability, transparency and equity and engagement. The full range of partnering approaches will be utilized in soliciting and embedding the input from individuals with lived experience, including sharing, consulting, deliberating and collaborating. The views of those with lived experience will be incorporated at all levels, including design, delivery and evaluation, and will ensure that treatment is client-centred and responsive to the needs of the population.

The validated Public Patient Engagement Evaluation Tool developed by McMaster University will be used to evaluate the effectiveness of our public and patient engagement. Supplemental questions will be added to these questionnaires to address unique items if needed.

In addition, the LLG OHT is currently formulating an approach for broad based community engagement which ideally would be initiated following approval of the full application by the Ministry. In addition, the LLG OHT will be engaging other potential partners who are not currently members of the LLG OHT who can further expand the benefits to a population health approach to the care of our attributed population. This includes a special emphasis on organizations who can help the LLG OHT address social determinants of health.

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 3.1.

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 LLG OHT will organize three project teams to implement each of the three Year 1 change initiatives. A further project team will focus on advancing digital initiatives as an enabler for the Year 1 change initiatives and future OHT development.

The following tables summarize the 3, 6 and 12 month objectives for each of the three change initiative projects along with a rationale for these objectives. A project management approach will be utilized to manage the projects and ensure progress and objective milestones are met. The implementation and objectives will be tightly linked to the performance and monitoring metrics described in section 4.1 of this application. Regularly reporting of progress will be provided to the OHT leadership table.

Change Initiative #1: Create a Primary Care Network (PCN) for the LLG OHT			
Rationale	**3 Month Objective(s)**	**6 Month Objective(s)**	**12 Month Objective(s)**
As primary care is the foundation of the health system, an organized and integrated PCN is essential to Year 1 priority and subsequent OHT local health system improvements	● Develop/ strengthen local PCNs in both Network 9 and Network 10	Creation of a single LLG OHT PCN	● Establishment of regular meetings of the Network 9 and 10 PCNs and of the LLG OHT PCN ● Identification of Primary Care members for the LLG OHT leadership committee/ collaboration council

Change Initiative #2: Work towards ensuring all residents are attached to a primary care home			
Rationale	**3 Month Objective(s)**	**6 Month Objective(s)**	**12 Month Objective(s)**
In order to maximize health outcomes, improve equitable access to health services and reduce inappropriate health system utilization	● Identify all primary care assets in both Network 9 and 10 ● Identify potential additional capacity at a primary care model level .	● Implement community communication strategy to connect unattached residents to available/ appropriate primary care capacity	● Create an LLG OHT primary care health human resources plan ● Develop an OHT primary care recruitment strategy ● Coordinate with South East LHIN use of Health Care Connect Coordinators in creating a local unattached patient intake process

Change Initiative #3: Create a system where mental health and addiction services are attached to all primary care settings			
Rationale	**3 Month Objective(s)**	**6 Month Objective(s)**	**12 Month Objective(s)**
Integrating mental health and addiction services at the primary care level offers the opportunity to: ● Focus on prevention ● Increase primary care capacity for mental health and addiction services ● Ensure timely access for mild to moderate symptomatic cases ● Supports a stepped care model	● Identify all mental health and addictions assets in both Network 9 and 10	● Develop a phased plan to attach mental health and addiction workers to primary care models within the LLG OHT Notes: 1. Most appropriate or optimal attachment may include permanent embedding/colocation, rotational colocation, and/or virtual 2. MHA Counsellor will also act as system navigator to triage and refer to other services (e.g. case management, BGH crisis team or Assertive Community Treatment (ACT) outpatient program)	● Implement the plan to attach mental health and addiction workers to primary care models within the LLG OHT

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.

Max word count: 1000

In the coming year as an approved OHT, we would benefit greatly from resources including:

- A consortium: It has been extremely helpful in the child and youth transformation to have a consortium to move priorities forward provincially and have some consistency across the province. It has allowed resource sharing, evaluation and a provincial and local lens. It is comprised of the Executive Directors of lead agencies. There is a governance structure. We have a budget which primarily comes from each participant to cover practical costs and some priority work. We did receive some Ministry funds, however the work of the consortium is not completely reliant on funds.
- A repository of shared resources: lessons learned, best practices, engagement and communication strategies, as well as template documents for policies, agreements and structures from other OHTs ahead of us. Of particular benefit from the child and youth MHA transformation was such things as sample data sharing agreements, vetted by a lawyer. Learning from other OHTs what collaborative leadership models and structures they have tried and understanding how they are functioning would be valuable as we further this development work in LLG.
- A "partnership table": composed of designated leaders from the consortium and Ministry personnel. Meetings on a regular basis can be extremely helpful to have the ongoing communication and provincial lens.
- Province wide branding and communication: consistent messaging for the general public to raise awareness and understanding of Ontario Health Teams would be beneficial. When people move, they should have access to the same health care in all areas of the province and how to access primary care and enter a health team.
- Data support: access to additional data including patient experience data and combined data for Network 9 and 10.

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.

Max word count: 1000

It is obvious that the most concerning impact on the development of the LLG OHT pertains to the course and associated impact of COVID-19 in the community. An increased focus on leveraging virtual visits will help manage patient access in the setting of barriers to in-person encounters.

There are many different funding models involved within the developing LLG OHT (i.e. Hospitals, FHO's, FHT's, CHCs etc.) and some of these models disadvantage one another with their incentives or penalties. It is important to point out that there are many policy barriers related to funding models that significantly impact the ability to shift key quadruple aim performance metrics, particularly related to health system utilization and physician funding.

For example, Emergency Department Alternative Funding Arrangements (EDAFA) and the essential role they play in stabilizing the provision of ED services particularly in rural hospitals may be destabilized with re-direction of CTAS 4 and 5 cases back to the primary care setting in the absence of other physician funding changes.

Contractual exemptions for after-hours care under the blended capitation models recognize the unique multifunctional role that family physicians have in rural settings. However, this exemption may have contributed to increased utilization of hospital resources due to a shift of primary care services to the hospital ED setting. A thoughtful but pragmatic solution or shift in policy may be needed, as this observation may limit the extent of progress on several quadruple indicators.

While the LLG OHT is continuing to explore a number of innovative ideas with the primary care community, more significant improvement would be expected with thoughtful and effective physician payment policy changes by the Ministry in partnership with the Ontario Medical Association.

Insufficient community resources (ie. Community Support Workers) that could be a barrier to enable implementation for our Priority Year 1 population.

Lack of infrastructure regionally to support alternative placements for those persons designated as Alternative Levels of Care i.e. Long-Term Care Bed capacity continues to have significant impacts across the entire health system that has been further exacerbated as a result of the COVID pandemic. While partnerships within the OHT along with leveraging the role of digital health will be helpful, the benefits will be incomplete.

The LLG OHT expects that as part of the maturation of the OHT framework, there will be both funding and governance reform. Current accountability frameworks for publicly funded health agencies using service accountability agreements (e.g. H-SAA, M-SAA etc) may contribute to potential discordance as management and governors strive to exercise fiduciary responsibilities to their own organizations while engaging in change projects that may impact organizational performance and accountabilities while advancing other system level changes.

Finally, further regulatory reform is needed to enable OHTs to fully encompass home and community care services as they assume responsibility for the attributed population across the full continuum of care. In addition, stronger linkages are required with other non-health sectors and related ministries and other public entities who principally provide funding and services related to the social determinants of health.

Lanark, Leeds and Grenville OHT

Appendices

APPENDNIX A: Draft Guiding Principles

To be finalized as part of the Collaborative Decision-Making Framework to follow.

Commitment to our Patients/Clients, Caregivers and Families

- In keeping with our respective organizational mission, vision, and value statements, delivering care that results in the best possible outcomes and experiences - to deliver better, faster, more coordinated, equitable and person-centred care is paramount to all that we do. We will be driven by the needs of our Patients/Clients, Caregivers, Families and Community while respecting the obligations each organization has to their partners including their commitments to funders, unions, donors, and patients/clients/residents and family members.

Commitment to a High Performing Local Health System

- We commit to be accountable by the application of evaluation frameworks to support quality improvement and to our Patients/Clients, Caregivers, Community, Families, community partners and funders.

Population Health, Equity and Access

- We are committed to eliminating barriers to access and achieving equitable, inclusive, respectful and culturally safe care and services, with particular focus on the unique barriers to health for rural seniors, Indigenous, Francophone or otherwise marginalized populations. We will support the building of community capacity for prevention and early intervention.

Authentic Partnerships and Co-Design in the System Transformation

- We are committed to authentic partnership and co-design in our planning, implementation and evaluation, embedding the perspective of patients/clients, caregivers and families in our work every step of the way.

Collaborative Culture

- Collaboration is grounded in recognizing our respective strengths and building on shared trust as we support our consensus based decision-making model. We will establish a culture of transparency, mutual respect, teamwork and co-design to identify opportunities to be more efficient and effective for the people we serve, rather than the interests we represent.

Coordination and Integration

- Solutions that are coordinated and integrated will better serve our patients/clients, caregivers and families by transforming people's experiences of care. We will build on our teamwork so that our patients/clients experience integrated care and seamless transitions throughout their care journey.

Innovation and Excellence

- A commitment to innovation and excellence will underpin the work of our OHT. We face common challenges and through our joint commitment to innovation and excellence, we will be creative and evidence-based in our solutions.

Creativity and Continuous Learning

- We support a culture of critical thinking, continuous learning and creativity that will better service our patients/clients, families, caregivers, partners and broader community.

Commitment to a Journey

- We commit to ongoing planning and evolution of our programs and services. Our planning will be continuous and will evolve and mature through our ongoing discussions and engagement.

Digital Transformation

- Provide patients/clients/caregivers/families with the opportunity to access their own information and providers to share information with one another in order to minimize duplication. We will be strategically driven and outcome oriented as we develop our foundational model of how we deploy digital health services across the region.

Spread and Sustainability

- We will act for the individual and learn for the population. The savings we create through collaborative efforts will be used to further LLG-OHT joint efforts to better serve our attributed population.

Organizational Capacities

- We will respect the capacity that each organization has to contribute to the OHT with respect to their financial resources, skilled labour force, and contributions of their volunteers including board of directors.

APPENDIX B: The PRimary Integrated Service Model (PRISM) for Older Adults At Risk and Affected by Complex Health Challenges

Background and Overview

The PRimary Integrated Service Model (PRISM) was launched in March of 2018 in response to the ever growing population of older adults at risk and affected by complex health challenges. It was identified that there was an opportunity for improved clinical capacity, service delivery and coordination for those diagnosed with or affected by cognitive, mental health and addictions, neurological and physical disorders. PRISM is the result of a mutual commitment to designing a better way to serve this priority population.

PRISM is a partnership between:

- Primary Care teams of Country Roads Community Health Centre and Rideau Community Health Services
- Specialty Geriatric Mental Health Services
    - The Royal Ottawa and
    - Providence Continuing Care
    - The Alzheimer's Society of Leeds Lanark and Grenville.

The steering committee includes Senior Leadership from each of these organizations as well as clinical staff dedicated to the implementation of processes and tools that are developed.

The PRISM team experience is that true integration can be achieved by embracing a philosophy of 'your roster is our roster' and by maintaining a quality improvement lens through implementing tests of change, evaluating and adapting while regularly communicating and grounding the team in a shared vision, common goals and common approaches.

The PRISM initiative includes the following agreed upon goals:

- Increase capacity among the primary care team members to proactively screen, assess and treat older adults who may be struggling with issues related to addiction, mental health and cognition
- Improve linkages and navigation between individuals, families and services/resources
- Provide timely knowledge exchange for primary care clinicians
- Provide a fully integrated team approach while caring for the whole person
- Promote healthy behaviours with a chronic disease self-management

The PRISM project has 3 major components:

- **3M Clinic**
- **Wellness Assessment Program**
- **Knowledge Transfer and Capacity building**

3M Clinic (Memory, Mental Health & Medicines)

The 3M Clinic provides monthly on site clinics offering patients direct assessment and consultation between specialty, primary and community care. The 3M clinic focuses not only on consultation, which is direct face to face service, but also case-based support. The process embraces a service learning approach through the consultation service, capacity building and skill development will occur. The clinic occurs once per month embedded in the Primary Care settings.

In addition an e consult service was implemented using email and telephone to offer advice and education to clinicians by the specialty team.

The 3M Clinic Team includes: a geriatric psychiatrist, Psych-Nurses, Primary Care Pharmacist and the Alzheimer Society Counsellor work directly within the Primary Care teams.

The shared use of health utilization data from the Electronic Medical Record ensures minimal duplication and an increase in levels of safety and clear communication.

Consults are on site, in real time, as well as by phone and email is utilized regularly.

Wellness Assessment Program

The cross-sectoral collaborative leading this initiative is in the midst of developing a Brain Health Protocol for Primary Care teams.

Prevention is a significant priority for all agencies involved. It has been identified that one of the most important aspects of achieving better health outcomes includes the patient perspective of what matters most to him/her. The Wellness Assessment Program aims to promote levels of awareness of healthy behaviours and skill development related to self-management.

The Wellness Assessment Program allows for identification of individual risk factors through a proactive dialogue between clinician and patient (family) about the influence healthy behaviours can have on one's brain health. The target population are particularly those who are at risk or susceptible to cognitive or mental health issues and providing prevention strategies.

This wellness narrative involves a set of "Did you Know" info-grams that provides a mechanism for organizing the conversation. In addition, there is a framework guiding the clinician-patient/family conversation with smart goals shifting the emphasis to prevention and enhancing his or her involvement in his or her healthcare.

Service Coordination & Knowledge Translation & Education

The PRISM project has provided a continuous opportunity for exchange of knowledge, skills and capacity building.

A population health frame of reference was used to review rostered patient data to better understand those at risk. The clinician response after reviewing the practice profile data

provided a baseline of levels of understanding and highlighted varying states of readiness among the Primary Care teams involved. Based on these conversations the PRISM team had a sense of direction for areas of needed capacity building and knowledge transfer.

Within the 3M clinics key information is identified, collected and summarized by the Primary Care team before consultations occur and recommendations are translated back to the Primary Care teams through direct support and mentorship of personnel involved.

Joint education sessions have been provided to Primary Care teams facilitated by Dr. Ken LeClair and the Alzheimer Society promoting awareness of current best practices and prevalence.

Moving Forward

Our focus continues to include sustainability and spread. One of the critical issues that has emerged from the literature, including the analysis of the Memory Clinics in Ontario, has been the fact that it often does not spread and become a standard of practice within the context of the overall primary care practice and any resulting improvements are often confined to the clinic.

The discussion around spread includes internal capacity building across all departments of the Community Health Centres. We hope to identify and capitalize on opportunities where we can use a population health, preventative approach in all aspects of our day to day operations.

The discussion of spread includes external spread of resources and strategies to other primary care settings in the community. This will be enabled when resources are complete and the protocols are tested for feasibility for use in primary care settings within the region and beyond.

APPENDIX C: Health Links Evaluation of Coordinated Care Planning

EVALUATION OF COORDINATED CARE PLANNING

Coordinated care involves identifying individuals with multiple care needs, developing a care plan that is patient-centered, and focuses on both the health and social needs of patients.

The key findings of the evaluation of coordinated care planning in South Eastern Ontario are presented below:

1 CHRONIC DISEASE AS A SILENT GLOBAL EPIDEMIC

Chronic diseases have been labeled as the silent global epidemic. While COVID-19 urges governments to rebuild their collective social welfare systems, chronic disease has remained the leading cause of death in the world.

2 INTEGRATION BETWEEN HEALTH AND SOCIAL SERVICES

Rather than only catering to individuals in times of a global pandemic, government can opt for creative solutions to rebuild its collective social welfare system proactively in the long-run by bridging the gap between health and social services.

This can be achieved through various means including widespread use of information technology, while ensuring flexibility to cater to local needs and structural guidelines.

3 INFORMATION TECHNOLOGY SHARING AND INTEGRATION

The COVID-19 pandemic is transforming how physicians deliver healthcare, through ushering the new wave of information technology and telemedicine.

This research highlights the urgency to transcend from doctors' offices into the health and social services sectors, by increasing physician uptake and continuing efforts towards integrating diverse electronic medical records systems.

4 FLEXIBILITY IN THE PROVISION OF HEALTHCARE RESOURCES

While flexibility is needed to enable each community to cater to local resources, especially in relation to patients' particular requirements, structural guidelines are considered important.

Having general protocols with formal processes can help to enable clear communication and team building among health care practitioners.

5 PRIMARY CARE PHYSICIAN ENGAGEMENT

Primary care physician engagement in coordinated care planning is needed in a sustainable manner to ensure continuity of care for patients with complex and chronic conditions by embedding care coordinators and system navigators into their practices.

Research carried out by the Health Services and Policy Research Institute at Queen's University

APPENDIX D: Health Links Evaluation from Patient and Caregiver Perspectives

HEALTH LINKS EVALUATION

PATIENT AND CAREGIVER PERSPECTIVES

Interviews with 14 patients and 5 caregivers were carried out to evaluate the Health Links program in the South Eastern Ontario region. Key quotes from patients and caregivers are provided below:

COORDINATED CARE PLANS (CCP):

INFORMATION SHARING

"If he ends up in Emergency, I make sure that the book [CCP] goes with him, so they have all the information that they need." - Caregiver

INDEPENDENCE & MOTIVATION

"It's given him some motivation to carry on and to try to live a normal life." - Caregiver

IMPACT ON CAREGIVERS

"I love it because all the information I might not have up here, it's all in that book, with phone numbers and the person I need to talk to." - Caregiver

SIMPLIFICATION & CLARITY

"I loved it because I had no idea where I was supposed to go to get help for him." - Caregiver

"Every elderly person that wants to stay in their home, should get a hold of this Health Links because it's a fantastic program." - Caregiver

"A coordinator came in and asked me what my goals were, which made it easier for me to deal with because I had something to follow." - Patient

IMPACT ON CAREGIVERS

"There needs to be System Navigators everywhere, because to hand someone, who's trying to be a caregiver, the mess of contracts and different agencies is craziness." - Caregiver

"Part of her care is making sure I can care for her, and the system is not built to do that. The system is not built to be the least bit concerned about me not burning out." - Caregiver

"The care team helped me out so much. One of the main reasons that we're still in our own home is because of the help that I've been able to get from them." - Caregiver

SYSTEM NAVIGATORS:

PATIENT ADVOCACY

"It's so nice to have, and to be able to talk to someone like X and she knows everything that's going on and she knows how how to access it." - Caregiver

COMMUNICATION IMPROVEMENTS

"I was not getting any follow-up or explanation from the hospital. But through Health Links and the System Navigator, it was done. So I was very pleased and it gave me a feeling of confidence." - Patient

IMPACT ON CAREGIVERS

"We know if we get a really bad situation that we can call her, and we can ask her what we should do or how we should handle it. I think that's so important." - Caregiver

PATIENTS STAYING AT HOME

"If something is going wrong, there's someone that I can get in touch with before it gets really wrong." - Patient

HOME CARE

"The home and community care services are very limited. They can lead you to the source of care, but the care providers themselves are given minimal amounts of money by the government. [...] They overwork their workers to the point where they either become ill and there's nobody to fill in the gap." - Caregiver

"They've been very good, and they come every day except the weekend. And they're very good for his hygiene and everything because I can't do that." - Caregiver

RESEARCH CARRIED OUT BY THE HEALTH SERVICES AND POLICY RESEARCH INSTITUTE AT QUEEN'S UNIVERSITY

APPENDIX E: Lived Experience Advisory Network (LEAN) Draft Terms of Reference

Purpose	The Lived Experience Advisory Network (LEAN) serves in an advisory capacity, making recommendations on matters that impact the experience of patients, clients, caregivers and families within the Lanark, Leeds and Grenville Ontario Health Team (LLG OHT). Committee members will be key partners in shaping the way care is delivered by actively collaborating with health care providers in the LLG OHT.
Responsibilities and Opportunities	The LEAN brings together individuals with a variety of experiences to: ● Identify opportunities to improve the quality of care and delivery of services provided within the OHT ● Participate in quality improvement initiatives and working groups ● Actively promote and create new and unique opportunities for communication, collaboration and partnerships among patients, clients, caregivers families and health providers ● Promote the inclusion of all voices in health care decision-making
Accountability and Reporting Relationships	The *LEAN* communicates directly with the *OHT Steering Committee* and updates the broader OHT about the work of this Council as required.
Membership	The LEAN will consist of 10-15 members. The role of an Advisor (network member) is to share his or her unique experiences, opinions and perspectives in order to strengthen engagement of patients, clients, caregivers, families and the public in important local health planning and delivery decisions. Members may participate on focused sub-committees or working groups of the LEAN as needed based on their interests and experiences with different aspects of the health care system (i.e. Collaborative Decision Making Working Group and Steering Committee). Members will be selected and recruited in such a manner to ensure diversity that is reflective of the Lanark, Leeds and Grenville population including age, geographic distribution, gender, cultural diversity, socio-economic status and experience with the health system. Membership will have a renewable two-year term.
Co-Chairs	The LEAN will be co-chaired by a LEAN Advisor and member of the OHT Steering Committee.

Responsibilities of Co-Chairs	• The Co-Chairs or delegate guide the activities of the LEAN • The Co-Chairs represent LEAN Advisors at appropriate functions • The Co-Chairs are responsible for escalating unresolved issues to the OHT Steering Committee • The Co-Chairs will bring forward and make recommendations to the OHT Steering Committee
Meetings	Minimum of 4 times per year and at the call of the Co-Chairs. Quorum is to be 50% of the LEAN membership plus one. Decision-making will be by consensus. Agenda and previous minutes will be distributed one week post monthly meeting to ensure items are followed-up. Distribution will be electronic unless a hard copy is requested.
Review	The LEAN will review these terms of reference every 2 years by August 31 and approve any revisions. Original date: August 26, 2020

APPENDIX F. Themes from Engagement with Lived Experience Advisors

As part of the planning for the Lanark, Leeds and Grenville Ontario Health Team Full Application submission, the team has been seeking the input of individuals who have lived experience in mental health and addictions. This included a consultation with a Family Advisory Committee from one of the Mental Health and Addiction agencies, a focus group with participants from across LLG OHT member organizations, as well as written feedback in the form of letters and emails. An overview of their challenges experienced within the local health system have been identified and are outlined in the table below by themes.

Theme in Experiences	Examples of Comments
Timely Access to Care	• Long waitlists for specialty services • Long waitlists for primary care providers • Unaware of what services exist or how to get help • Lack of crisis support leads to potentially avoidable emergency department visits
Coordination and Communication Across the System	• Lack of timely communication and smooth transitions between hospital services, community services and primary care • Lack of communication and collaboration with families in hospital admittance and discharge planning • Need for regular check-ins or key contact person for patients/clients • Need for improved continuity between detox and rehab • Need for “every door is the right door” philosophy
Stigma	• Need for education and awareness, highlighting the importance of normalizing mental health and addictions for public and providers
Other Services	• Need for transportation services in rural areas to access services • Need for community activities that are affordable and do not involve drugs and alcohol

Many of the stories we heard align with the key challenges identified in the provincial “Roadmap to wellness: a plan to build Ontario’s mental health and addictions system” (Ministry of Health, 2020).