Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

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

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

Ontario residents are not attributed based on where they live, but rather on how they access care which is important to ensure current patient-provider partnerships are maintained. However, maps have been created to illustrate patient flow patterns and natural linkages

[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.

between providers which will help inform discussions regarding ideal provider partnerships. While Ontario Health Teams will be responsible for the health outcomes and health care costs of the entire attributed population of one or more networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

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

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

Participation in Central Program Evaluation

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

Additional Notes

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

clearly mark this information “confidential” and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as “confidential” unless required by law.

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

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: Stacey Daub
	Title: CEO
	Organization: Headwaters Health Care Centre
	Email: sdaub@headwatershealth.ca
	Phone: 519-941-2410 ext. 2200
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Kim Delahunt
	Title: Interim CEO
	Organization: Headwaters Health Care Centre
	Email: kdelahunt@headwatershealth.ca
	Phone: 416-371-4623

1. About Your Population

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

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

1.1. Who will you be accountable for at maturity? (1000 words)

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

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

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

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

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

Maximum word count: 1000

The Hills of Headwaters Collaborative OHT partners suggest that the alignment of the attributable population as proposed in the Readiness Assessment against what was suggested for the Full Application is moderate. In particular and of concern is the segmentation of the Town of Caledon region to another OHT network.

As proposed, the population of the Hills of Headwaters Collaborative OHT is approximately 112,781 based on the 2016 Census (Dufferin County and Town of Caledon populations combined). This proposed population is based on previous sub-region development by the Ministry and LHINs, which founded health system improvements, investments and partnerships based on this geography. Historically this had taken the form of Caledon

[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.

Community Services and Headwaters Health Care Centre (HHCC) developing a specialist clinic in Caledon in partnership with Dufferin-based specialists.. This partnership has supported patients being able to receive care face–to-face within their local community, as well as receive support for virtual visits through the Ontario Telemedicine Network.

Recently, the ministry supported the expansion of an interprofessional primary care team. This expansion focused on the Dufferin Area Family Health Team (FHT) developing a location in Caledon. Now that the location is fully operational, the focus has recently turned to opening services to physicians beyond the Family Health Organization throughout the community with a vision of continuous expansion that will ultimately support the full population and all physicians. This expansion aligns to partners' strategic priorities that focus on the continued development of hubs and/or spokes for integrated care throughout Caledon. An early indication of this alignment is the co-location of the Canadian Mental Health Association (CMHA) Peel-Dufferin with the Dufferin Area FHT in Caledon. Other service providers are also considering opportunities to offer care from the Dufferin Area FHT location in Caledon, moving forward this will inform the development of a hub and spoke model of care throughout the Hills of Headwaters that will also incorporate virtual care supports for patients and caregivers.

The Hills of Headwaters Collaborative OHT partners, which includes family physicians recognizes the need for an expansion and inclusion of additional family physicians and primary care providers in order to support the entire attributed population. With an attributable population of 112,781 and a total of 70 primary care physicians there is a practical need to expand access to physicians. If an average practice size has a range of 1,200 to 1,500 patients the number of physicians required to support the entire Hills of Headwaters Collaborative OHT would be as low as 74 and as high as perhaps 94 depending on the model of care. There is commitment of physicians and partners to work with the ministry to add additional primary care resources in a manner that is aligned to the OHT vision. The Hills of Headwaters Collaborative OHT has also purposefully adopted a population health approach with the involvement of Wellington Dufferin Guelph Public Health and the Region of Peel, this will inform not only the types of health human resources required, including physicians, but also where to deploy resources to have the greatest impact. The focus will be to repatriate patients so the population has access to the right care, in the right place and at the right time.

This vision affords the Hills of Headwaters Collaborative OHT partners the opportunity, in partnership with physicians and patients, to expand primary care delivery through co-design and with a focus to integrate clinical care and delivery systems. As the OHT matures the needs of the population and providers, there is commitment to repatriating patients to receive care closer to home. This expansion will be done in full partnership with the ministry as consideration is given to which forms of Patient Enrolment Models are most aligned to the OHT vision.

Throughout this full application, consideration has been given to ensuring physician leadership, patient co-design, as well as what clinical and system level changes can be achieved in Year 1 and beyond. All of this has been based on a population of 112,781 that formulates the Hills of Headwaters Collaborative OHT.

It is important to also note that the Hills of Headwaters Collaborative OHT is associated with a rapidly growing population when compared to other regions in the province. With a higher than average change in population size and number of private dwellings in the last five years (2011 census to 2016 census) compared to Ontario, Dufferin County and the Town of Caledon are attracting many new residents. Shelburne, in particular, is the fastest growing municipality of at least 5,000 outside of a metropolitan area in Ontario and second fastest in Canada based on the 2016 census (See Table #1)

Table 1 – Population Growth in Hills of Headwaters from 2011 to 2016

	Shelburne	Dufferin County	Town of Caledon	Ontario
% Change in Population (2011 to 2016)	39%	9%	12%	5%
% Change in Number of Dwellings	33%	9%	11%	6%
Population Density per Square Kilometers	1238	42	97	15

Data Source: Statistics Canada, Focus on Geography

1.2. Who will you focus on Year 1? (1000 words)

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

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

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

If this Year 1 population differs from the one you proposed in your Self-Assessment, please provide an explanation.

Maximum word count: 1000

The focus for Year 1 will be on three priority subset populations within the Hills of the Headwaters geography. These populations include patients with palliative care needs, individuals seeking supports for mental health and addictions as well as patients with complex care needs. These subset populations were chosen based on community and local needs and further informed and validated by evidence and data provided by the Health Analytics Branch and local Public Health Unit. The data overwhelmingly supports the decisions to focus on these subsets of our population as priority populations within the Hills of Headwaters from both a need and financial standpoint. Refer to Table #2 for a summary of the expenses for the chosen subset populations. These subset populations represent three of the top 5 health profile group expenditures for the Hills of the Headwaters geography.

Table 2 – Total Expenses for Hills of Headwaters Subset Populations

Hills of the Headwaters Subset Population	Health Profile Groups (HPG)	Total Expenses (2017-2018)
Patients with Complex Care Needs	Major Chronic	$38,404,166
Individuals seeking Mental Health and Addictions Supports	Major Mental Health Other Mental Health	$31,588,918
Individuals with Palliative Care Needs	Palliative	$11,275,726

Source: OHT Data Package: Health Care Expenditure

Individuals with Palliative Care needs

For this subset of our population, the focus will be on developing clinically integrated pathways for patients seeking palliative care. The aim is to equally address patient and family needs during this time and do so in a flexible, adaptive and responsible manner. The

palliative population is defined as those defined as those who are living with, or at risk of developing, a life-threatening illness (HQO) that are dying and require end of life care. For the Hills of Headwaters population size for individuals with palliative care needs is estimated to be approximately 10% of the Home and Community Care population.

Continuing the work that the Hills of Headwaters Collaborative OHT members committed to during sub-region development over the past two years, Year 1 will focus on further integrating care delivery for the palliative population. Many palliative patients want to stay in their homes as long as possible. In FY2017, only 25% of Dufferin sub-region and 22% of Bolton-Caledon sub-region palliative patients received palliative home visits in the last 90 days of life. In the same time period, 58% of Dufferin sub-region and 55% of Bolton Caledon sub-region palliative patients had at least 1 unplanned ED visit in the last 30 days of life. In FY2016, 50% of Dufferin sub-region and 46% of Bolton-Caledon sub-region palliative patients died in hospital. Refer to table #3 for summary of palliative care performance measures for Dufferin and Bolton-Caledon LHIN sub regions. Please note that the Hills of Headwaters OHT will cover the Dufferin County and Town of Caledon geographies.

Table 3 – Palliative Care System Level Measures

	Dufferin and Area LHIN Sub-region	Bolton-Caledon LHIN Sub-region	Ontario
Home Visits in the last 90 days of life (FY2017)	25.4%	22.1%	22.9%
One of more ED visits in the last 30 days of life (FY2017)	58.4%	55.0%	55.0%
Percent of people who die in hospital (all hospital settings and acute only) (FY2016)	50.2%	45.9%	52.0%

Source: IHSP Environmental Scan, Health Analytics Branch, Ministry of Health

Mental Health & Addictions

Another subset population that the Hills of Headwaters OHT will focus on in Year 1 is those that are seeking support for mental health and addictions. In order to better provide care for this subset population, availability and access to mental health and addictions services have been identified as priority areas in Year 1. When mental health and addictions services cannot be accessed and/or support is unavailable in the community, patients often end up in hospital emergency departments (EDs), with some being admitted to a mental health bed. Unfortunately, this is the reality in the Headwaters region with the percentage of total ED visits and rate of mental health or intentional self-harm ED visits close to the provincial comparator or higher. This is especially true for young adults (18-24) and older adults (65+) in Headwaters, with higher rates of ED visits than the province being for mental health and intentional self harm causes. The same is true of mortality as a result of mental health or intentional self harm.

Table#4 – Emergency Department Visits, Revisits and Mortality Due to Mental Health and Self Harm for all Ages 12+

Geography	Emergency Department Visits	Emergency Department Revisits	Mortality
Hills of Headwaters (Dufferin County + Town of Caledon)	5% of Total ED Visits	26% of Total ED Visits	5% of Total Deaths
	Rate of 21.7 per 1000	3.8 per 1000	71.3 per 10 000
Ontario	6% of Total ED Visits	22% of Total ED Visits	2% of Total Deaths
	Rate of 24.4 per 1,000	3.4 per 1,000	80.7 per 10,000

Source: Intellihealth

Headwaters Health Care Centre, the only hospital located within the Hills of Headwaters Collaborative OHT geography, does not have any adult mental health beds. All adult inpatient mental health active cases for residents in this population occur in an out of region hospital.

The highest prevalence of ambulance transfers from community to hospital is for mental health and addiction related care for children and adults aged 18-64. At the same time Emergency Department visits are increasing by approximately 10% per year. Despite having no mental health beds, Headwaters Health Care Centre had over 1,800 inpatient mental health days, resulting in individual staying in hospital yet receiving no mental health treatment.

Table 5 – Utilization for Acute Mental Health Services

	Hills of Headwaters OHT	Ontario
Costs and cost drivers: Adult MH beds (FY2018)	0 inpatient adult mental health beds	38.9 per 100,000 population (18+)
Inpatient Utilization: Active cases per 100,000 population (15+) (FY2016)	310.3	548.5
Inpatient Utilization: Admissions per 100,000 population (15+) (FY2016)	293.2	511.7
Inpatient Utilization: Discharges per 100,000 population (15+) (FY2016)	296.3	515.2

Source: IHSP Environmental Scan, Health Analytics Branch, Ministry of Health

Patients with Complex Care Needs

At maturity, the Hills of the Headwaters Ontario Health Team will be a high-performing integrated care delivery system that provides fully coordinated, wrap-around health care services to patients. The Health Links approach to care is an example of integrated health care delivery that connects the full continuum of health care providers and care settings into one seamless partnership. The focus of Year 1 will include developing clinically integrated

pathways for the 4,660 residents in this geography identified by the Ministry as patients with complex care needs that would benefit from the Health Links approach to care.
As of Q1 FY2019, Dufferin sub-region has the highest (61%) proportion of patients with complex care needs supported by this approach to care. The Caledon sub-region is fourth, with 35% of target population supported. Overall, 53% of patients with complex care needs in the Hills of Headwaters Collaborative OHT have a completed coordinated care plan, compared to 13% for the province. Part of the Health Links strategy is to connect patients with complex care needs to primary care providers. In Q1 FY2019, 93% of identified Health Links patients in the Hills of Headwaters Collaborative OHT that were unattached at the time of identification, were rostered to a Primary Care Enrolment Model physician compared to 49% for the province. See table #6 for summary of patients with complex needs in Hills of the Headwaters.

The Hills of Headwaters Collaborative OHT's existing partnerships, shared purpose and early successes represents a significant strategic advantage in achieving Year 1 success.

Table 6 – Health Links Summary

	Hills of Headwaters OHT	Ontario
# of patients with complex needs	4,660	668,635
# of patients with a completed coordinated care plan (CCP)	2,446	84,707
% of target population with a completed CCP	52.5%	12.7%
% of individuals with a CCP who are newly attached to a primary care provider (PCP) through the Health Links approach.	93.0%	48.6%

Source: HQO (extracted from CHRIS for Central West LHIN), up to Q1 FY2019

1.3. Are there specific equity considerations within your population? (1000 words)

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

Maximum word count: 1000

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

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

The development of the sub-regions under the LHIN leadership supported an exploration of equity-based decision-making in prioritizing system changes. As the full application was developed, the Collaborative leadership once committed to an equity focus in considering priority patient populations.

While partners do not have specific programs targeted to Francophone, Indigenous peoples or multicultural groups, all are committed to providing programs and services that are Culturally Safe. In this case, anyone accessing services and care in Dufferin and Caledon will feel respected and safe when they interact with the health care system, free of racism and discrimination and supported to draw strengths from their identity, culture and community.

Partners feel strongly and have specific programs to support patients and clients affected by the misdistribution of economic resources. Crucial partners within the Hills of Headwaters Collaborative OHT are the County of Dufferin and Wellington-Dufferin-Guelph Public Health, who co-chair this work with health and social services coming together to develop shared action plans.

Within the Year 1 subset populations of patients with palliative care needs, individuals seeking supports for mental health and addictions as well as patients with complex care needs there are sub-population groups that have been identified to require specific focus. These sub-population groups include children (aged 0-6), older adults (55+) and individuals with low-income.

The development of the sub-regions under the Central West LHIN leadership supported an exploration of health equity focused work and decision making in prioritizing system changes. While developing the full application, the Collaborative leadership was surveyed and once

[3] Sub-region data was provided by the MOH to the LHINs in Fall 2018 as part of the Environmental Scan to support Integrated Health Service Plans. This data is available by request from your LHIN or from the MOH.

again highlighted health equity and targeting specific priority populations as imperative for the development of the Hills of the Headwaters OHT.

Partners feel strongly and have developed specific programs to support patients and clients affected by the social and economic factors that influence an individual's health or the social determinants of health. The social determinants of health can include but are not limited to income, gender, race, employment status and when compared with health outcomes, play key roles in an individual's health and wellbeing. For example, individuals living in poverty tend to have higher rates of diseases and die younger than those with higher income. For this reason, Hills of Headwaters Collaborative OHT is committed to highlighting the intersectionality between the social determinants of health and health outcomes as part of the. Key partners within the Hills of Headwaters Collaborative OHT for this work are the County of Dufferin and Wellington-Dufferin-Guelph Public Health who co-chair equity focused work with health and social service agencies and have developed shared action plans for future projects.

The Francophone and Indigenous populations in Hills of the Headwaters are relatively small. The Francophone population accounts for approximately 1.3% of the population while the Indigenous population is approximately 1.4% of the Headwaters residents. While community partners do not currently have specific programs targeted to Francophone or Indigenous populations, partners all are committed to providing programs and services that are Culturally Safe. In this case anyone accessing services and care in Dufferin and Caledon will feel respected and safe when they interact with the health care system, free of racism and discrimination and supported to draw strengths from their identity, culture and community.

Headwaters is currently going through a strong population growth with many migrating to the region that are unable to afford the cost of living in the Greater Toronto Area. This is especially true of young families and as a result there is a population spike of young children and young adults. These spikes match an older population that already existed in the Headwaters region. The changing and evolving age demographics of the Headwaters population is exactly why the children (0-6) and older adults (55+) populations have been identified to require specific focus. With these age groups growing rapidly, and with their unique importance and challenges, it is key to be proactive to maintain positive health outcomes.

The experiences and care received during early childhood have an impact on all aspects of health and well-being throughout life. As a result, adverse social and economic factors to the child and their family can have lasting negative health outcomes on children living in low income households.

Table #7 -

Sub-Population	Population Size	Social Determinants of Health Indicators
Children (Aged 0-6)	6.3%	Children under 6 in low income households = 9.1%
Older Adults (Aged 55+)	27.3%	Older Adults over 65 in low income households = 8.2%
Low Income Population (Population living below low-income measure (LIM-AT))	7.2%	Approximately 55% female Approximately 15% lone parent households

Source: 2016 Census, Wellington-Dufferin-Guelph Public Health Interactive Reports

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

(See supplementary Excel spreadsheet)

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

(See supplementary Excel spreadsheet)

2.2. How did you identify and decide the members of your team? (500 words)

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

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

Maximum word count: 500

The partnership that represents the Hills of Headwaters OHT is supported by a shared Collaborative that began planning together as early as 2012. At that time, local providers capitalized on existing partnerships to be one of the first adopters of the Health Links approach to care. From there, a strong culture of collaboration has led to numerous local innovations that offer foundational support for the proposed OHT. Evidence includes a Community Paramedic program that keeps patients in their home, and two community-based specialist clinics that support physical and virtual visits, with one co-located with primary care. In addition to being aligned to providers and physicians across the Hills of Headwaters, Central West Home and Community Care has a foundation of 24/7 supports that can be enhanced through further partnership and system integration. Physicians associated with Dufferin Area FHT have a single-instance medical record housed within the Headwaters Health Care Centre digital platform, accessible by community paramedics and care coordinators to support collaborative and integrated care.

This foundation represented a significant strategic advantage in achieving Year 1 success. Already, the Dufferin sub-region is recognized as having the highest (58%) proportion of patients with complex care needs supported by the approach to care. The Caledon region is close behind at fifth overall, with 33% of target populations supported. This success and the consistent application of the approach to care was possible by the relationship and partnership that are now being brought together to achieve the OHT vision: a vision that resonates with the partners because of this shared history and vision for the future, and not through a sense of urgency to respond.

The evidence for this is clear. With the provincial development of sub-regions in 2017, the Central West LHIN was able to immediately capitalize on these existing relations to very quickly form two strategic collaborative planning tables: one for Dufferin and one for Bolton-Caledon. While many of the same providers participated at both tables, participants recognized that population health and services needs differed between the two communities.

Ontario Health Teams create greater momentum for further integration. Without hesitation, the two previous collaborative planning tables have amalgamated to form a single Hills of Headwaters Collaborative. While maintaining a population health approach to meet the unique needs of the community it serves, the Collaborative will guide and support system transformation and integration by formally adopting shared:

- Purpose
- Principles

- Decision-making framework
- Commitments associated with advancing and meeting OHT requirements

The process for establishing the Hills of Headwaters Collaborative OHT was not one of selecting a partner but rather taking the existing partnership structure and defining a shared purpose to create one community working together to improve the health and well-being of everyone who lives and/or provides care in Dufferin-Caledon. With this shared purpose – aligned to the vision of OHTs – there is focus beyond the initial year and on elements that will create and sustain full maturity.

In partnership with patients and physicians, the Year 1 target population focuses on further integrating care delivery for the entire palliative, and mental health patient populations and for those with complex care needs. This is a continuation of work that the Collaborative members had committed to during sub-region development. With a focus on co-designing with patient and physicians and the vision of OHTs, these focuses offer a catalyst and momentum engine for local improvement

Given the nature of this partnership and the need to co-design together within the Hills of Headwaters Collaborative OHT all partners are members and have provided an Endorsement signifying their individual and collective commitment.

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

(See supplementary Excel spreadsheet)

2.4. How have members of your team worked together previously? (2000 words)

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

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

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

Maximum word count: 2000

Previous sections detailed the culture of partnership within the Hills of Headwaters Collaborative. Historically, this culture of openness and innovation may have been tied to the rural nature of the geography, however it has evolved over time to be an everyday factor that is and will remain foundational to the success of the OHT.

Current Partnerships Focused on System Change

In the Readiness Assessment, there was commitment to continue building shared clinical pathways. These pathways will create integration engines that will change how care is delivered and ensure seamlessness and the removal of “transitions.” While positioned as a Year 1 commitment, real planning and change is already taking place. The following are key areas of partnerships focused on clinical integration that is being conducted through patient, caregiver and physician co-design.

Palliative Care:

Beginning in March 2018, physicians, patients, Headwaters Health Care Centre, Dufferin Area FHT, Dufferin Community Hospice, Bethell Hospice Residence, Dufferin Oaks LTC, Shelburne Residence, Central West Palliative Care Network, Wellington Dufferin-Guelph Public Health, Central West Home and Community Care, and paramedic services have been meeting to redesign palliative care. Based on documented provincial standards and best practice models, this group is actively developing an operation model that will:

- Establish a single Central Intake (registry) for all patients with complex care needs, beginning with early identification of the palliative population
- Support a self-organizing group of physicians that developed a palliative rotation that supports cross continuum care, following the patient across all places of care

- Define bundles of care with associated resourcing for the full continuum of palliative care that will support patients and families from identification to end-of-life and bereavement
- Identify required health human resources and realign to form a single interprofessional end-of- life care team care that will work with family physicians and primary care across Dufferin and Caledon
- This end-of-life care team will be truly integrated interprofessionals working to full scope and partnership, aligned to vision of Ontario Health Teams

Mental Health and Addictions:

As of June 2018, physicians, patients, HHCC, Dufferin Area FHT, CMHA Peel-Dufferin, Services and Housing in Province (SHIP), Dufferin Children and Family Services, Friends and Advocates Peel Dufferin, Alzheimer's Dufferin, Dufferin-Peel Catholic Family Services, Central West Home and Community Care, Caledon Community Services, Caledon OPP, Dufferin Police Services, Shelburne Police Services, County of Dufferin, and Family Transition Place have committed to adopting the local palliative pathway development approach as a framework to:

- Design a shared care model across the continuum and across providers, using the realignment of resources to support crisis support 24/7 as an opportunity for integrating care.
- Replicate Short-Term Emergency Department Diversion (in-STED) program and offer short term crisis planning for individuals being discharged from the Emergency Department with next day telephone follow-up and access to sort term care management provided by a partner provider.
- Expand behavior therapy programs provided by Dufferin Area FHT, and build on the integrated delivery model between the County of Dufferin, Family Transition Place, SHIP and CMHA Dufferin-Peel to identify additional opportunities for integrated service delivery
- Complete a gap analysis and bridging strategy to address current gaps in mental health and addictions services sites across Dufferin and Caledon, with particular focus on determining what types of care partnership will reduce unnecessary ED/inpatient use
- In tandem with Data Sharing Agreements, patient education, and public awareness campaigns, focus on designing a system that will move from crisis to prevention and promotion for mental health and addictions

Integrated Care (Health Links and modernization of home care):

Beginning in summer of 2017, the Central West LHIN brought all sub-regions together to focus on the Integrated Care Initiative. This resulted in:

- Commitment for establishing a single Central Intake, a master patient record
- Implementation of an innovative and consistent tool for identifying and registering all patients with complex care needs, see figure below
- A coordinated and shared process for determine a lead for completing a coordinated Care Plan and process for warm handoff

The focus now is to operationalize across the Hills of Headwaters Collaborative OHT. In August 2019, physicians, patients, HHCC, Dufferin Area FHT, CMHA Peel-Dufferin, SHIP Alzheimer's Dufferin, Central West Home and Community Care, Dufferin Paramedic Service, County of Dufferin and Family Transition Place committed to supporting this activity. In addition partners also developed an associated work plan that will focus on:

- Modernize and reimagine Home and Community Care
- Smooth or eliminate transitions in care
- Design and or re-design Care Coordination and System Navigation

Figure: Registration Form

HealthLink

Central West Health Links
Coordinated Care Registration/Update Form

Send document via:
HPG Document Exchange:
Central West LHIN - [M]Health Link Mailbox
or
Fax to: Central Intake Line
1-844-916-0362

PATIENT DEMOGRAPHICS

Surname: First Name: Health Card Number (HCN): VC:
Address (street, city): Postal Code: If no HCN, reason: Select Reason From
Gender: ☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Transgender ☐ Other (specify) ☐ Prefer not to answer
Phone: Date of Birth: ccaaaa/mm
Alternate Contact Person Name: Relationship to Patient:
Phone:
What language does the patient feel most comfortable speaking in?
Is an Interpreter required? ☐ Yes ☐ No
Are accommodations required? ☐ Yes ☐ No If yes, specify:

SECTION A: REQUEST TO REGISTER

Requesting Organization Type: ☐ Community Support Service Agency ☐ Primary Care ☐ Community - Other ☐ Hospital - Emergency Dept. ☐ Hospital - Out Patient ☐ Hospital - Inpatient
Requesting Organization: Date of Request: ccaaaa/mm
Requester's Name: Requester's Phone:
Requester's Professional Designation:
Do you wish to be the lead organization for this patient: ☐ Yes ☐ No
Health Links Consent obtained: ☐ Yes Click here to access the Common Consent Script.
Consent Directive/Block
☐ Check this box if the patient wishes to block their CCP in provincial or regional health information systems such as ConnectingOntario so it cannot be accessed. To do this, call the LHIN Privacy Office at 1-800-733-1777 or 905-796-0040 ext.7751. Date of call to LHIN Privacy Office: ccaaaa/mm
Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify): ☐ Do Not Know
Patient has Primary Care Provider (PCP): If yes, PCP name: ☐ Yes ☐ No
If no, does the patient want a PCP: ☐ Yes ☐ No
Health Links Identification Screener:
(If yes to any of the four questions, the patient has complex needs and is appropriate for Coordinated Care)
Does the patient's social determinants of health put their health at risk? (Consider social/family supports, housing, poverty/income levels, etc.) ☐ Yes ☐ No
Do you think the patient's health will decline significantly in the next six months? ☐ Yes ☐ No
Has the patient had two or more Emergency Department or Primary Care visits in the last 90 days? ☐ Yes ☐ No
Does the patient currently have or require support from numerous service providers? ☐ Yes ☐ No

SECTION B: REQUEST TO CHANGE LEAD ORGANIZATION AND ACCESS

Current Lead Organization: Proposed New Lead Organization:
Request to add/revoke Coordinated Care Plan Access:
(1) Organization Name: ☐ Add Access ☐ Revoke Access
(2) Organization Name: ☐ Add Access ☐ Revoke Access

SECTION C: REQUEST TO END COORDINATED CARE

Requester's Name: End Date: ccaaaa/mm
Disposition: ☐ Death, location: Select Location From List ☐ Other, specify reason:
Date of Death: ccaaaa/mm

If you wish to submit supplementary patient information to assist in lead organization assignment, please attach it to the registration form and submit it as a package to the Central Intake fax line: 1-844-916-0362 or via HPG Document Exchange: Central West LHIN - [M]Health Link Mailbox

(CW_Survey_Consult-Confer-H_Cares)
Private & Confidential - This form contains Personal Health Information when completed.
Central West LHIN 1047
Created: May 10, 2017
Updated: September 28, 2018
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Health Equity:

The Dufferin County Equity Collaborative (DCEC) represents a partnership of stakeholders with a shared vision who are working together to improve the quality of life of Dufferin County residents. With a broad list of partners spanning the full range of health, social services, housing and a broad number of community providers, the DCEC's focus is to:

- Determine the opportunity to reformat DCEC to be the Dufferin-Caledon Equity Collaborative
- Focus on three main priority areas affecting the social determinants on health including:
    - Housing and homelessness, specifically innovating and expanding the stock and supply
    - Employment
    - Health equity with a specific focus on poverty and low income, and supporting traditional health partners and primary care to work in better partnership with social and community providers.

The Full Extent of Local Partnerships:

The depth and duration of partnerships across sectors and providers is wide-ranging and extensive. As an early test of readiness the Hills of Headwaters Collaborative OHT partners were surveyed to provide details of their relationships with and amongst each other, some dating back more than 20 years. In total partners were able to identify more than 80 formal partnerships with demonstrable outcomes and results. A unique characteristic of these partnerships, is the breadth and span across health care, community and social care, including police and justice. Given the amount of information available the full list can be found in Appendix C, the Hills of Headwaters Collaborative OHT feel this is an important form of evidence that supports the high level of maturity of these local partnerships.

2.5. How well does your team's membership align to patient/provider referral networks? (500 words)

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

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

Maximum word count: 500

Localization rates indicate that 52% of care provided to the most costly complex patient populations – specifically those with dementia and significant comorbidities, and complex care needs – are provided within the Hills of Headwaters. The second most costly – palliative care – has a localization rate of 57%. In both cases where care is offered outside the Hills of Headwaters, care is being delivered from large specialized networks such as the Southlake Regional Health Centre and the University Health Network (UHN).

Integrated care closer to home, resulting in increased localization, will occur through the ongoing focus on integrating clinical care pathways. It is understood that enhancements to the care infrastructure will need to be made over time, for example: based on current projections, the Hills of Headwaters should have ten dedicated hospice residence beds; however, the current beds available are shared across another two proposed OHTs in the LHIN boundaries. In some cases market shares outside the Hills of Headwaters Collaborative OHT may be clinically appropriate, such as the third most costly patient group – metastatic cancers with significant comorbidities – where patients require the support of another network such as Southlake and UHN. In this case however there is a need to emphasize the use of virtual care to support patients to receive the most appropriate level of care close to home through clinical partnerships.

Market shares and localization of specialists and family physicians, while acceptably high, will be a focus and impetus for clinical integration. The type of data shared though the development of this Full Application will also be shared with physicians across Hills of Headwaters for further validation and exploration. This data revealed that approximately 50% of specialist fees are billed within another networks, anecdotally this is believed to occur as a result of the scope of care that is offered locally. Examples of this would be orthopedics and psychiatry, where even though the specialist resources are available in the local community, Headwaters Health Care Centre does not do joint replacement and is not supported by psychiatry beds, therefore market share is affected negatively. In another case, urology is a newly supported specialty area that would up until now required patients to travel to another network, continuing to monitor this data will be a key focus for partners and physicians.

In terms of addressing high cost areas of care, palliative patients, mental health and addictions patients and patients with complex needs, the partners and providers that are supporting this full application are fully aligned, both in terms of the types of health care that

will need to be connected to patients and caregivers, and also in terms of meeting their social and community service needs. While data shows that emergency department and inpatient care is significantly aligned to the local network, partners feel there is more that can be done to ensure that access is appropriate and more care is integrated and available in the home and community settings.

Given the relative size of the proposed network and member providers the Hills of Headwaters Collaborative OHT would rate the alignment as high. There is considerable evidence that the selected priority population and cost drivers and referral patters are aligned. There is and will be a continuous efforts to repatriate patients into the Hills of Headwaters, this can be supported by both through partnerships with specialty care providers as well as through virtual care.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.5.1.

2.6.1. Collaborating Physicians

(See supplementary Excel spreadsheet)

2.6.2. Other Collaborating Organizations

(See supplementary Excel spreadsheet)

2.7. What is your team's integrated care delivery capacity in Year 1? (500 words)

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

Maximum word count: 500

As proposed, the Hills of Headwaters OHT has an associated population of 112,781. Prior to the submission of the OHT Readiness Assessment in May 2019, partners - including patients, physicians and other providers have already committed to transformation of palliative and end-of-life care. In doing so, family physicians have made a commitment to ensuring that anyone that needs end-of-life care, either associated with the Hills of Headwaters catchment area or repatriated to the community, will be provided all necessary care 24/7.

This commitment sets the standard and expectation for rapidly addressing mental health and addictions, as well as patients with complex care needs, including children and seniors. Addressing the needs of complex patients at a population level remains a priority.

Already a work group of partners – including patients, physicians and other providers – have identified an integrated care delivery team for end-of-life care. This resource team will be accountable to the Hills of Headwaters OHT and will be accountable for the care of patients and caregivers across all settings. This team will be responsive and able to support the entire end-of-life population across all of Dufferin and Caledon, and across numerous care settings, including (but not limited to) acute care, LTC, retirement homes, private dwellings and hospices, as well as various shelter settings as needed.

This forms the integrated care framework and approach that will guide other integrated clinical care pathways in Year 1, and will establish the groundwork for integrated funding and bundling of care at a population level.

Before any formal approval for the OHT, partners across the Hills of Headwaters are using the early success of the palliative framework as a pathway for mental health and addictions system improvement. An early opportunity is the establishment of an integrated crisis team that is able to deploy across all setting in the Hills of Headwaters area. Again, this work is being co-designed with the support of patients and physicians; in this particular case with both psychiatry and family physicians. The initial focus of Year 1 will be on any patient needing crisis support, estimated to be 2% of the population or approximately 2,447 patients. In Year 2 and beyond, the focus will shift to reimagining mental health and addictions through integrating care and removing care transitions, while also adopting an approach focusing on prevention and promotion at a population level, applicable to the entire population of 112,781.

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

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

(See supplementary Excel spreadsheet)

2.9. How will you expand your membership and services over time? (500 words)

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

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

Maximum word count: 500 words

The Hills of Headwaters OHT is being initiated with an extensive partnership reflective of a population-health approach. Beyond Year 1, this partnership will continue to evolve and incorporate collaborative partners that represent social and justice services, in recognition of the need to address the social determinants of health. While actively integrating a population-based approach to palliative and mental health and addictions, the Hills of Headwaters OHT partners will look to form effective and reciprocal relationships with tertiary care centres. Capitalizing on existing clinical relationships, these partnerships will be enhanced through the ability to articulate a seamless and integrated care pathway in the local community. In addition, this will include the expansion of tertiary care providers in the development of bundled care.

Technology-driven relationships and partnerships will also be the focus in Year 2 and beyond. In early 2018, primary care physicians using TELUS Practices Solutions adopted an early identification add-on developed by the eHealth Centre of Excellence in Waterloo. Partners are actively pursuing other technology platforms being developed by the eHealth Centre, specifically a digital robots that exchange information between various health records. In addition, exploring opportunities for shared virtual care technologies and patient portals will be a focus throughout the next stages of development.

In 2015 the Dufferin Area FHT and associated physicians moved to a single instance of the TELUS Practice Solution EMR. As this commitment was made Headwaters Health Care Centre partnered to host the EMR within existing the existing informational technology infrastructure. Today Headwaters Health Care has expanded this partnership to also provide overall support to physicians and the Dufferin Area FHT. This type of partnership can also be replicated to support physicians using the same EMR throughout Caledon. Early testing is already underway to ensure stability of the platform. Headwaters Health Care has committed to and is beginning the process to upgrade and adopt to Meditech Expanse, as a fully

interoperable Electronic Heath Record it may offer new opportunities for partnership across the continuum of care.

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

Maximum word count: 500 words

The proposed Hills of Headwaters OHT has a total of 70 primary care and 31 specialist physicians. In addition, there are four Nurse Practitioners and a physician assistant in the community who practice as part of Dufferin Area FHT. In addition the Hills of Headwaters area is supported by a thriving primary care midwifery practice with six Midwives that support prenatal, birth and postpartum care.

Primary care physicians have been part of ongoing engagement and co-design projects prior to and throughout the entire OHT Readiness and Full Application. Various physician leaders, in both formal and informal roles, continue to support outreach and engagement activities. Given the focus on clinical integration at a population level, all physicians, based on their patient's needs, will have some involvement with the Hills of Headwaters OHT. This affords the opportunity to use a needs- and experience-based design approach with physicians.

The Hills of Headwaters Collaborative OHT has adopted an investors' strategy, of which physicians and primary care are a key focus. The strategy involves two connected streams: the first is a peer-to-peer strategy to align physicians with the various Year 1 priority working groups, such as palliative, mental health, integrated care and modernization of home and community care, as well as the development of a Collaborative governance framework and long term development. This peer-to-peer strategy focuses on ensuring broad involvement across geographies, models of practice, cultural inclusivity and length of time in practice.

The second is the commitment to support a Hills of Headwaters Physicians Association is in development, with support from the Ontario Medical Association and local physician leadership this is in development at time of submission. In addition, the local association will support a virtual physician community that will leverage the same Zoom digital platform that is used to support a virtual community for patients and frontline staff.

Over the course of Year 1, the focus of this work will be to bring all 101 physicians together, including family physicians and specialists, to co-create a space that supports ongoing relationships and well as clinical and governance leadership involvement.

Given the ongoing population growth, referenced in previous sections as being between 9% and 39% between 2011 and 2016 Census, compared to 5% provincially, there is a need to conduct a health human resources capacity assessment. Initial focus will be on determine in the need for family physicians across the Hills of Headwaters Collaborative OHT. Again the focus being to repatriate patients, while respecting choice, but ensuring capacity to offer care closer to home. As additional physician resources are considered partners and Hills of Headwaters Physician Association will work proactively with the ministry to determine a process and preferred model of practice.

2.10. How did you develop your Full Application Submission? (1000 words)

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

Also consider in your response:

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

Maximum word count: 1000

The development of the Hills of Headwaters OHT is fully participatory and leadership is distributed across a broad and inclusive group that meets as the Hills of Headwaters Collaborative. Since this group was well established prior to the release of the OHT vision, these providers from across Dufferin and Caledon were well prepared and positioned to capitalize on the OHT process.

Shortly after submitting the Readiness Assessment, the Hills of Headwaters Collaborative OHT supported an extensive engagement session for providers, patients, caregivers, physicians and governors to establish a shared purpose. Supported by the Change Foundation, a symposium was held on June 25, 2019 for approximately 85 participants, who met to develop shared goals, openly discuss challenges and issues, and determine shared principles.

With this broad participation, the Hills of Headwaters Collaborative OHT was able to establish consensus on number of foundational pillars, aligned to the OHT vision that will ensure the success of the Hills of Headwaters OHT. Specifically, those pillars are:

- A shared purpose:
  - To create one community working together to improve the health and well-being of everyone who lives and provides care in Dufferin-Caledon
- Going beyond engagement by co-creating an *"Investors' Strategy"* that is based on co-designing through diverse perspectives that share a common purpose and are invested in supporting change. This strategy is:
  - Inclusive of frontline staff, primary and specialty care, patients and caregivers, citizens, governors and organizational leadership
  - Building on early sessions, this investors' strategy will support the full application process to ongoing maturity and will support the co-design of additional improvements for the health and well-being of the community
- Sign-off on principles:
  - Work side-by-side as patients, families, caregivers, providers, physicians and community members in co-designing the future of local health care in Dufferin-Caledon, focused on what matters most to our local citizens
  - Share leadership across social care, providers, and patients and caregivers to achieve the shared vision
  - Value the contributions of each of us by listening and seeking to understand our different viewpoints, and by being respectful when we disagree
  - Be open, honest and transparent in our work together, recognizing that it takes time to build trust and create safe spaces to work through the challenges that lie ahead
  - We (providers, patients and caregivers) are responsible to each other, to share our resources willingly, and to be transparent with our community
  - Recognize the strength that exists in all of us and use our diverse voices and opinions to push the boundaries of what we can do
  - Support each other to take risks and be courageous, knowing that some of the solutions to improving health care will require disruption and changes in how people work. When we recommend or make changes, we will be sensitive to and support those who are impacted.
- Partnering with patients, caregivers, providers and our community on shared priorities to integrate health and social care in our local region, with specific Year 1 and 2 focus on:
  - Better integrating mental health and addictions services to expand access and improve care
  - Creating an integrated palliative care team to expand access and improve care
  - Determining integrated care pathways for patients with complex care needs and reimagining home care to enable integration of care across our community
  - Decreasing the health equity gap across our community
  - Better connecting other health services to primary care and specialized care

As previously stated, the Investors' Strategy will support and enhance physician participation and leadership moving forward. In addition frontline staff, Governors, and patients and caregivers are targeted groups of investors that have been involved in full application development and will support ongoing transformation co-design.

Based on the success and consensus achieved from the June symposium, additional Investor Forums were held as part of the evolving maturity of partnership, and to support the OHT

development as a movement for integrating care locally. The following were the key dates, investors targeted and number of participants in the development of the full application:

- August 26: More than 40 Patient and Family Advisors from across all partners
- August 27: Meeting with 3 Indigenous community leaders
- September 9: Approximately 45 Governors and Leaders
- September 10: More than 30 Directors and Managers
- September 13: 104 Frontline staff from across all partners and communities
- October 4: 12 Family and Specialist Physicians leaders
- Between the Readiness Assessment submission and Full Application approximately 14 delegations to municipal and county councils

Patients and Family Advisors:

- The development of a patient advisory body for the Hills of Headwaters has been one the greatest early successes. Self-organized and with an ongoing inclusivity agenda, this group continues to build and grow. With a specific focus on unifying patient, client, citizenry, cultural groups, caregivers/partner into a single network, the Hills of Headwaters Collaborative OHT has been able to meet the vision of OHTs and have patients as key partners.
- This group continues to meet, having come together in the summer with an anticipated patient forum occurring in the fall of 2019.

Governors and Leaders:

- Approximately 45 governors and leaders met in early September to review and discuss governance considerations for the Hills of Headwaters. Importantly, this also offered an opportunity for informal network and relationship development.
- Governors self-identified a smaller group that would develop a “statement of purpose and commitment” and Collaborative Agreement for all governors of the Hills of Headwaters Collaborative.
- Governors also agreed to meeting over Year 1 to continue to build relationships and develop a shared vision.

Directors and Managers:

- The CEOs, EDs and leadership committed to the development of a Directors and Managers table comprised of diverse leadership from across the Hills of Headwaters partnership.
- With more than 40 invited to support, this group met for the first time on September 10, with expectations to level set on the vision for OHTs, the Hills of Headwaters Collaborative OHT as well as the Year 1 priorities.
- In the coming months, this group will develop terms of reference, guided by the Collaborative and its associated work plan, to ensure Year 1 targets are met.
- To be timely and effective, this group will explore the use of technology to create a virtual network across Dufferin and Caledon.

Frontline staff:

- On September 13, approximately 104 frontline staff from across Dufferin and Caledon partners participated in a half-day forum.
- The focus of this forum was to review the vision for Ontario Health Teams, aligned with international experiences in connecting care, and review the Hills of Headwaters shared purpose, priorities and principles.
- Frontline staff are excited to have the opportunity to be involved in system transformation and integration and added perspective and examples of existing partnerships that will align to year 1 commitments.
- All staff involved are considered to be “super connectors” and agents for change by their directors, managers and CEOs/EDs. As an important change management initiative, frontline staff engagement will be maintained as a virtual network through the Zoom technology platform. This will ensure they are able to maintain their commitment to patients and caregivers, and at the same time lead in the system transformation in the Hills of Headwaters.

With the high level of connectivity and partnership amongst partners over the course of the development of the Readiness Assessment and Full Application, communication leads also came together on September 16th and committed to forming their own supportive network. In addition to supporting partners that do not have formal roles communication staff, the communication leads also committed to establishing supports for patients, physicians and governors across the Hills of Headwaters. These supports will be based on taking an innovative approach to traditional media, as well as developing patient blogs and connecting networks for broad citizen engagement as local system transformation continues.

This serves as an example of the high level of participation and the maturity of the existing partnerships that will support the Hills of Headwaters to achieve success. It also serves as an early and tangible example of the role that a distributed model of leadership plays in leading change across a broad partnership.

Continuing to meet with and develop a shared understanding of partners and communities that will be important in in the maturity journey of the Hills of Headwaters Collaborative OHT. An important group to continue to meet with and develop a shared understanding of is the Indigenous community, while early in that path of discovery the Collaborative is committed to reconciliation. Meetings have and will continue to take place, as appropriate with community Elders and members of the Dufferin County Cultural Resource Circle.

3. How will you transform care?

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

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

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

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

3.1. What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity? (1000 words)

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

Maximum word count: 1000

Current Performance:

In considering an approach to developing Key Performance Indicators partners considered existing measures and performance. The following highlights existing performance that will be monitored for improvement as system redesign of patient care is undertaken.

Palliative Care:

Key performance indicators associated with the Hills of Headwaters Collaborative OHT include the following, which indicate this is an area of improvement:

Data	Dufferin sub-region	Bolton-Caledon sub-region	Central West	Ontario
Home Visits in the last 90 days of life (FY2017)	25.4%	22.1%	25.4%	22.9%
One of more ED visits in the last 30 days of life (FY2017)	58.4%	55.0%	58.3%	55.0%
Percent of people who die in hospital (all hospital settings and acute only) (FY2016)	50.2%	45.9%	52.9%	52.0%

Source: IHSP Environmental Scan, Health Analytics Branch, Ministry of Health

Mental Health:

The Hills of Headwaters Collaborative OHT does not currently have mental health beds in acute or community care settings which affects data reporting. With the nearest psychiatric bed located in Brampton, partners have committed to further integrating care in the community and determining an innovative crisis support model.

Data	Dufferin sub-region	Bolton-Caledon sub-region	Hills of Headwaters OHT	Central West	Ontario
Inpatient Utilization: Active cases per 100,000 population (15+) (FY2016)	342.0	251.0	310.3	361.1	548.5
Inpatient Utilization: Admissions per 100,000 population (15+) (FY2016)	325.1	233.7	293.2	344.9	511.7
Inpatient Utilization: Discharges per 100,000 population (15+) (FY2016)	325.1	242.3	296.3	347.0	515.2
Psychologists / 100,000 population (2016)	-	-	-	9.1	24.3

Source: IHSP Environmental Scan, Health Analytics Branch, Ministry of Health

Health Links Performance:

While Dufferin and Caledon have advanced provincially there is opportunity fully mature the approach and embed within the Hills of Headwaters Collaborative OHT.

Data	Dufferin sub-region	Bolton-Caledon sub-region	Hills of Headwaters OHT	Central West	Ontario
# of patients with complex needs	3,200	1,460	4,660	41,450	668,635
# of patients with a completed coordinated care plan (CCP)	1,935	511	2,446	10,967	84,707
% of target population with a completed CCP	60.5%	35.0%	52.5%	26.5%	12.7%
% of individuals with a CCP who are newly attached to a primary care provider (PCP) through the Health Links approach.	91.8%	100.0%	93.0%	93.1%	48.6%

Source: HQO (extracted from CHRIS for Central West LHIN), up to Q1 FY2019

The principles that will guide and inform the work of the Hills of Headwaters Collaborative OHT speak to the commitment to measurement and accountability, specifically:

We (providers, patients and caregivers) are responsible to each other, to share our resources willingly, to advance system integration and to be transparent with our community.

We pledge to support each other to take risks and to look for creative solutions while being courageous, knowing that some of the solutions to improving health care will require disruption and changes in how people work. When we recommend or make changes, we will be sensitive to and support those who are impacted.

Measurement matters in system transformation and the Collaborative looks forward to the ongoing review of outcome- and performance-related data, particularly as relationships grow and fully mature partnership are developed, in part through shared knowledge and accountability. With that as context and in consideration of measuring improvement, the Hills of Headwaters Collaborative OHT envisions the development of an iterative balanced scorecard, aligned to shared purpose and priorities, as well as OHT measures in development provincially.

As discussed previously, the Collaborative will proactively develop data sharing agreements with Public Health and the Institute for Clinical Evaluative Sciences to ensure decision-making is related to Hills of Headwaters system outcomes and performance.

The following would be considered a base set of measures: Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures.

Collected through Central Intake, the Hills of Headwaters will use the existing patient confidence score as a measure of patients' overall confidence in their ability to meet their care goals in the OHT. In Year 1, confidence scoring will also be applied to providers to measure their confidence in their ability to meet their patients' care goals.

This patient confidence score will develop a baseline measure and lead to various shared quality improvement initiatives within and across the Hills of Headwaters partners.

For the Integrating Palliative Care priority, the following set of measures align to both the Ontario Palliative Care Network and Health Quality Ontario Palliative Quality Frameworks, which will be implemented in Year 1:

- Percent of decedents that die in hospital
- Percent of decedents that in their place of choice (measure TBD)
- Percent of decedents that had an ED visit in the last 30 days of life
- Percent of decedents who received home visits from physicians and/or palliative home care in the last 90 days of life

For the Integrating Mental Health and Addictions, and the Integrating Care for Patients with Complex Care Need priorities, the following measures will be implemented:

- Reduced ambulance calls and ED visits
- Reduced time from Form to accessing inpatient care
- Decreasing time to treatment
- Seven-day physician follow up post-discharge
- Frequent ED visits (4+ per year) for mental health and addictions
- Decrease avoidable ED visits, visit rate for conditions best managed elsewhere
- Wait time for first home care service from community
- Caregiver distress
- All cause 30-day inpatient readmission rates
- Median time to long-term care placement

These measures align to the Hills of Headwaters Collaborative OHTs shared priorities with the understanding that associated work groups and providers will have additional measures of outcome and performance. The selected measures will be shared as part of the ongoing meeting of the Hills of Headwaters Collaborative.

As integrated teams and pathways are determined, these measures will provide a baseline assessment of impact. Sharing this data with patients, physicians and frontline staff through the various virtual networks and communities with also add context and clarity of impact. For examples, if the teams are effective in reducing the impact of hallway medicine measured through 30-day ED visits and/or avoidable ED visits, but patient confidence scores remain static or decrease, then further measurement and exploration will need to be considered in furthering system change.

In 2014, partners across the Central West LHIN area developed a patient confidence score as a measure of patients' overall confidence in their ability to meet their care goals in the OHT. In Year 1, this will also be applied to providers to measure their confidence in their ability to meet their patients' care goals.

3.2. How do you plan to redesign care and change practice? (2000 words)

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

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

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

Maximum word count: 2000

The Hills of Headwaters Collaborative OHT has purposefully overinvested time in the development of relationships, the development of a shared purpose, a commitment to common priorities and the establishment of a guiding principles. With the announcement of OHTs in February and the Readiness Assessment in May, the Collaborative itself has been meeting every two weeks to ensure these foundational elements were strong and unwavering. These elements have been shared and verified extensively across frontline staff, patients, physicians and providers in a transparent manner and subject to further refinement.

The local analogy for addressing this question goes as follows. If the development of the OHTs is looked at as a highway that will lead down a road ultimately arriving at a fully connected and integrated health and care system, the Hills of Headwaters Collaborative OHT partners felt it necessary to ensure the "vehicle" going on this journey is capable of taking this trip. As a vehicle for change, the Hills of Headwaters Collaborative OHT is ready to take this journey, and is committed to ensuring that everyone – patients, physicians, providers and the community itself – will arrive with success.

While hard to express in the confines of the Full Application, the development of the Hills of Headwaters is about more than the completion of this body of work. The partners look forward to a Ministry site visit so this specific partnership foundation can be experienced firsthand and the body of local readiness can be reviewed.

The measurements that are most important to enabling this change are the Patient Reported Experience Measures and the Provider Reported Experience Measures – that is, their respective confidence in achieving their – or their patients – care goals. Aligned to the Patient Declaration of Values for Ontario, these important measurements will ensure that providers have a shared system- and provider-level indication of the relative confidence in the Hills of Headwaters as a local health system. This measure will be a critical starting place to bring about a cultural shift from a siloed individual and ego-centric provider delivery mechanism to an eco-centric perspective that views the patient, caregiver and population as equals in meeting that care goals based on "What matters to me?" All of this is aligned to the articulated expectations that patients and caregivers have of Ontario's health care system.

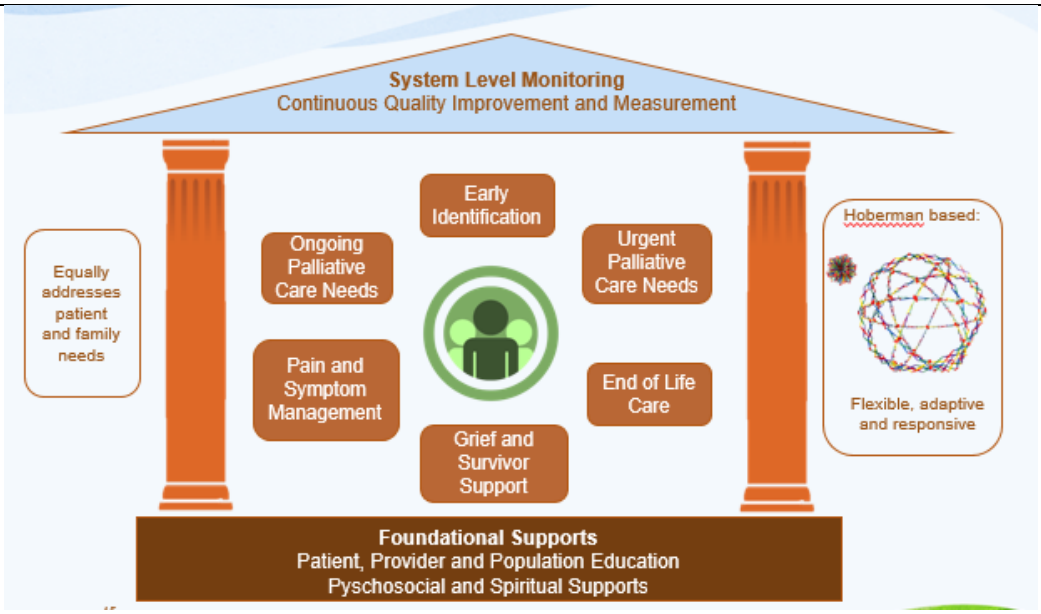
At the time of writing, and ahead of submission and/or formal approval, this change and shift in perspectives is already taking place. Palliative patients and physicians are involved in the redesign of care, in the changing of current practices redesign, and in the integration of services. In addition, this group includes the following providers:

- Dufferin Paramedic Services
- Dufferin County Community Hospice and Bethell Hospice Residence
- Central West Home and Community Care
- Dufferin Area Family Health Team
- Headwaters Health Care Centre
- Dufferin Oaks LTC and Shelburne Residence Retirement (both as sector representatives)
- Dufferin-Caledon physicians palliative call-group
- Friends and Advocates Peel

This group came together with a shared commitment and purpose, and began with a formal declaration of principles to guide their work. This declaration includes:

- Patients, families and caregivers are considered a part of the team and their respective needs are factored in at every stage.
- Any patient identified as having end-of-life care needs will be supported by a family physician (and primary care).
- There is acknowledgment of and commitment for a single team of truly integrated interprofessionals working to full scope and partnership, aligned to the vision of Ontario Health Teams.

With those principles as foundation, the partners took the current best practices from Ontario Palliative Care Network (OPCN), Health Quality Ontario and other provincial frameworks, and applied them to the local context to establish a Hills of Headwaters Integrated Palliative Care Framework, as depicted below.



This framework has associated bundles of care that will be further articulated and defined in Year 1. At the center of this integrated framework is a core team that will be shared and deployed across the entire Hills of Headwaters OHT. A focus on redesigning care led to the articulation of a core end-of-life team that will work with patients, caregivers and primary care providers. At end of life – initially identified as the last estimated six months of life – a core team will be comprised of a family physician and/or nurse practitioner and:

- Nurse
- Social Worker
- Patient Navigator (enhanced and reimagined Care Coordination)

The team will be accountable for fulfilling the following roles and responsibilities, all building from core competencies outlined by the OPCN:

- The core team is available 24/7 and aligned to the physician call group
- The team has access to all medical records, with a single medical record being a medium term objective
- The team is modelled after a base hospital program with standard order sets supplemented by physicians supports
- The team is available in all settings and for all needs at end-of-life
- Support for patients and families to come and go from involvement with the team as care needs escalate and de-escalate
- Real time access to one shared care plan as well as real time (secure) communications
- Prepare families/caregivers to effectively respond to and manage end-of-life care
- Competency to identify and predict the needs of patients and families, and act on those needs as appropriate
- Autonomy of the practice/team

- Act as an educational resource for patients, families and providers across the community
- Address diversity and equity needs

Operationalizing these roles and responsibilities will require change to current practices and local policies. It has been highlighted that some of these policies are local ways and means of operating can be immediately addressed, while others will take provincial support. All represent a focus on meeting the needs of patients and caregivers and on creating meaning system integration.

This palliative work group has also deployed a set of task groups to develop some early wins that will support ongoing change, recognizing that this level of practice and system change will take longer than a year. Those groups are:

- Early ID: Deploying a digital health solution in the physicians' EMR
- Call Group: Organizing a physician consultation call group that is available 24/7/365
- Pain and Symptom Management: Giving physicians immediate access to system management resources and removing ordering oversight bottlenecks
- Central Intake: Consistent registry for all palliative patients, mental health and addictions patients, and any patients with complex care needs

As highlighted previously, the Hills of Headwaters Collaborative is a distributed model of leadership that provides oversight and support for all the priority working groups. Again, partner providers – having witnessed the development of the palliative approach – have already met to adopt this framework and manner of leading change in practice.

The Collaborative feels strongly that, by spending the time investing in establishing a foundation purpose, priorities and principles, the Hills of Headwaters will be successful and looks forward to going on the journey.

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

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

3.3.1. How do you propose to coordinate care? (1000 words)

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

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

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

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

Maximum word count: 1000

Care coordination models will be redefined within the Hills of Headwaters OHT with a focus on building on the current strengths, competencies and infrastructure to enhance the delivery to achieve greater health system outcomes in support of a population health focus.

The current state of care coordination within this region creates a foundation of readiness for an improved model. The LHIN’s care coordinators are currently organized around geographic “neighbourhoods” of patients, physicians and providers across Dufferin and Caledon. In the Hills of Headwaters’ geographic area, there is a high level of maturity in the care coordination alignment and partnership with primary care. In this existing system, care coordinators carry caseloads built around primary care practices. This foundational model creates the opportunity to build an integrated approach care planning. These existing care coordination

resources are expected to enhance coordination functions beyond home and community care to span health and social needs. Similarly, the community support sector (including assisted living and supportive housing programs) created a care coordination model that supports full service care coordination for the clients they serve. As one example of integrated care readiness: the Assisted Living/Transitional Care and Home and Community Care teams within this OHT area have recently tested and implemented process improvements to clarify roles and responsibilities related to full service care coordination. These improvements have reduced duplicative efforts and enhanced partnerships for patients, primary care and partners. These care coordination teams actively round together to ensure care continuum and to ensure that common resources are best used to meet patient and family needs within the neighbourhood of care. The models of care coordination and primary care alignment will be replicated across all service partner organizations that currently support care coordinator functions in order to strengthen the ease with which primary care is connected with care in the community and to ensure smooth transitions in care, especially from acute care to community.

Existing LHIN care coordination functions will be used and modernized in conjunction with other coordination resources that exist within primary care, community support services, acute care and outpatient services, and service provider organizations, in order to ensure consistent outcomes, interventions, assessment and care planning activities. Through risk stratification processes identified through a Central Intake model, clients, patients, families and the interprofessional care team will work with the appropriately matched service intensity of one care coordination resource.

Central Intake will provide a single point of referral for all patients with complex care needs, eventually formulating a single patient registry for the Hills of Headwaters Collaborative OHT. Aligned to the vision for OHTs this will support patient resource matching as well as outcome and system performance monitoring and measurement.

Maximizing scopes of practice will ensure that the lead coordinator uses existing assessments to support the patient's care goal, in partnership with the patient/client and their support system. In turn, the lead coordinator will ensure that the care team (primary care, interprofessional care team and all required health and social care services) are well aligned to support the presenting care needs across the entire care continuum within the stratified care population level. As the client/patient's care needs change within the stratified care population level, the lead coordinator may transfer through a warm handoff to a more intensive or clinical-focused need. Throughout it all, the patient/client/family and interprofessional care team – including primary care – will be aware of the lead role.

Within the expected role composition of care coordination, a full range of service intensities will include system navigation; clinical care management with care pathway bundles and expected outcomes; referral management; joint care planning development, monitoring and implementation; advocacy; health and wellness/self-management education; team-based interprofessional coaching; and key collaboration.

Home and Community Care anticipates that approximately 20 FTE of Care Coordination functioned staff will be deployed to support the Hills of Headwaters Collaborative OHT as well as Home Care Operational Leadership.

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3.3.2. How will you help patients navigate the health care system? (1000 words)

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services the

need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

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

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

Maximum word count: 1000

In Year 1, system navigation services will provide support in three broad categories aligned to population health needs:

- System navigation will be available 24/7 for anyone to access self-service in the community through Healthline
    - Healthline (www.centralwesthealthline.ca) is an actively-managed repository of information for all health and social services providers in the region.
    - Management of this service will be assumed by the OHT for maintenance and to allow anybody to access the resource and self-navigate, even if they are not part of the Year 1 target population.
- Partners are part of a shared Central Intake for all patients with complex care needs who would benefit from care coordination and system navigation, to avoid the potential of hallway medicine and/or avoidable ED use.
- The Central Intake is based on proactive and retrospective identification of all residents of the Hills of Headwaters Collaborative OHT who meet any of the following criteria:
    - Would you be surprised if the patient's health declined significantly in the next six months?
    - Has the patient had two or more Emergency Department visits in the last 90 days?
    - Do the patient's social determinants of health put their health/wellbeing at risk?
    - Would you be surprised if the patient requires support from numerous service providers?
    - These criteria build on the recognized successes in Dufferin and Caledon related to maturing the Health Links approach to care and the adoption of a "What Matters to You" focus on patient care goals within a Coordinated Care Plan

- System navigation for complex care needs populations:
  - For patients requiring specialized system navigation due to a complex care need – such as palliative and end-of-life, or mental health and addictions – a dedicated System Navigator role has been identified as a member of the core team.
  - This role can be fulfilled by existing roles either in the community or through the modernizing of Home and Community Care resources.
  - The dedicated system navigator is to provide "emergency response" and connect patients, families and caregivers to a broad range of services, and to ensure this is done in a manner that does not create a transition; rather, the navigator will facilitate a seamless continuum of care.
  - A Central Intake that will have one phone number to call, marketed to the priority populations, primary care practices and other means as appropriate.

As the OHT matures and other clinical pathways are integrated, system navigation supports and services will be developed. The focus for any population with complex care needs will be to develop a personalized, patient-focused and "transitionless" care experience. To support this level of system transformation, the Hills of Headwaters, aligned to the findings of the Devlin Report, will create standards for data and information sharing between the hospital, community partners and primary care in order to support clinicians and team members gain a better understanding of how to navigate the patient and his/her care needs through the system.

To evaluative the effectiveness and ongoing development of system navigation the Hills of Headwaters Collaborative OHT will monitor the following measures:

- Decrease in 30-day readmission/visit to EDs
- Reduction in ED visits by palliative patients in the last 90-days of life
- System Resource Navigator confidence scoring – confidence in ability me meet the goals of care as indicated by patients and caregivers

3.3.3. How will you improve care transitions? (1000 words)

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

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

Maximum word count: 1000

There are many tangible examples of practical efforts to improve and/or remove transitions of care across the Dufferin and Caledon communities. The following are a sub-set that, when put together, have created the momentum for OHT development. They also reflect the degree of partnership that will be built on in the future. These examples include:

Community Paramedicine

The Dufferin County Community Paramedic Program was created in the fall of 2014. This program provides non-emergency, community-based services with a focus on health promotion, system navigation and injury prevention. The program was develop in partnership with the County of Dufferin, Headwaters Health Care Centre and the LHIN. The impact of the program was immediate, physicians immediately used the service to augment their own home visits as well as deploy Community Paramedics to retirement homes and residences during office hours, in affect doubling capacity to see and treat patients in the community.

Today, the program has evolved to the point that, in fiscal year 2018/19, a total of 202 patients received home visits, avoiding any potential ED use. In some cases Community Paramedics provide notes and charting directly into the physician's medical record, a practice that can be expanded. In other cases, they work seamlessly with Home and Community Care to ensure home care and primary care services are integrated.

Home and Community Care: Neighborhood Development

Beginning in 2015 and in response to the community's needs, the local Home and Community Care team created a flexible model of care that can respond and adapt to the transforming health care system. This new model, which began in Dufferin and Caledon, provided "boundary less" care that integrated with primary care and aligned with community services/organizations. The development of this new model was key to supporting physician partnerships, a shared care model guided by patient goals and preferences, and the creation of a Coordinated Care Plan.

In affect Care Coordinators build trusted and reciprocated clinical relationships with physicians. This leads to proactive coordination that is responsive to needs and opportunities raised by either physician, care coordinator, patient or caregiver. Ensuring that the patient is at the centre of care and communication is shared. On-site rounds occur at a predetermined frequency with phone calls and securing messaging occurring as needed. The next step to build on this relationship is to expand the small test of having Care Coordinators adding messages and clinical notes inside the TELUS Practice Solution EMR.

There is ongoing effort to embed and align to an ever-growing number of primary care and community service providers.

Expansion of Interprofessional Primary Care Team Resources

Over the course of fiscal years 2017/18 and 2018/19, the Dufferin Area FHT took on a strategic growth opportunity to expand services by developing an interprofessional team in the Caledon community. A second expansion was also supported to develop a mental health and addictions service at a population level in Dufferin.

The focus of both expansions, now fully implemented, was to:

- Improve access to primary care so that Dufferin and Caledon residents who need to access an interprofessional team can do so, receiving the right care at the right time and place.
- Enhance health equity and patient-centred care, building and expanding a high-quality primary health care system that is tailored to the community, and to patients and families.
- Provide proactive, coordinated and continuous comprehensive care that helps people manage their own health and maintain independence.
- Foster innovation and collaborative partnerships for primary care in sub-regions.
- Enhance effective resource use and support for local service integration.

In both cases, the Dufferin Area FHT facilitated meetings with additional service providers to discuss clinical pathways for the expansion plans. Based on community needs, the following integrated care teams were developed:

- Caledon: The focus was on developing a dedicated community-based team that can support chronic disease and mental health supports as a foundation, with other providers, such as CMHA Peel-Dufferin, co-locating to enhance mental health delivery in 2018/19. In the next fiscal year, the focus is on expanding co-location to other providers in order to remove transportation barriers for patients, and to further collaborative partnerships.
- Dufferin: The focus was on expanding access to mental health services at a population level to the entire community, beyond the affiliated Family Health Organization (FHO) physicians. The expansion was based on developing a Memorandum of Agreement between Dufferin Area FHT and CMHA Peel-Dufferin for the development of a shared Dialectic and Cognitive Behavioural Therapy programs.

Data Sharing Agreements and Integrated Medical Records

Through the development of the Health Links approach to care, all of the partners have signed various Data Sharing Agreements with Home and Community Care. This is another key development to integrate and coordinate care and navigate patients to the right care without the need to retell a history. Partners across the Hills of Headwaters geography are accustomed to a changing and evolving digital health landscape. As early Health Links adopters, Hills of the Headwaters partners also piloted the provincial Care Coordination Tool however ultimately the Client Health and Related Information System (CHRIS) tool was selected as the common digital asset to support the Coordinated Care Plan. The process of conducting due diligence and signing data sharing agreements is felt to have eased the path

for greater integration of clinical roles and proactively seeking collaborations that will result in digital health consistency in the interest of supporting patient care and clinicians.

As the Health Links matured and primary care become a greater partner in leading care coordination, the need to have consistent access to patient information across all physician providers became apparent. In 2016, Headwaters Health Care Centre supported the migration of family physicians' medical records to the TELUS Practice Solution EMR. This migration has supported additional small tests of access, such as Home and Community Care access and Community Paramedic. Evolving shared and integrated access practices within the context of a Digital Health Playbook will be key to supporting access to the right information in the right place, such as inpatient units and hospital Emergency Departments

As previously indicated, the focus for the Hills of Headwaters OHT and associated Collaborative partner providers has been to integrate care, going so far as to try and forcibly remove the "transitions in care" nomenclature in the local lexicon. Rather, the focus is on care as a continuum and journey that spans location/setting and patient needs.

Given there is no single solution for improving transitions of care across clinical pathways and/or delivery sites, the Hills of Headwaters Collaborative OHT supports a number of evolving work groups and has adopted a number of initiatives. Together and as a package of work, they establish a key set of ingredients that can be built on over the foreseeable future. Key among them is an established trust among providers to not only challenge the way the health system has evolved but also to look at new forms of partnership and relationships that will ensure patients have an improved health experience.

With those as some of the tangible efforts that have been made to date to integrate care, the following examples highlight the current work groups that fall under the Hills of Headwaters OHT Collaborative. This initial set of work groups is expected to evolve over time as emerging health and system needs change:

Integrated Care Work Group:

In 2012, local providers capitalized on existing partnerships to be one of the first adopters of the Health Links approach to care. Provincially, the Dufferin region is now recognized as having the highest (58%) proportion of patients with complex care needs supported by this approach to care. The Caledon region is close behind at fifth overall, with 33% of target population supported.

Much of this work was guided by the development of an Integrated Care group that has recently transitioned to focus specifically on Dufferin and Caledon.

One of the key adopted initiatives is Central Intake: a registry of all patients with complex care needs. Central Intake is aligned with the OHT vision, as well a number of suggested health system enhancements put forward by the Devlin reports. Those criteria – developed by a broad range of system provider, patients and physicians – include:

- Would you be surprised if the patient's health declined significantly in the next six months?
- Has the patient had two or more Emergency Department visits in the last 90 days?
- Do the patient's social determinants of health put their health/wellbeing at risk?

- Would you be surprised if the patient requires support from numerous service providers?

With all providers adopting this common framework, the focus for Year 1 would be to actively identify all patients with complex care needs for the entire Hills of Headwaters patient population.

The Hills of Headwaters OHT partnership will actively pursue the opportunity to create a Data Sharing Agreement with the Institute for Clinical Evaluative Sciences to test and enhance this model.

Moving forward, the analytical and outcome measurement will be to measure health system usage for these identified patients in order to establish a baseline and evaluate its success in integrating care and providing the right patient goals based care, in the right place and at the right time.

Central Intake and System Access:
The establishment of a Central Intake, available to all providers and partners across the span of health and care systems, creates an opportunity to segment patient needs and priority populations. With an understanding that community needs change over time, Central Intake will create an ongoing capacity to look at emerging patterns and determine changing needs at a population level.

Through the Integrated Care Work Group, a number of lead organizations – namely Dufferin Area FHT, CMHA, SHIP and Home and Community Care – are well positioned to take on care coordination and system navigation.

Locally, navigation and coordination will be supported through and aligned to existing system access points, such as situation tables, palliative care and hospital care rounds. This will support ongoing care navigation and also provide an opportunity to plan care for those with emerging complex care needs in the community, and ti mitigate acute care as the entry point to access care.

Palliative Care Work Group
As stated previously, an integrated care pathway for palliative care is a foundational cornerstone for the OHT development. The maturity of local partnerships has led to the articulation of a shared and principled approach to planning for this integration.

As stated, those principles are:

- Patients, families and caregivers are considered a part of the team and their respective needs are factored at every stage.
- Any patient identified as having end-of-life care needs will be supported by a family physician.
- There is acknowledgment and commitment for a single team of truly integrated interprofessionals working to full scope and partnership, aligned to vision of OHTs.

Through these principles, the work group has developed a Hills of Headwaters care pathway, based on the HQO palliative care best practice as well as the OPCN palliative care framework.

The pathway led to the formulation of a shared end-of-life care team that would work with any family physician and/or Nurse Practitioner. This core team, to be developed as an immediate Year 1 task, will be comprised of a:

- Nurse
- Social Worker
- Patient Navigator/Care Coordinator

In addition to competencies articulated through the OPCN framework, this end-of-life care team will:

- Be available 24/7 and aligned to the physician call group
- Have access to all medical records, with a single medical record being considered a medium term objective
- Model elements of a base hospital program, such as standard order sets supplemented by physicians supports
- Be mobile and virtual across all settings and needs at end-of-life
- Provide support for patients and families to come and go from involvement with the team as care needs escalate and de-escalate
- Have real time access to one shared care plan as well as real time (secure) communications
- Prepare families/caregivers to effectively respond to and manage end-of-life care
- Have the competency to identify and predict the needs of patients and families and to act on those needs as appropriate
- Have autonomy of the practice/team
- Act as an educational resource for patients, families and providers across the community

Shared Bundles of Care will also be articulated for the core team and the entire community team. These bundles will include a basket of services that support:

- Stable care
- Unstable / transitioning care
- End-of-life care
- Bereavement care

This model and framing for integrating care across the continuum of palliative care will be used to support the integration of additional care pathways. In the previous Readiness Assessment, this model had been committed to as a second phase of Year 1. However, based on the momentum to date, the Mental Health and Addictions Work Group has already committed to its adoption and is in the process of applying it to developing a shared care team for supporting patients/clients with crisis supports.

Through Central Intake, continuous quality improvements and ongoing segmentation, the Hills of Headwaters partners will investigate additional pathways that will improve population health and patient experience. There is some early indication that those pathways could include frail seniors, patients with dementia, and transitional-aged youth as examples of populations that would benefit from a “transitionless” system of care.

Determining success in care coordination will be based on:

- Improvement in the rate of emergency department visits best managed elsewhere per 1,000 people

- Reduced rate of hospitalizations for conditions that could be treated in an ambulatory setting per 1,000
- Patient and Provider, specifically Family Physicians, measure of confidence in ability to meet their/their patients goals of care

3.4. How will you provide virtual care? (refer to Appendix B)

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need.

Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

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

The Hills of Headwaters Collaborative partners have demonstrated being early adopters in several initiatives that develop and enhance the self-management and health literacy of residents within our community. The Orangeville Family Medicine Centre, affiliated with the Dufferin Area FHT utilize the MyHealth online self-booking application that allows patients to book their appointments online and cancel/change appointments as needed.

Physicians and patients can send secured text messages before and after the appointment to empower patients to self-manage their care and become more health literate with each interaction and communication with their physician.

For patients admitted to the hospital, Headwaters Health Care Centre has implemented an Integrated Bedside Terminal with the digital platform myHealthHub that enables patients to actively participate in their healthcare experience and improve their health literacy during hospitalization. The platform provides a suite of applications that are focused on empowering patients with access to information and educational material.

The iMD Health library application provides a comprehensive digital, interactive and educational approach to self-management and health literacy. Patient can also email content to themselves to follow up and retain the information gained during their hospitalization. This also allows patients to have videoconferencing and virtual visits with other providers and can facilitate transitions between hospital and community.

Patients currently admitted to acute care are actively involved in their care plan as clinical bedside documentation can be shared real time and patient can have meaningful input to their goals of care. These features, along with other applications, will be implemented with our year 1 target population and scalable to all other patients within our community.

Several other tools available to patients to support self-management and health literacy includes MyChart, an application that provides patients access to their medical record; my pockethealth, an application that provides access to their diagnostic images, and numerous other sources such as websites, self-referrals, and online materials provided by each respective population

type demonstrates self-management and Health Literacy is a priority for the Hills of Headwaters Collaborative OHT.

With these tools and the strength among the partners within the Hills of Headwaters Collaborative OHT, the partners are ready and excited to move forward with these opportunities.

Perhaps the most exciting and enabling opportunity within the Hills of Headwaters Collaborative OHT will be the clinical transformation with Meditech Expanse. Meditech Expanse is an advanced Enterprise Health Record that provides a patient portal and self-management applications for a number of chronic conditions including diabetes and cancer.

The Hills of Headwaters Collaborative OHT will follow the model employed by Ontario Shores Centre for Mental Health Sciences where Meditech Expanse has already been deployed to improve the care of mental health patients by allowing patient's access to the their health record and support their active participation in care planning and self-management.

Meditech Expanse has the ability to bridge clinical care information exchange between acute care, home care and primary care into one EMR while also empowering patients by offering them and caregivers access to their health information.

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

3.5.1. How will you improve patient self-management and health literacy? (500 words)

Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed

plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team's existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Maximum word count: 500

Previous sections have articulated the focus on patient confidence as a measure of the individual's ability to meet the care goals that are important to them. Coupled with an ongoing commitment to proactively identify and coordinate care for all patient with complex care needs, this approach has led to a foundational focus on determining what is important to the patient and caregiver, and to creating a space for them as members of their respective care team.

To date, there are 2,446 Coordinated Care Plans across Dufferin and Caledon. This is a good start but, with shared purpose through the OHT vision, there is renewed focus on integrating care for all patients that have a complex care need. The Dufferin Country Equity Collaborative, chaired by the County of Dufferin and Wellington-Dufferin-Guelph Public Health, has been working with partners to address equity issues across the Hills of Headwaters, with an initial focus on poverty, employment and housing.

In early September, partners participated in the Bridges-out-of-Poverty education program. The Bridges model is built on the concept that everyone in a community has a role to play in poverty reduction. Important to this is reframing the nature of self-management and health and care literacy.

In addition to this core learning partners across the geography have a diverse offering of self-management programs that support patients, clients and caregivers across the spectrum of palliative, mental health and addictions and those managing complex care needs:

- Hospice Dufferin, as well as Bethell Hospice, specialize in supporting self-managed care in palliative care as well as bereavement. Offering walk in programs,
- Health promotion workshops coving topics ranging from maternal child health, diabetes, maintaining positive mental health, exercise and falls offered by Home and Community Care, Dufferin Area FHT, Public Health, CMHA Peel-Dufferin, SHIP
- Self-management programs in overdose awareness programs offered by Family Transition Place, CMHA Peel- Dufferin, Public Health and SHIP
- Youth Education Programs designed to teach kids what healthy relationships are all about and to help eliminate violence in our communities offered by Family Transition Place

- Caregiver Learning Series for caregivers and professionals supporting someone with diagnosed or suspected Fetal Alcohol Spectrum Disorder by Dufferin Children and Family Services
- GLOW is a weekly social youth group that works to build self-esteem, a sense of connection to community, and pride about diverse sexual and gender identities supported by Dufferin Children and Family Services

The Mental Health and Addictions Work Group has also considered the issue of health literacy and how to develop various communication and information channels that meet patients and caregivers varying needs. As a small test, they have been developing key messages on how to access services and what services are available via the various screens across many public venues, including community service venues, hospitals and many physician offices. The key messages focus on breaking down barriers in information and communication. Included in these key messaged are easily accessible health coaching moments as developed by Dr. Mike Evans and the Health Design Lab, such as https://www.reframehealthlab.com/9010-stress/.

Aligned to Health Equity, supporting self-managed care and health literacy will be a long-term and multi-year priority woven into the fabric of all priorities.

The Integrated Care Work Group will be producing principles and implementation plans to maximize scopes of practice across all the roles and functions of existing resources in order to find efficiencies in both assessment and care delivery. Opportunities to better use resources such as the Home and Community Care Rapid Response Nurses, frontline nursing providers and the Community Paramedicine programs will be undertaken as means of improved self-management programming. Two new Home and Community Care nursing clinics will be opened by the end of this calendar year within the Hills of Headwaters region. These nursing clinics will serve as a catalyst for new models of care and congregate care delivery, including virtual care, remote monitoring and additional education functions, all of which will be co-designed and closely aligned with primary care resources.

As a Hills of Headwaters Patient Advisory / Community Wellness Council is established they will be a critical resource for determining areas of need for self-management as well as informing the creation networks of patient-to-patient peer support.

3.5.2. How will you support caregivers? (500 words)

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

Maximum word count: 500

The Hills of Headwaters Collaborative OHT is committed to including caregivers as full and recognized partners in care delivery and in co-designing integrated care. In addition to their roles as caregivers for patients, their own care needs will be considered in care planning. As a starting point – and with the focus on palliative care, mental health and addictions and patients with complex care needs – the partners are committed to measuring and reporting on caregiver distress.

According to the Bringing Care Home report released in March 2015, in 2012 approximately nine out of 10 Canadians who received care in the home relied on family caregivers, and 29% of these individuals had been receiving care from their primary caregiver for 10 or more years. On average, care receivers had about seven hours of help from family or friends and about two hours of professional care.

Language is emerging from the Change Foundation and other policy think tanks, to move from caregivers to "carepartners". In this emerging body of work, in Year 1 the Hills of Headwaters Collaborative OHT will consider opportunities to develop policies that align to caregiver identification program and family presence policy. Once a common branding has been created, this policy would transfer across multiple partners within our network. Using the palliative priority as an example, it is easy to see that a common identification for caregivers applied across all settings – such as hospital, hospice and community – would be of value to caregivers, patients, physicians and providers.

Patients and caregivers are already part of priority-setting and co-designing care in the identified priority areas. The Hills of Headwaters will also work proactively with them to determine caregiver-specific priorities and needs.

The existing screeners of Caregiver Burden scales will be better integrated into the shared Coordinated Care Planning activities to ensure that all integrated team members consider the needs and preferences of caregivers within care delivery.

Home and Community Care as well as Bethell Hospice and Dufferin Community Hospice conduct surveys and interviews with caregivers. These results:

- Responses to open-ended questions were reviewed by a team of staff members.
- Information is extracted related to patient & caregiver emotions, touchpoints in care, stage in palliative care journey, key themes and relevant experience notes

With this as a foundation in palliative care and while supporting the development of more robust measurement processes, the Hills of Headwaters Collaborative OHT will build upon this work and spread to other priority populations.

3.5.3. How will you provide patients with digital access to their own health information? (refer to Appendix B)

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

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

3.6. How will you identify and follow your patients throughout their care journey? (500 words)

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

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

Maximum word count: 500

For the past year, an Integrated Care Work Group has been working on a tool that will support the identification of all patients with complex care needs. The end result was a co-designed tool that focuses on four dimensions of potential complexity:

- Does the patient's social determinants of health put their health at risk? (Consider social/family supports, housing, poverty/income levels, etc.)
- Do you think the patient's health will decline significantly in the next six months?
- Has the patient had two or more ED visits in the last 90 days, or frequent primary care visits?
- Do you think the patient requires support from numerous service providers?

All providers will actively incorporate this tool into their own intake and identification processes. Based on the criteria above, they will gain consent from the patient and register the patient with the Central Intake. Central Intake will then pass that information along to System Resource Navigation staff to support the determination of a lead coordination agency most aligned to the patient goals of care. That lead organization will then develop a coordinated care plan, in partnership and with the support of the patient, other community providers and primary care and will follow the patient to ensure their needs are met and their experience is seamless.

In addition, and given the priority in Year 1 of palliative care, the LHIN supported the procurement of an Early ID tool for the TELUS Practice Solution EMR that was developed by the eHealth Centre for Excellence. The TELUS Practice Solution EMR is used by all physicians affiliated with Dufferin Area FHT as well as the Bolton Medical FHO. This technology is being implemented at the time of submission and identified patients will also be shared with the Central Intake.

Based on a deployment of existing intake resources in Home and Community Care, Central Intake will be responsible for tracking and following up with all patients in Year 1 regardless of the patient's palliative or complex care needs. We will actively pursue a data-sharing agreement with the Institute for Clinical Evaluative Sciences to assist in outcome measurement and quality improvement.

3.7. How will you address diverse population health needs?

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

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

3.7.1. How will you work with indigenous populations? (500 words)

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

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

Maximum word count: 500

Dufferin and Caledon form the highest plateau immediately south of Georgian Bay. Given that proximity, it forms the watershed between four of the Great Lakes – Huron, Erie, Ontario and Simcoe – and four river systems – Saugeen, Grand, Credit and Nottawasaga. Given this geography, this area exists as a crossroads and natural meeting place for many. This area is the traditional territories of the Chippewa, Ojibway, Mississauga, Huron-Wendat, Haudenosaunee, Anishnabek and Métis people. Historically, these Indigenous Nations include the Neutral Adirondon Confederacy, today include the Mississauga/Ojibwa Anishinaabeg and Six Nations/Haudenosaunee.

According to the 2016 Census, of those that participated and identified as Aboriginal, the total population across Dufferin and Caledon was 1,170 or 1.9% of the overall population. However, according to the members and Elders of the Dufferin County Cultural Resource Circle, that number is vastly under-reported.

The pathway to reconciliation with our Indigenous community and Elders is a steadfast commitment that the Hills of Headwaters Collaborative OHT leadership is individually and collectively committed to. Already many partners have governors that are reflective of our Indigenous community but more needs to be done.

Partners have participated in Indigenous Cultural Safety Training over the course of the past four years, laying a foundation of resect and understanding for the work that lies ahead in addressing reconciliation in a meaningful way. The Collaborative will be guided in this journey by members of the Indigenous community and seek to learn through partnership and listening. Already, Indigenous community member are joining the patient advisory group and

engaging with the local situation table to support community members facing issues of acutely elevated risk.

The principles of Active Offer and ability for Indigenous members to self-identify in accessing care will be reinforced in Year 1 to ensure that Indigenous members of our communities have equitable access to services, including navigation and care coordination. Going beyond this initial first step will be an important objective, with additional opportunities of support and partnership explored within Year 1. One early idea includes supports for traditional healing circles that will be guided, developed and run by our Indigenous partners.

3.7.2. How will you work with Francophone populations? (500 words)

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

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

Maximum word count: 500

The Hills of Headwaters is not located in the designated area for French Language Services (FLS), however our partners include three identified health service providers (HSP): Home and Community Care, CMHA Peel Dufferin and SHIP. There are no designated HSPs in the Hills of Headwaters.

Partners have committed to promoting the principles of Active Offer, and endorse the obligations and responsibilities found in the French Language Services Act. Providers are aligned to the Guide to Requirements and Obligations Relating to French Language Health Services and either have or will develop consistent mechanisms to address the needs of our local Francophone community, including by improving access to linguistically and culturally appropriate services. Many of our partners are members of the French Language Services Core Action Group, where they provide input in planning FLS and/or promote Active Offer of FLS. For example, CMHA Peel Dufferin plans collaborative educational opportunities to address mental health and addictions needs within the Francophone community. CMHA Peel Dufferin has developed an annual Active Offer work plan, and has a FLS internal committee to monitor its work plan implementation and to address needs through best practice recommendations. Many organizations also conduct Health Equity Impact Assessments (HEIA) to identify the needs of Francophones.

In 2018-19, 100% of partners funded by the LHIN had completed the Human Resource Capacity Plan section of their required FLS report, and reported 27 French-speaking staff at intermediate and advanced level. A total of 91 Francophone residents were identified as French-speaking and received services across health service providers. Fourteen per cent of our partners have a process in place to identify language of preference for service delivery (Reflet Salvéo, OZi Report, 2019).

Our partners will undergo Leadership Training on Active Offer, organized by Les Centres d'Accueil Héritage, in November 2019 to ensure that all partners are aware of the principles of Active Offer. The principles of Active Offer and identification of Francophones will be implemented in Year 1 and throughout the development to ensure that Francophones have equitable access to services.

The Hills of Headwaters Collaborative OHT will be proactive in complying with all requirements outlined in the French Language Services Act, and will make use of the French Language Services Supplement of the HEIA as a vital input into program development. The Hills of Headwaters OHT will continue to collaborate the Francophone community to ensure

care pathways are aligned with best or leading practices in planning and delivering care for Francophones.

3.7.3. Are there any other population groups you intent to work with or support? (500 words)

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

Maximum word count: 500

Chaired and supported by the County of Dufferin and Wellington-Dufferin-Guelph Public Health, the Dufferin County Equity Collaborative represents a strategic partnership of a broad base of stakeholders who have a shared mandate to increase social prosperity and decrease inequities for the Dufferin population affected by economic hardship. The membership has established strategic directions and evidence-informed priorities that can be actioned locally, and capitalize and enhance existing systems and programming.

Aligned and in partnership with the Tamarack Institute for Community Change, the framework for supporting this works falls into three domains of work:

Advocating and informing across all partners to:

- Champion and give voice to the need for system and policy changes that reduce inequities
- Inform stakeholders and decision-makers about local needs and priorities to influence policy and service design, delivery and evaluation to the

Minimizing service barriers

- Provide service from a system lens
- Understand service access through a client (patient, etc.) perspective
- Responding (to needs and designing system accordingly) from client perspective

Innovating Solutions:

- Evidence-informed planning and decisions
- Action orientated
- Recognize and act on opportunities to make immediate change to improve service access

With the support and involvement of the Hills of Headwaters Collaborative OHT partnership. This framework is focused on increasing the quality of life in the areas of housing and homelessness, employment and health equity.

3.8. How will you partner, engage, consult or otherwise involve patients, families, and caregivers in care redesign? (1000 words)

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.

Maximum word count: 1000

All partners are committed to a foundation of patient partnership and co-design, this has been a constant from the outset. Prior to the Readiness Assessment two patient leaders' were approached and joined to support the application team. From the time of that submission through to the completion of this Full Application patients have been equal partners at the Collaborative table. They have, and will continue to have, an equal role in decision making and co-designing the development of the Hills of Headwaters Collaborative OHT and associated working groups. There guidance and perspective have shaped Forums, such as the pivotal event held on June 25th, as well as designing the approach to a patient family investment strategy with a fall forum planned for the end of October.

So while a formal Patient Advisory body is still being formalized, a work group is being led by patients, with the partners supporting a co-design. This group continues to build and grow, with a specific focus on unifying patients, clients, broader citizenry, cultural groups and caregivers/partners into a single network. This is an early indicator of local capacity to meet the vision of OHTs as well as the alignment of the local approach to the Patient Declaration of Values for Ontario.

This work group continues to meet with an early focus of ensuring they have connections and relationships with all of the formal and informal patient/client/family/survivor groups from across Dufferin and Caledon. The Hills of Headwaters Collaborative OHT is committed to ensuring patients are supported and involved in co-design throughout this journey. These are key groups and are referred to as part of a larger Investors Strategy. The Investors Strategy focusses on creating a diverse network of perspective that are all connected to this work and invested in the change.

All of the priority work groups, including palliative, mental health and addictions, integrated care and health equity, have patients supporting redesign efforts and planning. As additional work groups such as digital health are formed patients will be core members to ensure planning and implementation is co-designed. Patients are part of the Hills of Headwaters Collaborative and have been involved in the determining our shared purpose, priorities and principles. Their insights and perspectives have shaped, and will continue to guide and influence how care is delivered and integrated as the OHT matures locally.

In addition to the development of a formal patient and caregiver advisory mechanism, the Hills of Headwaters Collaborative OHT is also working with associated communications leads to develop a shared communications plan. This plan will include traditional print media as well as innovative opportunities to reach citizens more broadly through social media, patient blogs and newsletters. This work has already started to take place, with local media developing a multi-part feature on the development of the OHTs and what this will mean for patients, caregivers and the local communities that are part of the Hills of Headwaters Collaborative.

As Year 1 nears completion the patient advisory body will be engaged in an evaluation of their involvement in co-designing transformative change. While evaluation will be a key component throughout the development this evaluation process will be conducted on an annual bases to ensure the Hills of Headwaters Collaborative OHT is meeting the needs of patients, families and caregivers in their involvement in redesign. Where opportunities are identified they will be incorporated into subsequent evaluations to ensure accountability is maintained.

4. How will your team work together?

4.1. Does your team share common goals, values and practices? (500 words)

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates.

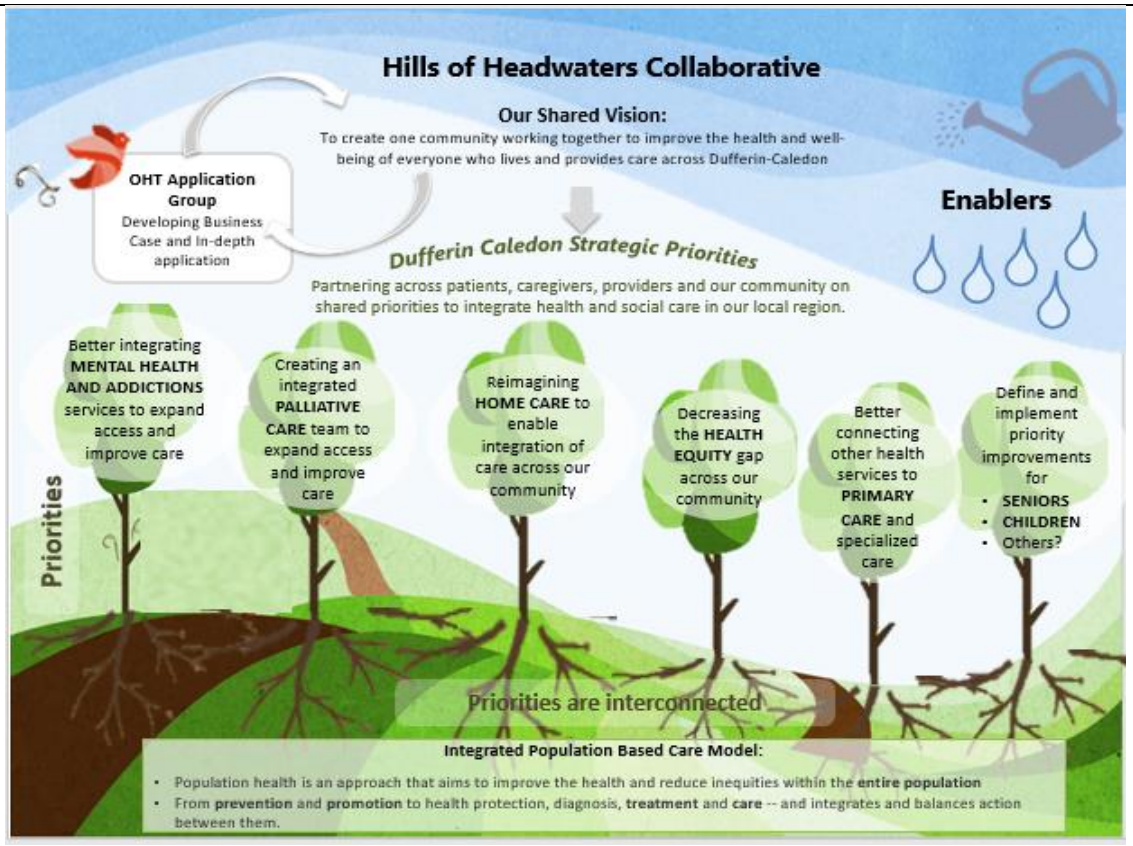
Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

Maximum word count: 500

Starting with the Readiness Assessment and ahead of approval to move forward with the Full Application, the Hills of Headwaters Collaborative OHT have developed common goals, values and priorities.

The symposium on June 25th brought together more than 85 partners, collaborators, patients, physicians, governs and health system leadership. Together, they created a shared purpose. Establish a shared purpose was a critical first step in establishing a commitment to the OHT vision framed by what is important to a collective a distributed partnership. In addition to shared purpose; patients, physicians, governors and health system leadership established a foundation of trust and relationship as well as a road map for next steps.

A schematic of the symposium outcomes is depicted as follows:



Aligned with the Quadruple Aim, the approved shared purpose of the Hills of Headwaters Collaborative OHT is to create one community working together to improve the health and well-being of everyone who lives and provides care in Dufferin Caledon. Given the strong history of partnership among the Collaborative partners, this shared purpose is reflective of the degree to which the Collaborative partners are aligned to the same vision even ahead of OHT approval.

This shared purpose will be achieved through an already-approved and committed-to set of strategic priorities that require partnering across patients, caregivers, providers and our community. The strategic priorities are aligned to an Integrated Population Based Care Model that aims to improve the health and reduce inequities within the entire population. This model also incorporates a continuum – from prevention and promotion, to health protection, diagnosis, treatment and care – and integrates and balances action between them.

To ensure the achievement of the purpose and meeting of the objectives, the Hills of Headwaters Collaborative OHT has also adopted shared principles. These are a core set that also establish and guide decision-making and ongoing governance development. These principles include:

- Working side-by-side as patients, caregivers, providers, physicians, and community members in co-designing the future of local health care in Dufferin Caledon, focused on what matters most to our local citizens

- Sharing leadership across social care, providers, and patients and caregivers to achieve our shared vision: to create one community working together to improve the health and well-being of everyone who lives and works in Dufferin Caledon
- Valuing the contributions of each of us by listening and seeking to understand our different viewpoints, and being respectful when we disagree
- Being open, honest and transparent in our work together, recognizing that it takes time to build trust and create safe spaces to work through the challenges that lie ahead
- Being responsible to each other, to share our resources willingly, and to be transparent with our community
- Recognizing the strength that exists in all of us and use our diverse voices and opinions to push the boundaries of what we can do
- Supporting each other to take risks, looking for creative solutions while being courageous, knowing that some of the solutions to improving health care will require disruption and changes in how people work. When we recommend or make changes, we will be sensitive to and support those who are impacted.

These foundational elements have been shared and validated broadly by, not only by the participants that were part of the symposium but also with governors, patients, frontline staff and providers across the Hills of Headwaters. While it a key requirement for OHTs in Year 1, in support of this foundational relationship all partners are members in the Hills of Headwaters Collaborative OHT, inclusive of patients, caregivers, physicians, providers, governors and leaders who have provided a formal endorsement. The Endorsement reads of follows:

Hills of Headwaters Collaborative

In what is expected to be evolutionary change occurring over multiple years the Hills of Headwaters Collaborative is seeking support for a ***shared purpose and vision*** as well an initial set of ***shared priorities***.

This will fulfill Ministry of Health requirement for Ontario Health Team Full Application to include signatures of support from community providers, associated Boards as well as Family and Specialists Physicians. This builds on endorsements included in the Hills of Headwaters Collaborative Readiness Assessment previously submitted in May 2019.

The following intentions were co-designed and validated with patients, physicians, providers and governors submitted as follows:

Shared Purpose and Vision:

> *"To create one community working together to improve the health and well-being of everyone who lives and provides care across Dufferin-Caledon."*

Priorities:

Partnering across patients, caregivers, providers and our community on shared priorities to integrate health and social care in our local region, with an initial focus on:

- Better integrating **MENTAL HEALTH AND ADDICTIONS** services to expand access and improve care
- Creating an integrated **PALLIATIVE CARE** team to expand access and improve care
- Enable **INTEGRATION OF CARE** across our community while reimagine Home Care delivery
- Decreasing the **HEALTH EQUITY** gap across our community
- Better connecting other health services to **PRIMARY CARE** and specialized care

Endorsement:

Name:	
Organization/Clinic:	
E-mail address (for follow-up)	
Signature:	

(See reverse for a graphical representation as well as associated principles)

4.2. What are the proposed governance and leadership structures for your team? (1500 words)

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

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

- ***How will your team be governed or make shared decisions?*** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?
- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.
- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***

Maximum word count: 1500

Governance:

On September 10, 2019 an inclusive group of governors representing the Collaborative partners met to discuss the development of a governance model that would support the Hills of Headwaters Collaborative and OHT. The consensus was to develop Governors and Leaders Collaborative agreements that will establish roles, responsibilities, decision-making and inclusion of a dispute resolution as well as an exit process, all aligned to supporting the OHT vision. A smaller group of representative governors will be developing a statement of commitment that will be signed by all partner governors.

Patient, Francophone and Indigenous participation in the governance will be a key priority for inclusion in Year 1 development. Governors have committed to establishing informal networks over the course of the year, as many had not met prior to September 10. Planning is underway to support a series of governance and leadership forums to support ongoing maturity of relations and to support ongoing planning.

Management and Oversight:

The Hills of Headwaters partners have developed a joint decision-making body referred to as the Collaborative. The Hills of Headwaters Collaborative OHT is comprised of a body of executive leadership reflective of all partners, including patients, acute, primary care, palliative and hospice care, interprofessional care team, community support, home and community care, mental health and addictions, long-term care, community and social services, children's services, and public health.

This group was in place prior to the Readiness Assessment submission and has guided the work to date. Decision-making has been based on, and will continue to be based on for the foreseeable future, a consensus model that notes where there is dissension. Partners have been key to supporting and participating in various development activities from organizing meetings and participating in Investors Strategies, to contributing to various sections of the Full Application.

The Hills of Headwaters Collaborative OHT– comprised of patients, physicians and senior executive leadership from across the broad range of partners – will have leadership and management support. This group met initially on September 10 and will continue to meet in support of the Collaborative, identifying issues, mitigation strategies, and funding and integration opportunities. In addition, this group is embedded and leading implementation of priority work group objectives.

Operational Leadership:

Given the need to be operationally responsive and nimble, a smaller group has lead the development of strategic planning and project management. This group is co-chaired by leadership from Headwaters Health Care Centre and the Dufferin Area FHT. One full-time in-kind support from the LHIN's Planning and Integration staff has supported operational functionality with Home and Community Care participating in the Collaborative and operational leadership.

The Hills of Headwaters Collaborative OHT is committed to supporting the ongoing integration of the health and care system, and gain shares that will be re-invested in supporting direct patient care. Further sections detail the non-financial resources needed to support the ongoing development of the OHT locally as partners do not have the dedicated resources to support OHT maturity. Section 6 will be dedicated to articulating the leadership and back-office supports needed to support the Hills of Headwaters Collaborative. To date, this work has been successful due to the commitment and dedication of leadership and ability for them to go above-and-beyond. Moving forward, the Hills of Headwaters will need the support of human resources that can support the Collaborative.

Throughout the course of responding to the OHT vision for the Hills of Headwaters, governors, patients, physicians, communicators and leadership have had the support and guidance of the Change Foundation. As operational leadership and governance models are further developed, the Change Foundation's insights into global experiences in health system integration will be sought out to ensure the Hills of Headwaters Collaborative OHT is advancing as a provincial model of excellence.

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

At maturity, Ontario Health Team will have the ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team? (1500 words)

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

Maximum word count: 1500

As health information custodians (HICs), many of the Hills of Headwaters Collaborative OHT partner organizations have appropriate legal authorities under PHIPA to collect, use and disclose patient personal health information (PHI) for care and treatment. Local privacy and access requirements, such as agent agreements, client/patient access request and correction procedures and information safeguards such as auditing and monitoring practices are employed by HIC partners to protect patient privacy and ensure compliance. HIC partners also have appropriate authorities under PHIPA to use PHI for administrative and secondary purposes, including decision support, analytics and research.

Over the course of the past two years, Home and Community Care has developed a large number of data sharing agreements (DSAs) amongst health care providers across the Hills of Headwaters. These DSAs offer baseline standards for information, safeguards, and roles and responsibilities for privacy and access, and can be used as a model or modified to support care delivery within the Hills of Headwaters Collaborative. Over time, the partners envision the development of a single master DSA that will enable PHI sharing.

The Hills of Headwaters Collaborative OHT will collectively support the use of the CHRIS system hosted by HSSO and used by the LHIN to store patient records. In particular and to support the sharing of information across providers, for patients associated with Year 1 focus of palliative patients, mental health and addictions patients, and patients with complex care needs the Coordinated Care Plan will be used as the distribution mechanism. With DSAs in place already, multiple community partners access CHRIS through health partner gateway (HPG) as part of their clinical processes.

Partners have also committed to support a shared Central Intake. Intake staff associated with Central Intake will take any/all referrals for patients identified as having a complex care need that would benefit from a Coordinated Care Plan. A system navigator dedicated to the Hills of

Headwaters will identify a lead organization to complete a Coordinated Care Plan that will be available 24/7 to all partners involved in that patients care.

Headwaters Health Care Centre is one of four area hospitals working together to transform care through a shared Health Information System (HIS). Expected to be implemented in 2020 MEDITECH Expanse is a powerful, web-based tool that brings all of a patient's medical information into one unified health record and gives clinicians the a full picture of the patient's health and medical history anywhere and at any time. This new platform, that includes patient portals, will allow clinicians to more easily identify risks and make timelier, better informed decisions leading to improved outcomes.

At the same time partners are investigating the opportunity to deploy a Robotic Process Automation (RPA) workforce, trained by eHealth Centre for Excellence. This technology enables secure digital sharing of coordinated care plan elements between two different point-of-care systems such as CHRIS and Meditech Expanse or TELUS Practice Solution. Enabling care team members to initiate patient supports within their normal work routine. In the case of the Hills of Headwaters Collaborative OHT, during off hours an automated process would identify palliative, mental health and/or patients with complex care needs inserted in their charts and have had an update to their care planning needs, extract key data elements, and updates those elements into the same patient's record in another care provider system to allow for a shared understanding and adjusted action plans.

4.3.2. How will you digitally enable information sharing across your team? (refer to Appendix B)

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

5. How will your team learn & improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any? (500 words)

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

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

Maximum word count: 500

The historical structure, nature and pattern of funding allocations across the Hills of Headwaters has been well documented. While this has led to various funding pressures across all providers, none of these have or will be detrimental to the maturity of the partnership. In the absence of performance or compliance issues, there will be no need for accountability structures between members related to these issues.

It is expected that by aligning to the OHT vision and through integration of roles this sharing of resources will create efficiencies that can inform more effective deployment of finite resources, for example the ability to modernize care coordination and embed the role across numerous providers.

The Hills of Headwaters Collaborative OHT is also committed to working with the Ontario Health Agency and Ministry of Health to capitalize on any and all opportunities to address structural and funding equity issues that have impacted on service delivery and patient access to care.

Performance management and oversight will be built into the collaborative agreement. The objective will be to raise the level of performance and patient outcomes across the Hills of Headwaters Collaborative OHT.

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

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

5.2.1. What previous experiences does your team have with quality and performance improvement and continuous learning? (1000 words)

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

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

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

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

Maximum word count: 1000

Quality Framework

Headwaters Health Care Centre and Home and Community Care spent the past five years consulting with each other in the creation of their Quality Improvement Plans and through Pay for Results programming. These consultations have led to partnerships and successfully-funded joint improvement initiatives, which led to improved practices to avoid both emergency department and inpatient admissions.

Additionally, partners across the Hills of Headwaters Collaborative OHT have a strong and sustained history of quality improvement initiatives and performance improvement. Some examples of these include:

- Implementing programs and protocols aligned with best practice guidelines, and strategies to improve integrated care management.
- Managing cross-sectoral/multi-organizational improvement initiatives as a result of integrated care programs and shared programs.
- Creating Quality Improvement Task Forces and other committees to manage quality improvement internally.
- Developing quality improvement plans with key performance indicators and other measures that are audited throughout the year to ensure targets are being met.
- Undergoing Ministry inspections (for home care and long-term care partners)

- Accreditation

The Hills of Headwaters Collaborative OHT will identify and produce a shared Year 1 Quality Improvement Plan. This plan will be co-created in consultation with patients, caregivers, physicians, providers and the broader public. Our previously-stated commitment to adopt the Patient and Provider Confidence measures affords us a foundation for a shared plan that will provide opportunities for education, and a commitment for a shared culture of continuous quality improvement. The Hills of Headwaters Collaborative OHT will work with Health Quality Ontario/Ontario Heath to develop capacity for a shared Quality Improvement Plan for the OHT.

The shared purpose for the Hills of Headwaters Collaborative OHT is to create one community working together to improve the health and well-being of everyone who lives and works in Dufferin Caledon. With that in mind, the development of a Quality Improvement Plan will, by necessity, take the approach of a quadruple aim:

- Improving the patient experience of care, including quality and satisfaction
- Improving the health of populations
- Reducing the per capita cost of health care
- Improving the care and experience of the provider. For Hills of Headwaters, this will include the caregiver

Performance Improvement

Previous sections indicated a commitment to measuring and monitoring system performance. Measurement and continuous performance monitoring is important as system transformation takes place., The Collaborative looks forward to the ongoing review of outcome- and performance-related data, particularly as relationships grow and fully mature partnerships are developed, in part through shared knowledge and accountability. With that as context and in consideration of measuring improvement, the Hills of Headwaters Collaborative OHT envisions the development of an iterative balanced scorecard, aligned to shared purpose and priorities as well as OHT measures in development provincially.

As previously discussed, the Collaborative will proactively develop data-sharing agreements with Public Health and the Institute for Clinical Evaluative Sciences to ensure decision making is related to Hills of Headwaters system outcomes and performance.

The following would be considered a base set of measures:

- Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures are under development
    - The Hills of Headwaters will use the existing Patient Confidence score collected through Central Intake as a measure of patients' overall confidence in their ability to meet their goals of care in the OHT. In Year 1, this will also be applied to providers to measure their confidence to meet their patient's goals of care.

- Confidence Scores will determine a baseline measure and lead to various shared Quality Improvement initiatives within and across the Hills of Headwaters partners.

- For the Integrating Palliative Care priority, this set of measures tie to the OPCN framework, which is being implement in Year 1:
  - % of decedents that die in hospital
  - % of decedents that had and ED visit in the last 30 days of life
  - % of decedents who received a home visit from a physician and/or palliative home care in the last 90 days of life
- For the Integrating Mental Health and Addictions and Integrating Care for Patients with Complex Care Need priorities :
    - Seven-day physician follow up post-discharge
    - Frequent ED visits (four+ per year) for mental health and addictions
    - Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
    - Wait time for first home care service from community
    - Caregiver distress

These measures align to the shared priorities with the understanding that associated work groups and providers will have additional outcome and performance measures. The selected measures will be shared as part of the ongoing meeting of the Hills of Headwaters Collaborative.

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement? (refer to Appendix B)

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

5.3. How does your team use patient input to change practice? (500 words)

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

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

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

Maximum word count: 500

Hills of Headwaters Collaborative OHT partners have a rich history of community engagement and partnership. This ranges from patient engagement frameworks to committees and/or councils that incorporate the patient voice. At Headwaters Health Care Centre, the Patient Family Advisory has a breadth of involvement that ranges from improving the design and flow of the ED and ambulatory care to involvement in human resources recruitment committees to supporting strategic planning. In all, they are partners in bringing the voice of the patient and community to improve planning.

The Dufferin Area Family Health Team also incorporates patients in the design and planning of programs and services. In recent years, the patient and community voice has taken on a more formal role by way of the FHT governance. In 2017, the Board advanced skills-based and community/patient representation and, in 2018, put in place a patient who serves as president of the FHT Board.

Spanning the delivery of social services, housing and long-term care, the County of Dufferin is committed to clients. A key example is the Community Advisory Board, comprised of a range of community members representing the broader public, not-for-profit and private sectors. Together, these community members, developed plans for ending homelessness in Dufferin County. Giving voice to those most in need is a key objective of the Community Advisory Board.

Throughout the summer of 2019, and particularly after the symposium on June 25, all these groups have been meeting and organizing discussions of their own. Patients are key component and are committed to co-designing integrated care across Dufferin and Caledon. With the support of the Hills of Headwaters Collaborative OHT leadership, there is support for a shared “Patient Family Advisory Committee”, while patients themselves have indicated their discomfort with “PFAC”, there has been an early consideration for this to be called a Hills of Headwaters Community Wellness Council. Regardless of title, the foundation for this OHT is based on a patient co-design in alignment and support of the Ontario Patient Declaration of Values.

Home and Community Care is redesigning a Complaints Management process from initial reporting to the resolution. This redesign will incorporate patient and caregiver advisor feedback to identify key touchpoints in the lifecycle of a complaint, establish a timeline and standard for complaint resolution as well as inform communication protocol for each touchpoint with the complainant. All received concerns represent opportunities to change practice, with patient input guiding many of those changes.

5.4. How does your team use community input to change practice? (500 words)

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

Maximum word count: 500

The system partners supporting the Hills of Headwaters OHT proposal all have a rich history of community engagement and partnership. This ranges from patient engagement frameworks to committees and/or councils that incorporate patient voice into planning and committees and/or councils. At Headwaters the Patient Family Advisors have a broad breadth of involvement from improving the design and flow of the ED and ambulatory care, human resources recruitment committees to supporting strategic planning. In all they are partners in bringing the voice of the patient and community to enrich planning.

The Dufferin Area FHT also incorporates patients with lived experience in the design and planning of programs and services. In recent years the patient and community voice has taken on a more formal role by way of the FHT governance. In 2017 the Board advanced a skills based and community/patient representation, currently a patient serves as President of the FHT Board.

Spanning the delivery of Social Services, Housing as well as Long-Term Care, the County of Dufferin is committed to clients. A key example is the Community Advisory Board comprised of a range of community members as partners representing the broader public, not-for-profit and private sectors. Together these community members, in their advisory role, developed plans for ending homelessness in Dufferin County. Giving voice to those most in need in a key objective of the Community Advisory Board.

Moving forward, and in partnership with the supporting partners of the Hills of Headwaters Ontario Health Team they will create a shared Patient Family Advisory committee to ensure the foundation is based on a patient co-design. This will ensure that all planning is aligned to the Ontario Patient Declaration of Values.

Up to this point specific partners have made delegations and had discussions with township and municipal officials about OHTs. Moving forward this will be done in partnership as the Hills of Headwaters Collaborative to ensure that community leadership is aware of activities and work that partners either individually or collectively are undertaking to support their citizens.

5.5. What is your team's capacity to manage cross-provider funding and understand health care spending? (500 words)

Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever pooled financial resources to advance integrated care (e.g., jointly resourcing FTEs to support care coordination)? Does your team have any experience tracking patient costs or health care spending across different sectors?

There is a breadth of capacity and experience among partners in managing cross-provider funding for integrated care. Recently, partner organizations have facilitated bundled care, improved client/patient flow from acute care to home care, integrated health and social service care pathways, and jointly funded programs. Many of our partner organizations have worked together and shared funding for various programs and services. For example:

- The Dufferin Area Family Health Team managed funding for a partnership program with the Canadian Mental Health Association (CMHA) for the delivery of behavioural therapy programs.
- Headwaters Health Care Centre (HHCC) has a wealth of experience managing cross-provider funding, including managing bundled care, hospital-to-home programming, electronic medical record support, etc.
- Caledon Community Services supports a specialist clinic and a telemedicine clinic.
- Dufferin Children and Family Services and Family Transition Place have developed shared budgets for the development of satellite clinics
- CMHA Peel-Dufferin, Services and Housing in the Province, Family Transition Place and the County of Dufferin have managed cross-provider funding for the delivery of transitional bed care
- Musculoskeletal Hip and Knee and bundled care for stroke rehabilitation
- The Integrated Care Team for Transitional Care with HHCC and LHIN Home and Community Care included joint leadership roles.
- Short-term transitional care models involved a partnership between service provider organizations, community support services, HHCC and Home and Community Care.
- Health Links involves joint leadership between HHCC, the previous CCAC and primary care, with patient flows and admission rates being jointly monitored.

A few of the Hills of Headwaters Collaborative OHT partners have experience tracking patient/client costs across different sectors. Those partners, namely CMHA Peel Dufferin, SHIP, the County of Dufferin and Dufferin Children and Family Services, are provincially structured organizations with branches in different regions. These partners are required to track spending service delivery, and the costs and outcomes for clients/patients receiving service/care in various locations or throughout different points of the care continuum, with funding coming from a variety of different sources.

Moving forward, through the Central Intake, all partners will become versed in system accountability, as outcomes and system monitoring, balanced against patient confidence, is regularly monitored for further system improvement.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan? (1500 words)

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

Maximum word count: 1500

Implementation of the OHT vision within the Hills of Headwaters Collaborative OHT is well underway, without a formal approval as an OHT. Based on the desire of patients, physicians and providers to make meaningful change occur now, both implementation and change management are currently underway. For those reasons, this 30 day, 60 day, 90 day and six month plan is based on a start date of December 31, 2019. By that time and based on the current momentum generated by the OHT vision, the Hills of Headwaters Collaborative OHT will be well positioned to meet these objectives.

Throughout Year 1 and beyond, a common enabler and strength of the Hills of Headwaters OHT maturity will be the focus on point-of-care integration and an ongoing investors' strategy, discussed further in section 6.2 as part of the Change Management plan.

The following is a high level work implementation plan that balances strategic and operational imperatives for early and continuous success and momentum:

First 30 days:

- Common branding in place, either provincially mandated or locally identified (Subject to ministry approval).
- Collaborative Agreement framework developed for the Hills of Headwaters OHT.
- Implementation of an innovative communications strategy, developed in partnership with patients, caregivers, physicians and partners and supported by a shared group of communication staff.
- In consultation with priority work groups, take stock of all currently stated objectives and milestones, and map all projects for Collaborative oversight and support.
- Draft Hills of Headwaters Physicians Association term of reference and charter, and present them to physicians.
- Draft Hills of Headwaters Patient and Carepartner Relationship Charter and present it to members for approval.
- Host a virtual network for frontline staff and care providers with the participation of patients and physicians.

Within 60 days:

- The palliative priority work group has completed a recruitment plan for a core end-of-life Care Team with an identified single-fund and accountability holder, with a memorandum of agreement with the Hills of Headwaters Collaborative.
- Host a second Governors and Leaders Forum hosted – this time in Caledon – with a focus on determining shared principles and priorities for the next 18months, aligned with the OHT vision for governance.
- Chairs of the priority work groups present to the Hills of Headwaters Collaborative OHT on work planning and plans to advance integration of care in next fiscal year.
- With support of the communicators, the Hills of Headwaters Community Wellness Council have approved a visitor's policy as well as "Carepartner" name badge for deployment across the Hills of Headwaters.
- The Collaborative has reviewed and approved an initial balanced scorecard, in partnership and as appropriate with the Ontario Health Agency, Ministry and Institute for Clinical Evaluative Sciences.
- Virtual network for physicians across the Hills of Headwaters has had its second meeting.

Within 90 days:

- Using Central Intake, partners have systematically implemented the integrated care referral tool and identified all 4,664 patients with complex care needs across the Hills of Headwaters.
- Aligned to the quadruple aim, the Hills of Headwaters Collaborative OHT has a baseline of patient and provider confidence measures and approval for a shared Quality Improvement Plan.
- Hills of Headwaters Governors, patients, carepartners and physicians have a well-established momentum and base relationship that supports strategic planning aligned to shared priorities.
- Palliative work group is implementing and recruiting a team to support all End-of-Life palliative patients, and begin planning Care Coordination and System Navigation approaches for less complex patient profiles in Home and Community Care

Six month milestones:

- In keeping with collaborative agreement requirements, the Hills of Headwaters Collaborative OHT has conducted a broad partner survey to evaluate the first six months, taking stock of what is working well and what components of the relationship represents areas of opportunity.
    - Survey participants will include work group members, the patient and carepartner group, the physicians association, and the frontline virtual network.
- Palliative bundles of care have been validated and will be implemented, and a single fund holder and associated accountability agreement is in place to support.

- The mental health and addictions work group has identified an integrated care pathway, with an associated crisis and transitional care team identified and ready for recruitment/realignment.
- The integrated care work group has implemented a 24/7 support mechanism that includes crisis and navigation for all patients with complex care needs.
- For each of the 2020/21 work group priorities and commitments, a health equity impact and digital health assessments have been completed.
- Funding and allocation staff from across the Hills of Headwaters have drafted a single fund holder proposal and pathway for consideration of Governors and Leaders.
- A common online patient-booking digital asset has been identified and is being deployed in key markets, such as physician offices and community supports.
- Development of framework for Neighbourhood Network of Care for Home and Community Care including outcome and accountability framework.
- Begin planning and testing new assessment protocols for Year 1 population.

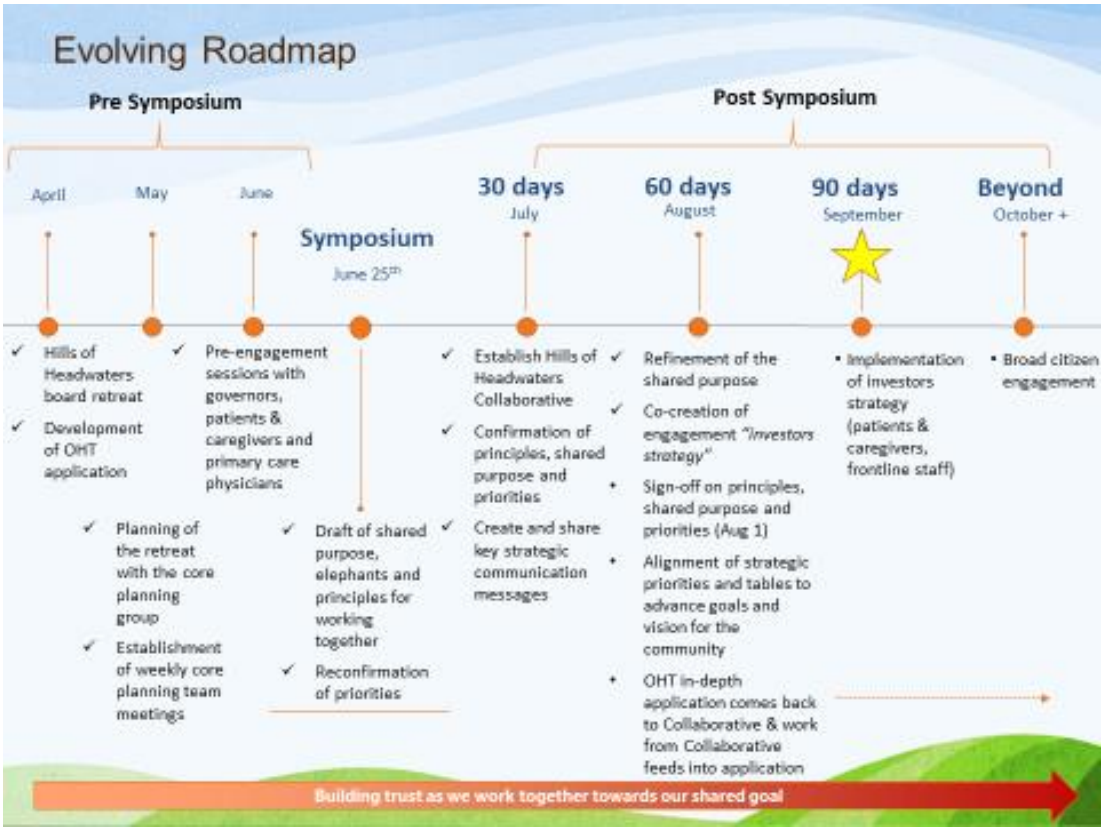
6.2. What is your change management plan? (1000 words)

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

Maximum word count: 1000

Change management has been an ongoing commitment in the Hills of Headwaters for much of the past four years, beginning with patient goals of care through the Health Links approach and continuing on to a focus on population health in sub-regions. Regardless of the initiative, a focus on integrating care through partnership has been the focus of the evolving roadmap and led to this opportunity for alignment with the OHT vision

The following depicts the timeline and associated milestones associated with efforts that have supported the development of the Full Application. Particular focus is on distributed leadership and shifting to a decentralized power dynamics, developing a shared purpose, commitment to priorities, and establishing shared principles for the path ahead. Each of these elements create cornerstones that will support and sustain the overall growth and development of the OHT.



Connecting and co-designing with diverse groups has been a key strategy in support of the Full Application will be continued into Year 1 and beyond. This strategy goes beyond passive "engagement" and focuses on patients and caregivers, physicians, providers, leadership and governors, as investors in the shared purpose. Guided by lessons taken from the US, UK, Europe, New Zealand and Australia, the Change Foundation and the core team developed the following Investors' Strategy that guided the development of the foundational elements:

The Hills of Headwaters Collaborative OHT is committed to building on the initial investors and maintaining these relationships to support an innovative change management strategy that aligns to the momentum that has been created through the vision of OHT.

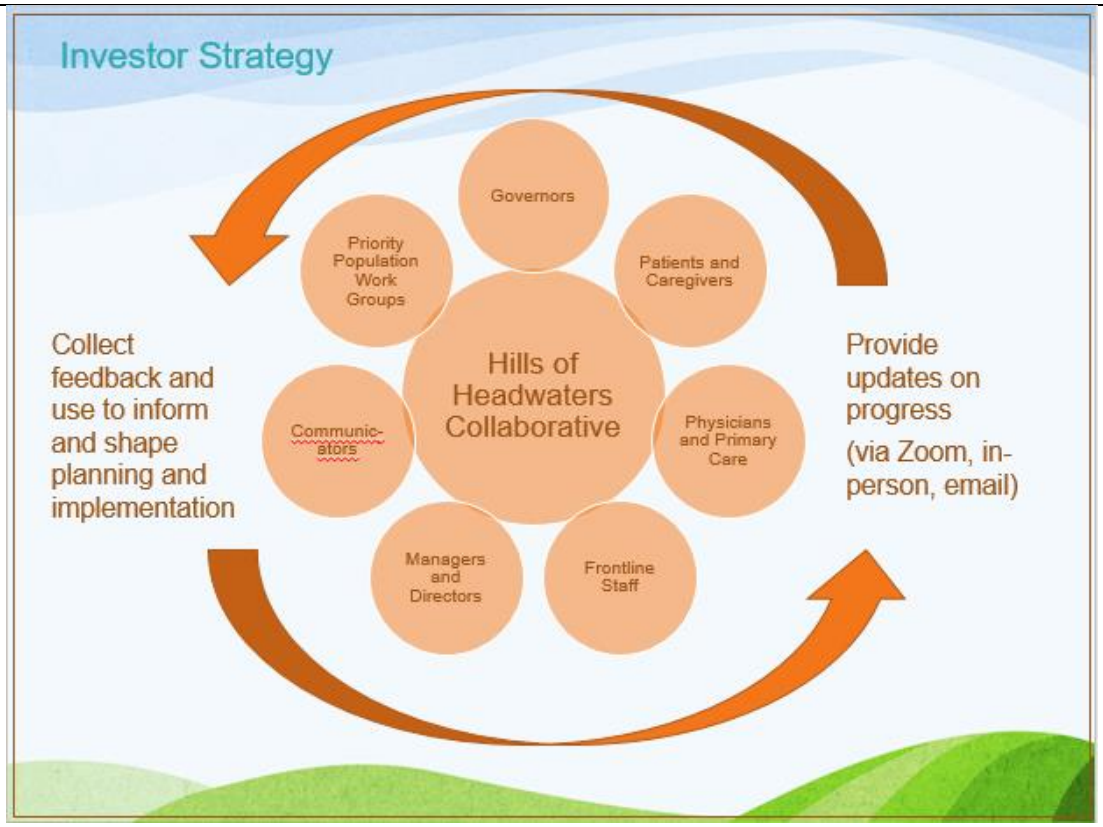
The focus of this Full Application points to the consideration and shared commitment to achieving meaningful system transformation over time but with particular focus on the confines of Year 1. It is therefore reasonable to assume that, like in many other jurisdictions, this is not about slow incrementalism rather an underpinning of disruptive change. Disruptive not in the sense of damaging, rather reconsidering how health and care delivery can be reframed based on a seismic shift.

Traditional models of change management therefore do not fit, and require their own disruptive change. Helen Bevan and Steve Fairman in their 2018 Change and Transformation White Paper identify five key enablers for that will support a new approach that align to achieving the vision of OHTs for Ontario:

1. Activate disruptors, heretics, radicals and mavericks:
    - The authors call it “rock the boat and stay in it” not engaging those that are destructive rather moving away from top down models of command and control this will enable those that can work with others to create meaningful change,
2. Lead transformation from the edges:
    - Moving change to those leading from the edge of the operations based on strong trust based relationships within and outside the organization
3. Change your story:
    - Bringing new perspectives to shape thoughts and actions – in the local context, patients, front-line staff, physicians, non-traditional partners
4. Curate rather than create knowledge:
    - Know how created by learning in action and experience – already being used locally, the symposium and staff forum utilized curated decks/live tweets to shape and move the initiatives and outcomes forward.
5. Build bridges to connect the disconnected:
    - Focus is to move beyond traditional networks based on organization or interest and look to make connections beyond to those that are unfamiliar

Much of the work to date has been guided and informed by these five principles for change. Through the diverse and distributive leadership model developed by the Hills of Headwaters Collaborative OHT this has enabled a diverse collection of thoughts and perspectives that has and will continue to create a shared purpose and commitment to action.

The diagram below depicts how the Hills of Headwaters Collaborative OHT has adopted many of these principles. The Collaborative itself is comprised of perspectives that have changed the perspectives of traditional health system planning towards health and social care. Aligned to the expressed vision for OHTs and many of the resources available through the RISE platform, The Hills of Headwaters Collaborative OHT is also bridging to co-designing change with groups that have not traditionally been involved. Patients, physicians, and front-line staff with lead change from the edges, the depiction of this relationship in the diagram is purposeful, tis degree of change cannot occur in a traditional hierarchy.



Moving forward and in order to support meaningful change the role of the Hills of Headwaters Collaborative OHT will be to create the conditions and permissions to realize Year 1 commitment. These commitments will be realized through the efforts of a collective group of diverse leaders that will connect people, ideas and learnings from Dufferin and Caledon.

6.3. How will you maintain care levels or care for patients who are not part of your Year 1 population? (500 words)

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

Maximum word count: 500

The Hills of Headwaters Collaborative OHT partners remain steadfast in their commitment to meeting accountability agreements. In fact, that commitment is foundational to the point-of-care integration that is part of the Year 1 commitment, where the focus will be on maintaining and enhancing care levels through the integration of care. The hope is that patient and provider confidence will also be enhanced through integrating care and co-designing that care with patients, based on care goals.

A single Central Intake to be launched on October 15, 2019 will allow identification of all patients with complex care needs, with a vision to include all patients requiring care. This will create capacity to ensure patients are continuing to receive quality care. As Central Intake continues to be enhanced through momentum and commitments across partners this will support a fully integrated system of care in the Hills of Headwaters Collaborative OHT.

6.4. Have you identified any systemic barriers or facilitators to change? (1000 words)

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*.

Maximum word count: 1000

Facilitators of change:

The Hills of Headwaters Collaborative OHT is committed to the vision of the OHT and, as such, has identified key facilitators:

- Legislative amendments to PHIPA that allows for direct patient access and a universal patient identifier.
- Commitment to not pilot, locally or provincially and rather scale fast or fail fast.
- While physician compensation has been well discussed over the course of OHT Full Application, a facilitator is the opening of FHO positions through managed entry. For the Hills of Headwaters, this means repatriating patients to receive care closer to home in a model of care that supports continuity and patient relationship development, interprofessional care and predictive compensation.
- Flexile and adaptive budgets that can move across providers and sectors, following patient's social determinants of health.
- Partnership with the Ministry to address structural underfunding, support an annualized approach to addressing this gap, coupled with Hills of Headwaters Collaborative OHT system improvements and efficiencies.
- Support for direct digital integration through a mandated and common digital health information exchange policy.
- Rationalize clinical systems to drive consolidation.

Systematic Barriers (or Future Opportunities in the Hills of Headwaters):

The following are a representative number of barriers that reflect early opportunities to support the development of all OHTs:

- E-notification: notifies Home and Community Care when a patient known to them has been seen at or admitted to an acute care facility. This notification also has capabilities to notify the circle of care but is not consistently available across the province. In support of the OHT vision, and aligned to the palliative, mental health and addictions, and supporting patients with complex care priorities, this functions should be switched on across the entire province.
- Multi-sector Accountability Agreements and/or Hospital Sector Accountability Agreements that are sector specific and restrictive, and not inclusive of partners such as Family Health Teams.
- Overly specific funding models that can't be adapted for other applications or moved to other organizations, including disease state or institution funding allocations.
- Privacy legislation related to data-sharing agreements.

- The movement of health record information between providers, physicians and patients is an emergency area of interest. Once again this technology is costly and reflective of another “pilot” that creates inequality between networks and patients.

6.5. What non-financial resources or supports would your team find most helpful? (1000 words)

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

Maximum word count: 1000

According to Ministry-provided data, the Hills of Headwaters Collaborative OHT has been identified as a small network. While the Collaborative agrees with this identification, we also feel strongly that the Hills of Headwaters represents the type of shared and distributed partnerships that will ensure the success of OHTs provincially.

To facilitate the success of its development through Year 1 objectives and into full maturity, the Hills of Headwaters Collaborative OHT requires base human resource. Many of these resources could be deployed from the LHIN system and have in fact supported the development to date. Given the relative size of the partner organizations, those required resource include:

- Executive level support for the Collaborative itself to provide leadership and oversight.
- Project management resources to support project momentum and reporting.
- Decision support to facilitate the development and data mining associated with a balanced scorecard and integrated Quality Improvement Plan
- System navigation to ensure patients, families and caregivers receive an integrated care experience
- Support staff to ensure patients, physicians and governors receive the organizational and administrative supports that ensure continued partnership and growth.

Other non-financial resources would include partner access to CHRIS without the requirement of access through the Health Partner Gateway. An additional resource would be the commitment of Health Shared Services Ontario to facilitate timely updates that will support the expansion and use of the Coordinated Care Plan.

6.6. Risk analysis

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

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

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

(See supplementary Excel spreadsheet)

6.7. Additional comments (500 words)

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

Maximum word count: 500

The Hills of Headwaters Collaborative OHT is unified in the commitment to achieving system transformation. Momentum and change is already taking place and, while the development and approval process for the creation of an Ontario Health Team has been generative of this momentum, it is also a drain on limited resources.

With that in mind, the Hills of Headwaters Collaborative OHT would ask for fast-track approval. Patients, physicians, frontline staff, partners, leadership and governors are all willing to meet with the Ministry as soon as possible to demonstrate that the narrative of this Full Application is a lived experience and commitment in Dufferin and Caledon.

System transformation of this magnitude will have to occur over a lengthy period of time in order to reach full maturity and impact. Given that the partners wish to seize on the momentum to date and the opportunity and get to work without delay and serve as a provincial model for change.

7. Membership Approval

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

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

(See attached)

APPENDIX A: Home & Community Care

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

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

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

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

A.1 What is your team's long-term vision for the design and delivery of home and community care? (1500 words)

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

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

Maximum word count: 1500

With the patient and caregiver voice at the forefront of service redesign the Hills of Headwaters Collaborative OHT will apply patient journey mapping to redesign home and community care along health and social population profiles that focus on rising risk profiles of the broad focus of clinical, social and behavioural care.

The long term vision of home care sees integrated care delivery teams organized around primary care where care begins in the community.

The delivery of home and community care will be offered by Health Service Providers that will include the full continuum of community support services, home service supports (formerly Service Provider Organizations), direct nursing care programs, primary care allied interprofessional teams and care coordination functions. All partners will be Health Information Custodians responsible for documenting and sharing information contained within

coordinated care plans and service planning documentation focused on outcome based pathways and long term independent models of care.

The patient and care team will experience and operate as one core team (regardless of employment arrangement) and the patient will have one main point of contact as a lead who will have full access to all elements of information related to the patient and family's needs, goals and care issues within an integrated digital approach.

The main areas of focus for home care redesign will include the following:

- Transformed home and community care assessment practices and information sharing across all partners is order to streamline efficiencies and improve the patient and provider care experience (data sharing standards to be established)
- Service pathways for stratified patient profiles of home and community care cohorts which will include outcome based pathways in order to allow for more autonomous and accountable care delivery by home and community care providers
- Increase in virtual care approaches into the home and community care delivery model
- More congregate care delivery and associated funding models that support value for money and maximize the efficient utilization of health human resources
- Interprofessional care design that supports maximizing scopes of practice and reduces redundant processes in order to support an improved care experience and assist with health human resource challenges
- Appropriate level of intensity of care coordination and system navigation functions consistently across the Hills of Headwaters Collaborative OHT and by all coordination roles that support primary care, patient transitions, self-management and population health risk monitoring
- Timely access to home and community care services at points of transitions from acute care back to community through smooth handoff to neighbourhood networks of care
- Funding approaches for home and community care that explores increased wage parity between home and community care resources and other clinical care settings
- Funding models that appropriately compensate home and community care delivery providers
- Home and Community Care Service Delivery-Neighbourhood Networks of Care with the following goals that will facilitate partnership and efficiencies:
    - Formally connect providers to work together
    - To effectively manage care for populations
    - Incent care in the most appropriate setting
    - Reduce inappropriate demand to create
    - Simplify the system through integration and reducing administrative complexity

In considering the full scope of services of home care and community support service care delivery across patient risk/complexity profiles and differing level of care needs, the home and community care partner organizations in partnership with the existing LHIN Home and Community Care leadership team and patient representatives, will collaborate to develop networks of full service care delivery. These networks of care will be based on primary care alignment and natural neighbourhood profiles in order to increase an integrated team approach by improved consistency and dedication of providers working together. Through shared and agreed to principles, all home and community care partners (Service Provider Organizations and Community Support Service providers) will voluntarily explore how to best align service capacity resources and business processes to create a network of care approach within reasonable neighbourhood geographies. This approach will not only strengthen relationship and trust to work as an interprofessional care team but it will also support increased service accountabilities at a neighbourhood level and streamline administrative functions and reduce duplication in many facets of service delivery and integrated care coordination. These networks of care will execute on the foundation of evolving care pathways in order to streamline care provision, avoiding duplication and providing more cost effective and value based health care.

Through the risk stratification that will take place through Central Intake, access to Home and Community Care services will be matched to the presenting needs based on the most appropriate service intervention and the strength of the neighbourhood networks. This focused approach of all partners working more closely together will result in the patient having care delivery by the best matched service intervention that will reduce the potential of duplication and will in turn create less fragmentation in care delivery. The network of care approach will allow providers to organize staffing models in new ways that can increase better scheduling practices within neighbourhoods that can improve the working conditions of front line home care workers thereby creating better stability of the valued work force.

Based on lessons learned from several years of small scale planning and implementation of tests of change that has taken place within this region, the Hills of Headwaters Collaborative OHT will expand and implement care models based on examples such as Health Links, Health Quality Ontario's best practices related to bundled care, transitions in care, wound care, and the PACE models of integrated care as well as relevant components of previous levels of care modelling.

Common pathways of care will be developed within population health levels and this will increase consistency of care across the Hills of Headwaters Collaborative OHT. Roles and responsibilities of the delivery partners will be clarified, and will contribute to a core set of team members supporting primary care leading to an improved expected outcomes of care will maximize scopes of practice. Areas of assessment and care planning will be done consistently and will not be repeated unless significant changes make it necessary.

Expansion of upstream preventative and rehabilitation models of care will be delivered by the most appropriate community provider based on the success of the restorative and "living well" approach to care as has been executed by the CW LHIN through the Home Independence Program.

Care will be better integrated in the future of home and community care as there will be streamlined practices to one central point of contact for patients/caregivers and other

interprofessional team members. More home and community care will be delivered in "Convenient Care" sites or congregate settings which will make use of existing home care, community based Nursing Care Clinics and will offer enhanced interprofessional service offerings. Support services, programs and resources will be accessed from across primary care, social services and home and community care to coordinate a true integrated approach to care.

Care Coordination Functions in Home and Community Care Delivery

Care Coordination will take place across the entire continuum with increased intensity and consistency for the most complex patient needs. The scopes of practice of all health and social partners will be maximized where the most appropriate partner will be accountable for collaborating in the design and monitoring with patients/caregivers and primary care in the care plan implementation. In some instances (as examples), this will mean the front line nurse providing care in the home is the lead coordinator, or the Assisted Living Coordinator, home care coordinator, physio in the family health team or primary care themselves may serve as the lead coordinator. The Hills of Headwaters OHT partners will collaboratively develop the standard operational requirements of coordination and individual patient care planning accountability so that regardless of who employs a coordinator function the role is consistently executed so that primary care and patients and families can reliably count on that main point of contact.

Home Care Delivery through Virtual Care

The successes of virtual care delivery in home and community care will be expanded to increase access to care through virtual means. Models such as e Shift (virtual Directing Nurse providing direction and supervision of care to an enhanced PSW at the bedside), that have been launched by the Central West LHIN Home and Community Care will continue to be expanded in order to support increase access to care through efficient means that support expanded scopes of practice, value for money and a novel approach to reducing risks related to health human resource risks. In addition, the virtual approach to care of OTN Guest link will continue to be leveraged to support virtual care between primary care, care coordination, neighbourhood network care team and primary care. This intervention has been particularly successful for patients that have mobility or transportation issues impacting their ability to access primary care. By increasing the use of the virtual visit and partnering more purposefully with primary care in utilizing the technology, the savings to patients, the system and clinicians will be formidable.

Care delivery at the bedside will be maximized through the use of virtual care to support the integrated care team in collaborating in real time. Additionally, models of virtual care to support self-management and health teaching approaches will be leveraged while aligning all telehomecare and direct nursing interventions in order to support the full range of transition and upstream care approaches. Virtual care in wound care related to complex diabetes needs for the year one focus population will see a significant improvement in care delivery. Through digital tools and remote monitoring the patient care team and leaders can evaluate care delivery progress to expected outcomes thereby increasing real time accountability and performance oversight.

Early testing of patient self-assessment models will be explored within hospital transitions through the creation of home care self-assessment tools that will be embedded within the bedside terminals at Headwaters Healthcare Centre. This will not only reduce assessment redundancies but will also support more patient centred care.

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

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

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

(See supplementary Excel spreadsheet)

The expected volume of the attributed population in the Hills of Headwaters Collaborative OHT that requires Home Care is expected to be approximately 3,500 patients. Home care demands within Dufferin and Caledon has been under reported over the last several years due to wait listing practices given an associated lack of funding and home care spending is also not accurately tracked due to a lack of health human resource capacity to fulfill approved service plans for active home care patients. Given the Year 1 focus aligns with the most complex health and social needs, these are the only patients that are currently actively receiving home care services. It is anticipated that the current volume of home care services will remain as the same population volumes that require home care services in year one.

The goal in Year 1 is to maintain home care stability while working toward a transformed longer term vision of modernized and better integrated home care. Incremental changes in home care will occur in year one with a goal to reduce duplication of assessments and coordination among service providers, community support service providers, FHTs, CHC's and other interprofessional models of care. Focused efforts on operating as interprofessional team will occur through a coordinated operationalization of primary care, service provider, care coordination team and community support service partner within the first year of the OHT home and community care offering.

Within the first year Centralized Intake for home and community care will take place within the same framework as the broad Central Intake approach leveraged from the existing Central West LHIN Home and Community Care intake infrastructure. All assets of home and community care will be required to execute on the central intake approach. Existing practices of central intake for Home Care, Convalescent Care, Assisted Living/Supportive Housing and LHIN led Exercise and Falls Prevention Classes, Adult Day Programs will be maximized and improved where required in order to best utilize skills and infrastructure to connect patients and families to care quickly. A full review of assessment practices will be undertaken in order to look for efficiencies and redundancies in processes that impact access to care, patient experience and provider experience and those areas that require a transformed approach will be prioritized in year one to be improved in order to build a solid foundation of broad system level intake. The success and lessons learned from the of the joint Integrated Care Coordinator role between Headwaters Healthcare Centre and the Central West LHIN Home and Community Care Team will be advanced in order to maximize an appropriate streamlined transitional coordination approach from hospital to home.

Some opportunities include stratifying care coordination functions at intake and assessment to ensure that the most appropriate level of transition planning is offered. Beyond this the most responsible role for coordinating care and creating service plans will be tested across the population health profiles that are created in Year 1. Currently a trial is underway that utilizes a home and community care coordinator who follows a patient between the hospital and into the community for the most complex transitions. Alternatively in Year 1 a trial will be explored for the less complex patient cohorts to have a lead nurse coordinator assigned to serve as the transition coach from hospital into the community. In both scenarios strong and appropriate methods of partnering with primary care and other team members will be essential in supporting integrated care planning and oversight of care delivery in the home and community care space. The desired state is that primary care will be able to be more involved in individual care planning that will include identifying resource needs that can be operationalized by many different parts of the system not solely the traditional parts of the home care delivery offering. For this reason the initial focus to support care coordination modeling that includes the broadest definition of coordination will be required that is beyond the traditional home care basket of services alone. Change management and education to existing care coordinator roles across the system will take place.

Central West LHIN Home and Community Care has all Care Coordination functions aligned by sub regions that match this OHT boundary and all care coordinators are aligned to primary care practices with caseloads being built primarily around the primary care practice and active home care patients. This model requires enhancements in order to increase the strength of collaboration with primary care and in order to be more upstream in home care delivery and planning. The review of the alignment model would take place in year one in collaboration with primary care leaders, patients and front line staff so as to plan what future alterations to the approach may be required.

Care delivery at a network neighbourhood level will require a great deal of joint planning and leadership. While in Year 1 the existing contracts and service volumes are expected to remain the same the work to begin to plan, develop shared principles across the home care and CSS sectors in order to move to voluntary alignment of service volumes that will support integrated lead teams by neighbourhoods.

In Year 1 an expected increase of congregate service delivery offerings of several nursing clinics will be in place with planning and contracting already well underway. These clinics have been planned to be able to eventually expand to full interprofessional care models, therefore continual planning and implementation will take place in year one and beyond.
Virtual care of eShift is expected in year one to expand to treating palliative care needs in home care.

A focus on the year one population will afford the opportunity to refine the Rapid Response Nursing program in home care to focus on rapid transitional intervention for those populations in the Hills of Headwaters that would most need this intervention. By jointly planning with the Community Paramedicine program both resources can be best leveraged to maximize rapid avoidance assessments, self-management and health promotion in order to avoid an ED visit yet be executed in a manner that ensures no duplication of services.

In support of the integration of palliative care Home and Community Care will be involved in supporting the development of a dedicated End-of-Life Core Team that will operate within a

Buurtzorg model. Focus will be to ensure the team is able to provide care to the full scope of practice and care. This will in turn identify other areas for improvement and modernization of Home and Community Care within the Hills of Headwaters Collaborative OHT.

A.3 How do you propose to transition home and community care responsibilities? (1000 words)

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

Maximum word count: 1000

While recognizing that some functions will remain regionally supported, the following Central West LHIN Home and Community Care resources are expected to be leveraged by the Hills of Headwaters Collaborative OHT in Year 1:

- Central Intake,
- Care Coordination including community programs and transitional care
- Health Care Connect
- Healthline.ca
- Information and Referral
- Long Term Care Placement
- Direct Hired Nursing and Pharmacy Programs
- Exercise and Falls Prevention Class

Existing leadership roles will be assigned as deployed resources to the Hills of Headwaters Collaborative OHT in Year 1 while initially remaining as resources of Ontario Health until the full governance and leadership structure of the Hills of Headwaters Collaborative OHT is in place.

As the Home and Community Care leadership structure and appropriate operational support are aligned by geography the resources will be easily mapped to the Hills of Headwaters Collaborative OHT without risk of destabilizing home care and access to care services.

Appropriate support functions of Finance, Decision Support, Quality/Risk, Contract, Performance and Procurement, Information Technology and Human Resources will also need to continue to support the day to day operations of delivering home and community care within this OHT therefore these dedicated resources being embedded within the Ontario Health organization and dedicated to the Hills of Headwaters Collaborative OHT will be critical for its success.

Digital assets of CHRIS and HPG, Guest Link of OTN programming (as some examples).will also be maintained initially as digital assets required to maintain home and community care stability in year one. As the Hills of Headwaters Collaborative OHT matures a review of clinical digital supports will take place and alignment of information sharing and reduction of any duplication of information management will be a prime goal of review.

For the transition period, all existing SPO contracts are expected to be transitioned over to the OHT based on presence of market share representation with the Hills of Headwaters Collaborative OHT geography. As the model of care evolves and integrated opportunities

exist the potential realignment of full service home care contracts or staffing models should be explored as outlined in the previous sections related to the vision of the neighbourhood networks of care.

The resources of the Central West Home and Community Care teams in the Dufferin and Caledon, including specialized services, will be deployed as they are now to serve these neighbourhoods and the associated primary care and community partners within the Hills of Headwaters Collaborative OHT. The Initial Care Team function of intake will also be leveraged to begin to build and expand the Central Intake model and in the meantime the intake function of this team will continue to support the intake and transitional service planning for all home care patient needs.

At maturity these resources will be used to execute on the transformed home and community care vision and the priorities of the Hills of Headwaters Collaborative OHT.

A.4 Have you identified any barriers to home and community care modernization? (1000 words)

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

Maximum word count: 1000

- Although only a guidance document the Assisted Living and Seniors Supportive Policy Guideline of 2011 serves as a conceptually incongruent approach to the care continuum required to meet the needs of this community. The OHT partners will look to maximize the operationalization of the full care continuum in this community, based on the population health needs and strengths of service delivery to execute improved value for money and patient-centred care responsiveness.
- Funding models appropriately compensate home and community care delivery providers
- Expanding the definition of approved agency in Home Care and Community Services Act will be explored to consider working as a better integrated care team while also maximizing critical value for money and eligibility of services.
- All partners being appropriately considered as Health Information Custodians under PHIPA to strengthen real time health information sharing and care planning as well as access to provincial clinical care viewers.
- In order to see system level and care delivery outcomes, there needs to be an investment in standardizing data definitions particularly as multiple sectors come together, all who up to now have different understanding of data and approaches to capture data.
- Wage parity between home and community care compensation and other clinical care settings and the increasing risks in maintaining a stable health human resources that contribute to reliable and continuous home care.
- Health Human Resource risks exist in the home and community care sector. New considerations of funding models in home and community care should be examined where more full time work can be offered. (PSW and Nursing shortages specifically are risk areas)
- The definition of home care visit must include virtual care under the Home and Community Care Act.
- Appropriate funding to increase incentives for physicians to partner more purposefully with home and community care for home visiting or virtual care visiting are required.
- Requirement to fund home and community care (in the broadest sense) in this community at appropriate per capita home and community care levels.
- Existing contractual obligations and timelines for medical equipment and supplies will limit and or restrict the magnitude of change that can take place in Home and Community Care.

APPENDIX B: Digital Health

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

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

Responses will also help the Ministry understand what supports teams may need in the area of digital health.

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

B.1 Current State Assessment

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

(See supplementary Excel spreadsheet)

B.2 Digital Health Plans

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

B.2.1 Virtual Care (1000 words)

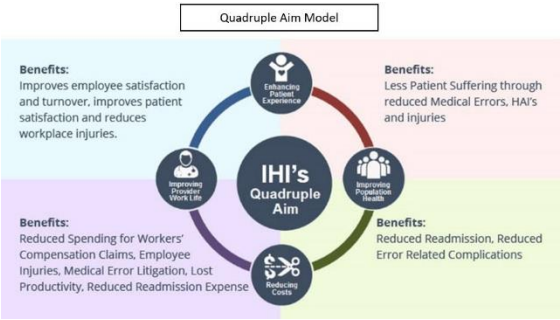
Describe your plan for how you will build off your team's existing digital capabilities to further expand virtual offerings in Year 1. If some or all of the members of your team do not have virtual care capacity, what steps will you take to ensure that by the end of Year 1 your team offers one or more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

Maximum word count: 1000

Year 1:

- Throughout Year 1, the Hills of Headwaters Collaborative will establish a digital and virtual care working group consisting of patients, clinicians and IT experts across the continuum to work collaboratively to develop our OHT's Digital Health Plan. The working group will adopt the shared purposes and principals from the Collaborative and will utilize the Digital Playbook as a reference document to ensure the digital health plan is effective, comprehensive, and achievable. The working group and the digital health plan will embrace and adhere to the seven policies provided within the playbook, and utilize the applications catalog to ensure the plan utilizes current provincial resources and establishes a strong foundation of local infrastructure and capabilities.
- The diversity of the working group will ensure the technical, clinical and end user perspectives are captured within the digital plan and aligned with the target population in year 1 (palliative, mental health, and complex health link patients).
- Our OHT collaborative has completed the digital assessment survey (see appendix) and the digital working group will complete a more comprehensive environmental scan within the 1st 60 days of inception to establish our local digital/virtual capabilities. Stakeholder input and consultation sessions will help establish important local themes and priorities to address within the digital health plan.
- Recognizing our digital assessment survey demonstrated the majority of our partners currently have access to OTN and tele-homecare services provides our OHT with a common digital platform to enable virtual visits. The partners with expertise in virtual care can establish a virtual care forum where we can build a collective network and offer support to other OHT members who lack experience with virtual visits.

- With an understanding of our partners who currently lack or are limited in virtual care capacity, the working group will be positioned to build a virtual care strategy within the digital health plan to ensure all members have access to virtual care in year 1. The virtual care strategy can integrate virtual care visits within the clinical care paths for palliative care, mental health and complex patient transitions through the healthcare system and between OHT partners. For those partners without access to virtual care, the working group can explore several options where video conferencing devices may be relocated, redeployed, shared and/or loaned to collaborative partners in the short term to meet our patient's needs, and also develop a longer-term plan to acquire additional devices for our community.
- As the performance metrics and utilization indicators are considered, it is believed our OHT can achieve a 2-5% Year 1 target for patients to have virtual care provided. The Collaborative has already established a baseline of over a thousand annual OTN encounters for patients and clinicians and these encounters include the target population in year 1. The majority of partners within the collaborative already have access to OTN/PCVC services and with the establishment of the palliative care and mental health working groups already working effectively and aligned with our shared purpose and the priorities for an OHT, there is little concern regarding the ability for the teams to meet this target. The inventory of tools within our OHT also supports the achievement of the year 1 targets. Primary care, home care, Mental health care, and acute care have already provided virtual care within our community. As the other working groups continue to redesign care and integrate partners within the care plans of our patients, the access and utilization of virtual visits will increase beyond the current methods.
- With the establishment of the digital working group that includes patients, clinicians and IT experts, the key performance indicators that reflect effectiveness and efficiencies can be collaboratively developed to ensure a multitude of priorities are evaluated. The working group will utilize the **Quadruple Aim Model** during its evaluation and also implement a simple balanced scorecard with the standard four quadrants to consistently measure and evaluate the KPI's determined by the committee members. Metrics such as (but not limited to):
    - Patient and clinical satisfaction rates
    - Utilization rates by each target patient population
    - Number of avoided in-person clinic visits
    - Number of avoided ED visits



- These metrics, as well as those listed within the playbook will provide the digital working group, and the OHT collaborative the ability to continually improve the use of virtual care using the Institute of Health Improvement (IHI) model of improvement and the Plan-Do-Study-ACT (PDSA) models to successfully achieve our digital health plan and year 1 targets.

- The digital working group will also adopt and incorporate a change management framework to support the digital health plan. Beyond the support provided within the playbook, the digital working group will also utilize the support of the Province to ensure our success in year 1 and beyond.
- The OHT collaborative members recognize change can be challenging and there will be unexpected events during year 1. However, one of the strengths of this OHT collaborative has been its innovative nature and creativity in partnering to support our community and its needs. The anticipated members of the working group have worked collaboratively in the past and there is a trust among members that allows the objectives and goals to overcome the challenges during the process.

B.2.2 Digital Access to Health Information (1000 words)

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

Maximum word count: 1000

Year 1:

- The Hills of Headwaters Collaborative OHT is fortunate to have several partners who possess significant expertise in information technology, digital platforms, and virtual care capabilities. This expertise is evident within the Collaborative by the numerous examples of innovations, collaborations and various digital tools that have been in place for several years. Many of the partners are well positioned to bring tremendous value and experience to the digital care working group to build on the current capabilities and ensure our target population of patients have access to some of their health information.
- As a starting point, Headwaters Health Care Centre already provide patients digital access to their health information through the integrated bedside terminals, where patients can actively look at their medical information as clinicians are documenting and review the care plan at the bedside. The IBT digital platform also allows for various applications to be available to patients during their hospitalization. Most notably, patients can see their medical records with the use of MyChart, a software application that patients can sign up for and have access to their health information from Headwaters and Sunnybrook hospital. Headwaters supports patients signing up for MyChart when they are registering in the hospital. To date, over 1000 patients have signed up for MyChart. Once registered, patients can launch MyChart while in hospital (or from other locations) and gain access to their health information.
- The IBT platform also provides patients with access to health information and educational material directly and in real-time at the bedside. Patients can simply launch the iMD Health application and health information specifically related to their medical condition, or gain access to drug information regarding their medications, the purpose, common side effects and potential reactions are all available to patients at the bedside. This digital platform and patient access to their health information (as well as other opportunities not yet discussed) can facilitate access to other clinical partner applications and significantly enhance the overall patient experience as they access their own health information.
- Beyond the bedside terminal, the diagnostic imaging department has also supported patients having access to their health information by interfacing with an application known as "MypocketHealth"[4]. A digital portal that allows patients to sign up and gain access to their digital images that were completed at Headwaters. This can then be shared by the patient with

[4] https://hhcc.mypockethealth.com/request

their primary care physicians or their home care team and can be accessed anywhere they have access to the internet/Wi-Fi. These applications will help facilitate achieving the target of 10-15% in Year 1.

- Another more commonly known opportunity for patients to gain access to their health information is through a patient portal application with LifeLabs called “My Results”. Patients are required to register and create a username and password that will allow them access to all laboratory results processed by LifeLabs. This access to their health information, as well as the diagnostic imaging and the medical information during their acute care visit provides a foundation of health information that the digital working group can expand from.
- The opportunity to increase patient access to health information will greatly increase in year 2 when the acute care facility will have completed the implementation of a new hospital information system, which includes a patient portal in Meditech Expanse.

Ontario Shores Advances
Patient Engagement with MEDITECH

About

- Ontario Shores Centre for Mental Health Sciences is a 346-bed public teaching hospital in Whitby, Ontario, that provides a wide range of assessment and treatment services to those living with complex and serious mental illness
- As the first HIMSS Davies Enterprise Award and HIMSS EMRAM Stage 7 recipient in Canada, Ontario Shores is recognized as one of the world's leading advocates for the "recovery model" of mental health care, which is focused on restoring fuller function and quality of life to patients.

Challenge

Prior to their EHR implementation, Ontario Shores patients had limited access to their own care data. Their health information requests were processed manually by the organization's health information management (HIM) department, which could take weeks. Communication with caregivers between appointments was limited, and medical record information was not easily shareable with providers outside of Ontario Shores' network. Executives at Ontario Shores identified an opportunity to extend medical information access to patients, in support of maintaining care continuity and strengthening patient engagement.

Execution

During the implementation of **MEDITECH's patient portal**, Ontario Shores focused on four primary patient engagement goals:

- Enhancing patient access to their care providers and their own care data
- Supporting the paradigm shift toward service-user-driven care
- Eliminating gaps in patient engagement and partnership between patients, families, and healthcare providers
- Evolving existing practices and culture from a provider-centric model to a patient-provider partnership.

Clinicians, patients, and other healthcare professionals at Ontario Shores were involved with the design, planning, and implementation of the portal from the start.

Results

After implementing the portal, Ontario Shores observed significant, measurable benefits for both patients and healthcare organizations, including:

- **Improvement in 7 out of 8 patient mental health recovery domains, including self-empowerment, basic functioning, and overall well-being**
- **67% greater likelihood that portal users attend appointments**
- **30% lower likelihood that portal users request information**
- **16% improvement in patient self-assessment scores.**

Download the full version of this case study: ehr.meditech.com/case-studies ↗

"The patient portal is a valuable tool that empowers patients to be active participants in their own care. Clinicians are able to partner with patients to further support their recovery goals and stay connected to their progress."

Sanaz Riahi, Senior Director, Professional Practice and Clinical Information at Ontario Shores Centre for Mental Health Sciences

B.2.3 Digitally Enabled Information Sharing (1000 words)

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

Maximum word count: 1000

The Hills of Headwaters Collaborative members have worked collaboratively for several years and there have been several Data Sharing Agreements (DSA) established to securely share digital information across providers. These partners include, but will not be limited to:

- Dufferin EMS
- County of Dufferin Community Support Services and Long-Term Care
- Headwaters Health Care Centre
- Home and Community Care
- Dufferin Area FHT
- CMHA Peel Dufferin
- SHIP
- Alzheimer's Dufferin
- Bethell Hospice
- Dufferin Hospice

- The digital care working group will benefit from the rich availability of cyber security expertise from a multitude of partners who have been responsible for ensuring the safe transmission of patient information to numerous health service providers and health agencies. This expertise will be further enhanced with the Digital Health Access, Privacy and Security Policy available within the Digital Playbook. The requirements within the policy and the currently available resources within the collaborative help to ensure the Hills of Headwaters Collaborative OHT will have an effective plan to protect patient health data and securely share digital information.
- Currently within the Hills of Headwaters Collaborative OHT the Wellington Dufferin Guelph Public Health Unit has been a central figure providing enhanced demographic information and the added insight to social determinants of health and local population. Partners are well positioned to build very intelligent integrated care pathways based on partnerships and engagement within the Hills of Headwaters Collaborative OHT. This culture, applied to the digital health space, will be a powerful enabler that allows our collaborative to overcome obstacles and barriers.
- Many of the partners already demonstrate compliance with best practice in privacy, confidentiality and data security as they continually interact with a number of digital applications such as eHealth's Connecting Ontario, Ontario MD, Hospital Report

Manager, Clinical Connects, Meditech, and CHRIS as partners participate in the circle of care. Many of the partners also have established best practices such as random audits and internal phishing exercises to enhance awareness and vigilance.

- Connectivity and security is tested routinely before new applications "go live" and are continually monitored by information systems. Many of the partners within the Hills of Headwaters Collaborative OHT protect their patient information with best practices in passwords and high security firewalls within their institutions and each facility completes a Privacy Impact Assessment (PIA) for each new application that is introduced.
- While it is recognized among the membership there will be variation in the current policies, procedures and protocols, the digital working group will have the expertise to review the available practices within the Collaborative partnership and work towards harmonizing the privacy and security model within Year 1.
- Committee members within the digital care working group would also utilize access to PHIPA expertise to develop an application to the Ministry for an order that will support the Hills of Headwaters Collaborative OHT to function as a single Health Information Custodian (HIC).
- Memorandum of agreement among members will provide an effective method to address data requests within the Collaborative partnership with a focus on ensuring the security and sensibility of the request in the best interests of patient care.
- For smaller partners within the Hills of Headwaters Collaborative OHT who have not previously required access to eHealth Ontario and/or other digital health platforms they will gain support within the Collaborative to ensure they are able to meet the compliance with privacy and security of a newly formed OHT. The digital care working group would support those members in their enrollment to provincial health assets within the 90-days of OHT approval. The digital care working group would reach out for external support from eHealth Ontario and the Digital Health Secretariat.

The expertise that exists within the OHT Collaborative allows for many of the members to be invested and actively involved in various roles and responsibilities and thereby establish a stronger and more cooperative infrastructure for cyber security and data privacy.

B.2.4 Digitally Enabled Quality Improvement (500 words)

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

Maximum word count: 500

- Each of the members within the Hills of Headwaters Collaborative have a variety of digital health tools and information assets that can improve quality and performance. Data repositories rich with patient information and a variety of analytical tools including run charts, control charts, Power BI (Microsoft application) and in some cases the use of Artificial Intelligence (AI) have been used by our OHT members to drive quality and performance improvement.
- More impressive is the culture of partnership within the Hills of Headwaters Collaborative OHT that focuses on working together to improve the delivery of care to our community. Home and Community Care and Headwaters Health Care Centre have partnered on several occasions to share information and improve the quality of care provided to several clinical conditions, including palliative care, heart failure, and wound care.
- One example of team level engagement has been the work done by the Wellington Dufferin Guelph Public Health Unit, who has been a leader within our community and within the Hills of Headwaters Collaborative OHT. Their team has effectively utilized a variety of digital health tools and information to build an impressive and highly comprehensive sociodemographic distribution of residents within Dufferin and Caledon. Their website provides open access to all partners and associated teams to closely exam the community and gain insight communities and neighbourhoods.
- Public Health has also been a willing partner to build expertise and capabilities with its partners. In May 2019 they invited the partners to an Advanced Microsoft Power Business Intelligence workshop. With no cost to the partners Public Health provided hands on training and education for partners to better utilize their data and build informative dashboard to monitor performance and improve quality of care. Public Health Unit also has access to a digital platform hosted by Hamilton Health Sciences called Integrated Decision Support (IDS). If the data from our various partners in mental health, primary care, home care, acute care could be captured within this digital platform, Public Health has the expertise to mine the data and effectively determine new opportunities for improving quality and system performance.
- There has also been an active sharing of information among members within the collaborative as home care, acute care, public health, CMHA Peel-Dufferin, physicians and Dufferin EMS have all collaborated on various projects to improve community health, reduce ED visits, and helps patients and families receive care closer to home. The digital care working group will also provide a forum for data sharing, training, and enhanced capabilities to be achieved.

B.2.5 Other digital health plans (500 words)

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

Maximum word count: 500

- The Hills of Headwaters Collaborative OHT has a level of partnership and commitment to support that has existed for years across Dufferin and Caledon. In 2014, the Dufferin Area FHT and associated physicians were using Practice Solutions (PS) as their Electronic Medical Record (EMR) but each site had its own server. There was no interconnectivity between EMR's, this resulted in duplication of patient charts and redundancies in clinical care. With approximately 50,000 patients registered within Dufferin Area FHT, the magnitude of the problem was significant. To resolve the issue, Headwaers Health Care Centre partnered to present a proposal to the LHIN in July 2014. Funding was secured in the fall 2014 and physician engagement and approval, the hospital worked with TELUS Practice Solution to complete the project in November 2016. All the Dufferin Area FHT sites as well as all physician clinics were merged onto one server and one instance of the TELUS Practice Solution EMR that is now housed at Headwaters Health Care Centre.
- William Osler, CMHA and Headwaters have also been strong partners in utilizing OTN services to provide virtual care and help avoid unnecessary patient transfers and delays in care.
- Headwaters utilizes Tele-ICU services in partnership with William Osler to help patients, wherever possible, to stay closer to home as well as expedite their transfer to a tertiary level intensive care unit. Headwaters also facilitates virtual care by utilizing telehomecare services for patients with congestive heart failure and COPD.
- Dufferin EMS has supported patients with telehomecare services in partnership with family practice. Many of the partners within the Hills of Headwaters Collaborative OHT have also utilized Personal Computer Video Conferencing (PCVC) and support the opportunity for patients to have virtual visits within their community.
- Within Headwaters Health Care Centre, the organization has made virtual care a priority. 96 Integrated Bedside Terminals (IBT's) referred to as "the Hub" have been installed at the patient's bedside to empower patients with access to information and work collaboratively with the clinical team

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

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

Name:	Lewis Park
Title & Organization:	Manager, Information Technology, Headwaters Health Care Centre
Email:	lpark@headwatershealth.ca
Phone:	519-941-2702 x 2901

Appendix C: Partnerships

Partners from **Alzheimer's Dufferin**	Focus/Priority Area	Length of partnership	Outcomes and Results
Aging Well in Dufferin (various community partners, Alzheimer Dufferin, Dufferin Area FHT, Telecheck, Paramedics, Hospice Dufferin, OPP, County of Dufferin)	Safe Beds for Seniors, Seniors at Risk Program Awareness in the Community	Ongoing	1 safe bed located in the Avalon (no longer active) AWID Facebook Page, Travelling Road Show of Awareness
Alzheimer Dufferin, Dufferin Oaks, Hospice Dufferin	Collaborative Support Groups	Ongoing	Caregiver Connections: Ambiguous Loss/Grief Group –started February 2019
Partners from **Caledon Community Services**	Focus/Priority Area	Length of partnership	Outcomes and Results
CCS & Home and Community Care	Transitions in Care	6+ years	Health Links, CCP, Assisted Living and Transitional Care Programs. Decrease waitlist for services, increase access to PSW support and respite services in Caledon.
CCS & Behavioural Support Ontario	Transitions in Care	6+ years	Increase supportive services to clients with increasing acuity and behavioural issues with the

			support of the Psychogeriatric Resource Consultant (PRCs)
CCS & Headwaters Health Care Center & WOHS Brampton Civic	Transitions in Care	6+ years	Decrease ALC beds by supporting care transitions from hospital to home; hospital to transitional community beds; supporting Wait at Home clients
CCS & Headwaters Health Care Center	Transitions in Care	6+ years	Increase access to and the availability of specialist care services locally in Caledon
CCS & WOHS Diabetes Team	Transitions in Care	6+ years	Increase access to and the availability of diabetes education and clinical services locally in Caledon.
CCS & Region of Peel	Transitions in Care	1+ year	Increase access to and the availability of Dental Screening Clinics locally in Caledon
CCS & Trillium Health Partners Telemedicine Health Program (OTN)	MH&A / Transitions in Care	6+ years	Increase access to and the availability of mental health services locally in Caledon
CCS & CMHA	MH&A	1+ year	Increase access to and the availability of mental health services locally in Caledon
CCS & Exchange Partners	Transitions in Care	6+ years	Increase access to programs and

			services for all ages in Caledon
CCS & Dufferin Area FHT	Transitions in Care	< 1 year	Work collaboratively to increase the availability of specialist and other health care services locally in Caledon
CCS & PHO (Dr. El Khouly	Transitions in Care	6+ years	Work collaboratively to inform local PCPs of the programs and services in Caledon & provide opportunities for local PCPs to offer their specialty knowledge to the community
Partners from **CMHA**	FOCUS/PRIORITY AREA	LENGTH OF PARTNERSHIP	OUTCOMES AND RESULTS
CMHA, DCAFS, OPP, OPS, FTP, ASD, Victim Services, SHIP, Choices, Shelburne Police, Dufferin Area FHT, Headwaters HCC	Dufferin Situation Table	Since March 2016	Effectively supported over 100 referrals for support during situations of Acutely Elevated Risk
CMHA, Community Living Dufferin, Dufferin Area FHT, Primary Care, Crisis 24.7, Headwaters HCC	Case conferencing re: complex clients	Ongoing	Identified CLD clients with concurrent disorders have been supported via ongoing case conferences to coordinate care, problem solve and support crisis planning
CMHA, Dufferin Area FHT, SHIP, FTP	DBT program	Spring 2019	Supporting high risk clients via DBT program to increase coping and decrease use of crisis services.

CMHA, Headwaters HCC, WOHS	Community Psychiatry	Spring 2018	Implement and deliver community-based psychiatry services (Dr. Babani)
CMHA, Dufferin Area FHT	Shared Space	2018	Have worked together to support both agencies need for space to accommodate improved services. Dufferin Area FHT has utilized CMHA space in Orangeville and CMHA continues to use Dufferin Area FHT space in Shelburne and Bolton.
CMHA, Dr. C Kitamura, Baycrest Health Sciences	Geriatric Psychiatry	Since 2017	Providing assessment and follow up geri-psych services for clients of CMHA Seniors program and educational sessions to staff
CMHA – various	Dufferin HS&JCC	10 + years	Working as community table on Human Services and Justice initiatives/issues impacting Dufferin County
CMHA – Various	Dufferin Community Advisory Board	10+ years	Working as a community table to address housing and homelessness issues impacting Dufferin County.
CMHA – Various, Alzheimer Society of Dufferin	Behavioural Supports Ontario	2017	Supporting BSO network activity/clients in the community
CMHA – Oliver House et al.	Increasing community supports to Oliver House	2019	Have worked with community to

			increase supports to residents of Oliver House (ATR, Addiction Services, SGS)
CMHA, Caledon Specialist Clinic, Moyo, Peel Region, YMCA GTA	Narcotic Strategy: Caledon Substance Use	2019	Build understanding of work being done around substance use in Caledon. Build understanding of info we have around substance use in Caledon + brief sharing of drug strategy environmental scan. Challenges in reaching out to/ serving Caledon wrt substance use + potential collaborative solutioning
CMHA- Various	The Exchange Collaborative (Caledon)	2015	The overall purpose of The Exchange Collaboration and Service Integration Action Group is to: • Generate ideas for joint programming to promote prosperity-building • Innovate in service delivery - work collaboratively with other organizations to plan and execute joint programs at and through The Exchange • Improve inclusive services and programs for a diverse community • Ensure a high level of community and volunteer engagement

			• Communicate plans for upcoming programs to be hosted at/through the Exchange
CMHA, Comfort Keepers, Knowledge to Action Consulting, Bolton Mills Retirement Living, Caledon Seniors Council, The Palgrave United Community Kitchen, Caledon Community Services, Caledon Seniors' Centre, Caledon Meals on Wheels, Caledon Dufferin Victim Services, Home Instead, CW Self-Management Program, Seniors Saviour Solutions, Elder Abuse Ontario, PAARC, Town of Caledon, Volunteer MBC, Home Care Assistance- several more	Caledon's Adult 55+Communiyt Network Group	2018	Community partners gather and discuss new programs for Adults 55+ in the Caledon Area. Agencies present new programs to the group. Agencies look to improve community navigation
Partners from Dufferin Area FHT	Focus/Priority Area	Length of partnership	Outcomes and Results
Dufferin Area FHT and Community Paramedics for Remote Patient Monitoring Program	Monitor patients with COPD, CHF and DM remotely to keep them safe at home and out of hospital	2 years	Have monitored approx. 40 patients over the two years

Dufferin Area FHT and FTP, CMHA, SHIP for DBT Program	Dialectical Behaviour Therapy (DBT) is a therapeutic, skills oriented, and mindfulness-based program designed to improve distress tolerance, emotion regulation, and interpersonal effectiveness through participation in individual and group therapy, as well as skills coaching. Target population are people with high suicidal ideation.	In year one of program	Baseline measures were gathered from each participant regarding their challenges with coping, regulating emotion, and self-harm/suicidal behaviour as well as the frequency of hospitalization, ER visits, or use of crisis services. This data will be gathered again in October 2019 and then in April 2020. However, the program has had a high engagement from the 10 participants, and many of them report reduced suicidal thoughts or behaviours and greater use of skills to deal with distress.
Dufferin Area FHT and Early ON Centre/Dufferin County in Orangeville for Starting Solids Program	For parents and/or caregivers with babies 0 – 12 months who are wanting to start their child on solids.	2 years, 4x per year	Approx. 80 participants over the two years
Dufferin Area FHT and Eramosa Physiotherapy for Walk for Wellness	Promote wellness by hosting a community walk at a local trail every Friday, rain or shine, from May to November. Led by Dufferin Area FHT providers and a Physiotherapist from Eramosa.	3 years	Average 14 people per walk, and a total of 40 people currently registered.
Dufferin Area FHT and Eramosa Physiotherapy for Osteofitness	To provide practical strategies to improve bone health for patients with osteoporosis and osteopenia, including an exercise component led be a physiotherapist.	3 years	Approx. 300 patients have attended this group in the past three years.
Dufferin Area FHT with Headwaters	An education and exercise program designed to help people with hip	In year two	306 patients seen in year one. Q1 in year 2 94 patients

Physiotherapy and Eramosa Physiotherapy for GLAD Program.	and knee osteoarthritis (OA) manage their symptoms of pain and loss of function.		seen. Most patients showed improvement on pain rating scale, 40 metre walk test and 30 second chair stand test.
Dufferin Area FHT and Alzheimer Society for Memory Clinic	Provide a comprehensive and multidisciplinary assessment of patients and their caregivers to aid in the diagnosis of cognitive impairment. Support patients and caregivers by developing individualized community care plans.	7 years	See approx. 80 to 90 patients per year. Currently exceeding the following target outcomes: 1) Of those pts referred to MC that drive, % of patients who are assessed for driving capability 2) % of patients who are linked to community resources 3) % of pts/caregivers provided with a written MC patient plan 4) % of pts seen in memory clinic screened for malnutrition
Dufferin Area FHT and Zehrs Grocery Store for Treasure Your Bones Program	This program assists patients to slowly make changes towards healthy eating and regular activity as well as improving their relationship with food. They set goals and make plans towards change for better health, including a dietitian guided tour at Zehrs to assist with healthy shopping food choices.	5 years	Approx. 60 patients last year.
Partners from **DCAFS**	**Focus/Priority Area**	**Length of partnership**	**Outcomes and Results**
Family Transition Place	Sexual Assault Treatment Program; VAW/CAS Collaborative Agreement; North Dufferin Service Partnership; Joint Program Delivery (eg –	DCAFS was involved in the development of FTP at the time it incorporated. Our	• increased awareness/attention to the impact of domestic violence on the well-being of

	Caring Dads); much more over the years.	partnership goes back to a time prior to FTP's incorporation.	children and family system • streamlined parental support (for both moms and dads) • new opportunities for easier access to service for those in north Dufferin • a cohesive and easy to navigate response to sexual assault across age spans in Dufferin/ shared clinical pathways
Headwaters Health Care Centre	Mental Health Crisis Response & Assessment for patients 0-18; Sexual Assault Treatment Program; Healthlinks; Long-Term Care and Seniors Planning; OHT proposal submission; much more over the years.	Formalized relationships around crisis assessment and sexual assault have been in existence for approximately 20 years.	• Crisis assessments are completed by the agency that provides follow up for mental health services for children and youth, 0-18; reducing # of times families have to re-tell their story and increasing consistency of service delivery/shared clinical pathways • a cohesive and easy to navigate response to sexual assault across age spans in Dufferin/ shared clinical pathways • increased number of those with developmental disabilities and complex children/youth being served through healthlinks • sustainable supported living plans in partnership with long term care for the older

			people we serve who have developmental disabilities
Local Police Services	Joint responses to calls related to child protection; mental health; vulnerable people on an as needed basis. Formalized protocols regarding joint investigations.	Partnerships dating back beyond 1978. Formalized partnerships are reviewed periodically.	• Streamlined service delivery
WDG Public Health	Data sharing for population health based information and community planning; post-partum support group;	Partnerships dating back beyond 1985; post-partum group running for approximately 17 years	• Population based health data • Increased support and safety for family's impacted by post-partum depression
County of Dufferin	Shared leadership for local children's planning table; formal service delivery agreement regarding special needs resourcing;	Historically our agency received municipal funding and there was a requirement for a municipal rep on our board. We have been co-leading the children's planning table since 2009 and became the service delivery agent for special needs resourcing in 2018.	• Population based health data is used to formulate community action plans related to the well-being and development of young people in Dufferin – this has resulted in education campaigns; community well-being report cards; etc. • Improve service pathways for children with additional/complex needs
Central West LHIN	MFTD respite day program process partners; significant work together through special needs strategy, particularly related to Coordinated Service Planning.	MFTD participants are approved through the LHIN – program has been running for approximately18 years.	• Shared clinical pathways and shared systems response

		Special Needs Strategy work began in 2014.	
Partners from **Dufferin Oaks**	**Focus/Priority Area**	**Length of partnership**	**Outcomes and Results**
Directors of LTC, Facilities and Retirement Homes and Community Partners: Headwaters Healthcare WDG Public Health Alzheimer's Society CW LHIN – BSO and Home and Community Care Paramedic Services CMHA Peel	Enhancing the Continuum of care across the region amongst service partners	15+ Years	Enhanced communication amongst all partners Paramedical support for IV in LTC facilities to decrease number of transfers to hospital
Palliative Care Collaborative Hospice Dufferin Bethel House Physicians LHIN	Improve the patient experience across the region Developing a seamless collaboration of care for those seeking palliative care	Recent	
Dufferin County Community Support Services partnerships:			
Aging Well in Dufferin	Collaboration	Last 10 years	Enhanced communication amongst partners

March of Dimes Canada – Bathing Program	Collaboration	Last 10 years	Cross programming supports, ADP-Bathing, ADP-Assisted Living Supports
SHIP and March of Dimes for Assisted Living Programming	Collaboration		
Lord Dufferin Centre	Collaboration	10 years	Meals on Wheels and Bridging you Home Program
Dufferin Oaks	Collaboration	10 years	Meals on Wheels and Congregate Dining Program
CMHA Peel	Collaboration	4 years	Seniors At Risk Service Coordination
CWLHIN Sub-region Collaborative	Collaboration	2-3 years	Enhanced communication amongst community service providers
DC Moves	Its mandate is to update the participating members and community on initiatives focused under three priority		

	pillars – Community Wellbeing, Poverty Reduction (re constituted in Dec 2019 as the Dufferin County Equity Collaborative – DCEC) and Resource Sharing.		
Partners from **Family Transition Place**	Focus/Priority Area	Length of partnership	Outcomes and Results
Headwaters Health Care/DCAFS/FTP	Sexual Assault	20+ years	Victims and survivors of sexual assault receive medical treatment, including the possibility of a rape kit being completed, plus support of a social worker, at Headwaters; children and youth receive counselling support from a DCAFS staff clinician, women and men who have experienced sexual assault receive counselling support from FTP clinical counsellors. In 2018/2019 FTP saw 145 unique individuals, with 1039 sessions. (can headwaters include the metrics for the full partnership as we only have our own.)
SHIP/FTP	Supportive housing	5+ years	7 apartment units are held by SHIP in Orangeville for FTP clients who have experienced trauma due to abuse concurrently with

			moderate to severe mental health issues. Clients are supported for trauma while in housing by FTP staff, and housing is supported by SHIP staff. In 18/19 54 women were supported with 446 sessions. 7 women were housed in the units and the remainder of the number were supported through community drop ins and supports to enable them to find and retain housing.
FTP/DCAFS/North Dufferin Wellness Clinic	Support and counselling	New – starting September	Counselling and support from DCAFS and FTP will be offered in conjunction with NDWC's walk in clinic
FTP/SHIP	OTN psychiatry/medical/counselling	5 years	FTP partners with SHIP to host an OTN unit on site. In 17/18, 121 events were logged, in 18/19 there were 89 OTN events logged, 72 of which were clinical
Partners from **Hospice Dufferin**	Focus/Priority Area	Length of partnership	Outcomes and Results
Alzheimer Society of Dufferin/Hospice Dufferin	Palliative		Hospice Dufferin volunteers are trained and prepared to provide appropriate service to clients living with Alzheimer's

			disease and other dementias. Trained Hospice Dufferin volunteers are prepared to work with clients/caregivers referred by Alzheimer's society.
Dufferin Oaks/ Alzheimer Society/ Hospice Dufferin	Palliative	January 2019	The three agencies hold a monthly caregiver group
Bethell Hospice/ Hospice Dufferin	Palliative	May 2015	The three agencies share two Spiritual care coordinators across the LHIN geographic area.
Headwaters Hospital/ Hospice Dufferin Hospice Dufferin/ Avalon LTC	Palliative	1984 to present.	Hospice Dufferin provides palliative care social worker and volunteers to patients/residents.
Partners (From SHIP)	**Focus/Priority Area**	**Length of partnership**	**Outcomes and Results**
CMHA, PCHS ***Type of Partnership:*** Early Intervention	Mental Health & Addictions	July 2011 to present	• ER Visits and psychiatric hospitalizations reduced • Provide Early intervention and case management support to 15-20 clients annually • Provided Nursing support to all Dufferin EI clients when needed

FTP ***Type of Partnership:*** Supportive Housing		October 2014 to present	• Housing stability • Long term case management • Increased quality of life • SHIP provides 10 housing units and tenancy support and FTP provides the clinical support
County of Dufferin ***Type of Partnership:*** Edelbrock Clinic		December 2018 to present	• Complete immediate assessment and determine next steps based on results • Complete intake form and record all information into SHIPs Client Record Management System (CRMS) • Refer client to appropriate services as needed • Assist client with the completion of application forms for other community services
County of Dufferin ***Type of Partnership:*** Housing First		October 2014 to present	• Work with housing first clients to secure choice based housing. • Provide intensive case management. • Developed appropriate linkages, crisis plans and referrals within this community. • Met with existing and new landlords to acquire additional housing stock.
Dufferin Area FHT ***Type of Partnership:*** DBT		January 2019 to present	The goal is to collaborate in the development, implementation, and resourcing of a Dufferin DBT Program as an evidence-based approach to treating individuals struggling with complex needs, chronic Distress, and safety concerns – especially suicidality and self-harm.

Dufferin Situation Table ***Type of Partnership:*** Committee Member			
County of Dufferin, CMHA, FTP ***Type of Partnership:*** Housing Stabilization	Mental Health & Addictions	3 months (Jan–March 2019)	• Increase service access • Improve client journey • Improved health and social outcomes • Decreased crisis resulting in fewer police calls • Reduced visits to the ER department and re-hospitalizations • Identification of Health Links clients and the creation of Coordinated Care Plans
CWLHIN ***Type of Partnership:*** CCP in HPG and Health Links		Ongoing	• Care coordination and transitions
Headwaters ***Type of Partnership:*** In-STED		July 2014 to present	• Reduced multiple emergency department visits. • Addresses a person's most critical needs and links them to services. • supports connections to community-based resources upon ED discharge
A variety of Dufferin Service providers ***Type of Partnership:*** Poverty Reduction		February 2017	• Develop a "Global Financial Flex Fund" that assists and supports homeless individuals located within Dufferin County. • Provided opportunity for individuals that are faced with socioeconomic barriers that prevent them from sustaining core

			principals within the social determinants of health (housing, employment, education, food security, etc.)
Georgian College, County of Dufferin, CMHA ***Type of Partnership:*** SPE		April 2016 to present	• flexible job opportunities for economic independence • employment support and coaching • linkages to employment opportunities
A variety of Dufferin Service providers ***Type of Partnership:*** Safe Bed (Brampton location)		2010 to present	• provide crisis stabilization • provide short term accommodation (14 days) • Dufferin partner provides transportation costs to location
Type of Partnership: Telemedicine Sub Region Work ***Type of Partnership:*** Committee Member	Palliative Care		• SHIP Dufferin staff and the Dufferin community have access to Telemedicine at 30 Centre Street. All Dufferin staff have been registered with PCVC SHIP has participated at the sub region tables. Heart House Hospice facilitated 5 End of Life sessions that were attended by SHIP including 1 Dufferin staff
Home and Community Care ***Type of Partnership:*** MH Consult	Home Care	2015 to present	• supports Care Coordinators in connecting individuals on homecare service who are identified as Health Links and presenting with mental health concerns to appropriate community resources and services

Dufferin Community Services Type of partnership: Assisted Living	Health Equity	2014 to present	• Reduce the volume of visits made by seniors to the ERs by providing supportive in-home interventions • Provide case management services in-home that directs seniors to primary care providers and specialized services e.g. mental health, versus ER, reducing ER use • Provide seniors in hospital with further community capacity to assist them to remain independent, avoiding use of ALC beds, promoting earlier discharge from ALC beds and preventing inappropriate admission to LTC
DCEC ***Type of Partnership:*** Committee Member			• The Health Equity committee at SHIP has facilitated the Health Equity Impact Assessment tool with the Dufferin teams and is looking to implement some of the recommendations.
	Primary Care		

Team/Table (From **Dufferin Community Services**)	Partners	Focus/Priority Area	Length of partnership	Outcomes and Results
Dufferin Coalition for Kids (DuCK)	AYSP Autism Ontario Big Brothers Big Sisters of Dufferin and District Choices Youth Shelter	Dufferin Coalition for Kids is the designated Ministry of Education and Ministry of Children and Youth Services planning table for service planning for children ages	DuCK was developed from a committee of Dufferin County health and social service providers for families that originated in	Evidence informed planning: • Communication/awareness initiatives • Mental Health, Substance Misuse, and Addiction Prevention (MHSMAP) research and tools for school • Parental Supports and Developmental Awareness (PSDA) provide organizations across

	Community Care Access Centre Community Living Dufferin Conseil scolaire Viamonde The Corporation of the County of Dufferin Dufferin Child & Family Services Dufferin Parent Support Network Dufferin Peel Catholic District School Board ErinoakKids Family Transition Place Kerry's Place Autism Services Ministry of Children and Youth Services Ministry of Education Orangeville Public Library Town of Orangeville Upper Grand District School Board Wellington-Dufferin-Guelph Public Health	0-18 in Dufferin County. DuCK is comprised of 20 different local and provincial organizations that support children and their families, and has two Action Groups and a Communications Committee. DuCK promotes collaboration and relationship building among community partners and ensures that the work of the Action Groups and Committee is aligned with provincial and local strategies. Duck is co-chaired by the Manager of Children's Services at the County and the Executive Director of Dufferin Child and Family Services.	1986 as the Dufferin Child Care Committee.	Dufferin County with consistent, evidence-based parenting messages to share with their clients
Community Advisory Board (CAB)	Orangeville Food Bank	To facilitate communication among service	Community Advisory Board has	"Reaching Home" is a community-based program aimed at preventing and reducing homelessness. It

	White Owl Native Ancestry Community Living Dufferin Centre for Career & Employment Services, Georgian College CHOICES Youth Shelter Family Transition Place Salvation Army High Country United Church CMHA Services & Housing In the Province County of Dufferin Canada Mortgage and Housing Corporation (CMHC) Service Canada	agencies and to award funding to prevent/eliminate homelessness.	been in place in Dufferin since around 2008. (Federal funded program that changes parameters every few years.)	provides direct funding to support efforts in developing local solutions to homelessness. Currently - Funds Housing First Support Coordinator position that carry case load of most vulnerable people in housing crisis.
DCEC	Alzheimer Society of Dufferin County Bethell Hospice Foundation Canadian Mental Health Association (CMHA) Peel-Dufferin Catholic Family Services Peel-Dufferin Choices Youth Shelter	3 main areas of focus: Housing and Homelessness, Employment and Health Equity	December 2018	Housing: Investigate collaborative solutions for mixed housing with mixed living/sharing arrangements for different client groups, recognizing that it may involve zoning, joint planning, pooling dollars, building business cases and seeking grants (i.e. Golden Girls, etc.) • Golden Girls presentation to sub-group on June 6th • Creation of a list of considerations to be submitted to the consultant WSP for the Official Plan

	Community Torchlight Dufferin Area Family Health Team Dufferin Child & Family Services Dufferin County Community Services Family Transition Place Friends & Advocates Peel Georgian College Habitat for Humanity Headwaters Health Care Centre Homewood Health Centre Hospice Dufferin Humber College Central West Local Health Integration Network (LHIN) Ontario Telemedicine Network Orangeville Food Bank Orangeville Police Services Services and Housing in the Province (SHIP)			update as part of the Municipal Comprehensive Review • Brainstorming of potential future actions and areas where further investigation is needed Employment: Connect with Workforce Planning Board Waterloo Wellington Dufferin and local Economic Development officers on groundwork and research what others are doing including Dufferin Board of Trade, the Peel Halton Workforce Development Group, Ec Dev Steering Committee, etc. • Held two data sharing meetings connecting with work being done by WWD WFP, DC ECDEV, DBOT, SBEC. Validated and updated understanding about our Employment challenges and needs • Created awareness across the group about projects and activities in progress regarding Employment and opportunities to leverage each other's work to improve outcomes for employees and employers • Able to build on WFP Committee Dufferin work, updating the plans previously drafted with new information, preparing for moving forward with strategies and actions Health Equity - Develop and deliver health equity training(s) - To build capacity and raise awareness of local health equity issues • Health Equity workshops scheduled:

	United Way Guelph Wellington Dufferin Upper Grand District School Board Wellington-Dufferin-Guelph Public Health Workforce Planning Board of Waterloo Wellington Dufferin			Treating Patients with C.A.R.E. and the Empathy Effect-June 4 Bridges Out of Poverty –September 16 GW Task Force to Eliminate Poverty with Community Members speaking to lived experience-Fall 2019 CW LHIN & William Osler Health System -Fall 2019 • Communication: Developme nt of Health Equity messages • Promotion/informing: Developed and implementation of social media accounts, Join-In and updated website
DC MOVES	Leadership Table (There is a mailing list rather than a list of 'members. Too large to put here.) Headwaters Communities in Action (HCIA) Georgian College Orangeville Campus and Centre for Career & Employment Community Services Community Services, County of Dufferin Wellington-Dufferin-Guelph Public Health Unit	To increase collaboration between, and integration of, social service delivery and social service providers operating in Dufferin County. three priority pillars – Community Wellbeing, Poverty Reduction (now DCEC) and Resource Sharing.	2016	Information sharing through electronic newsletters (What's On The Moves) Forums for in person networking and info sharing. Of note community wellbeing is in part addressed by health equity at DCEC, as well as 'equity/poverty'.