Ontario Health Team: Full Application

Introduction

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

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

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

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

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

OHT Implementation & COVID-19

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

Information to Support the Application Completion

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

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

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

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

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

Participation in Central Program Evaluation

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

Submission and Approval Timelines

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

[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.

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

Additional Notes

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

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Veronica Nelson
	Title: Vice President & Chief Operating Officer
	Organization: Ross Memorial Hospital
	Email: vnelson@rmh.org
	Phone: 705-328-6086 or mobile 705-879-9632
Contact for central program evaluation	Name: Veronica Nelson
	Title: Vice President & Chief Operating Officer

Please indicate an individual who the Central Program Evaluation team can contact for follow up	Organization: Ross Memorial Hospital
	Email: vnelson@rmh.org
	Phone: 705-328-6086 or mobile 705-879-9632

1. About Your Population

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

1.1. Who will you be accountable for at maturity?

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

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

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(500/500)
City of Kawartha Lakes (CKL) covers 3,067 square km and a population of approximately 80,000 residents. The 2016 Census reported for the first time that seniors outnumber children in Canada. This is prevalent in CKL where seniors 65+ (28.7%) outnumber children <18 (15.3%) (Attributed Population data) notwithstanding the steady population growth.
Patients served in CKL come from a range of socio-economic backgrounds, with a lower-than average median household income and a high unemployment rate (9% CKL versus 5.6% Ontario – Statistics Canada).
Population also has a higher-than-average prevalence of chronic disease, e.g. diabetes, joint disorders, upper respiratory conditions, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) (Attributed Population data). Dementia is the highest-cost clinical condition for the population, and CKL has a high volume of patients with dementia compared with the provincial average.
20% of the network does not have a primary care provider and of the 80% that does, access may be limited for various reasons including the primary care provider being located outside of CKL. CKL has almost double the number of CTAS 4/5 ED visits for

[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.

its enrolled population. Approximately 34% of patient population in acute care is designated as requiring Alternate Level of Care (ALC) at any time.
At full maturity (some years ahead), KL-OHT will be accountable for all residents of our region. Our vision at maturity is to establish connected local care including preventative care, primary care, acute, chronic, LTC and convalescent care that encompasses mental health and support services. Care will be designed and developed to address social determinants of health, individualized health needs and more vulnerable members of our population.
Social determinants of health affecting our population include poverty, homelessness, access to public transportation and access to coordinated care. These factors contribute to a higher-than-average population of frail, complex, elderly patients and a high volume of patients requiring care for mental health and addictions.
Top conditions for members of our attributed population sought care reflect the demographic profile of our catchment area in which seniors represent more than 28% of the population. The number one reason individual's accessed care was Pain/Sprain/Strain followed by Acute ENT conditions, digestive and hepatobiliary issues and diabetes. Our partners include primary care teams, long term and transition care, home and community care (LHIN, Public Health), community support / mental health agencies, and paramedicine; all key contributors to comprehensive care for our population.
Since the Progress Report:
- Lead Members have signed the Interim KL-OHT Agreement; Partnership, Data Sharing and Fund Holder & Indemnity Agreement; committed to the Collaborative Decision Making Model.
- Engaged additional community members who have signed Partnership and Data Sharing Agreements.
- Collaborated on the COVID-19 Assessment Centre and Mobile Unit.
- Launched the KL-OHT brand, website and email address including developing plans for COVID-19 friendly engagement sessions aligned to our communications and community engagement plans.
- Developed Community Engagement Plan and initiated a joint Patient Family & Advisory Council.
- Completed Digital Inventory including co-locating all patient access/portals onto the KL-OHT website.

1.2. Who will you focus on in Year 1?

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

Please describe the proposed population that your team would focus on in Year 1 and

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

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

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433/500

The KL-OHT will initially focus on individuals aged 65 years or more who have multiple co-morbidities; have experienced repeated hospitalizations, and/or have a poor or absent social support network. This population is most at risk of missing services or falling through system gaps.

The data provided further validated our selected Yr1 population focus. The data provided greater insight into the need to reinvent navigation services to more consistently and reliably connect seniors to the continuum of acute care and community support services. The top 3 most costly Health Profile Groups (HPG) are Dementia with significant comorbidities ($31.6M), Acute Palliative ($28.9M) and Heart Failure with significant comorbidities ($10M). These further validate Yr1 population choice. As we work on improving care, we aim to reduce costs, thus freeing up resources enabling care for more people. In all 3 HPGs, the majority of care is in the KL-OHT region, 74%, 60% and 55% respectively.

With regard to social determinants of health, the population of CKL experiences insecure housing, poverty, employment challenges and food security as well as challenges with mental health and addictions. This has been further exacerbated by the COVID pandemic.

We have convened the Navigation Working Group whose members include front-line employees for whom navigation is part of their role, along with client and system stakeholders. The group has identified three key objectives:

1. Develop a new model of health system navigation for the OHT Year One target population
2. Pilot test and evaluate outcomes for the new system including satisfaction of providers and users
3. Contribute to the development and implementation of the OHT as indicated/requested.

The Navigation Working Group will lead a project to design, pilot test and then scale up a new navigation process with the goals of better serving the needs of clients, patients and caregivers through enhanced integration of service, greater consistency in the navigation process and more seamless transitions primary care, acute care and community care.

Our client stakeholders will validate our care providers' mechanisms and processes. Navigation is one barrier to equitable care. Siloed / territorial funding is also complicating the delivery of efficient care. Building on our experience with the existing shared funding envelopes, the OHT offers the potential to leverage a single funding envelope across HSPs to benefits clients and patients. For example, there are only a handful of such arrangements currently e.g. Home First, shared coordination resources, etc.
We heard from our advisory groups that another barrier to care is access to local services such as primary care (i.e. long waiting lists), residential hospice beds and availability of care for other agencies (i.e. housing).

1.3. Are there specific equity considerations within your population?

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

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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

(538/1000)
In March 2019, the CELHIN supported the completion of a report from the Trent University Homelessness Research Collective into homelessness, housing vulnerability and health care across the City of Kawartha Lakes (CKL) and Haliburton County. The report identified many recommendations to improve health equity (social inclusion, housing, parenting, support services, income and transportation); primary care (chronic conditions and sources/access); and acute care (providing care and considering addictions). The KL-OHT will endeavour to address the key findings and recommendations.
There are no First Nations bands within Kawartha Lakes although there are Indigenous peoples living in the community. Data from the 2016 Census based on the question "Do you identify as a member of the aboriginal community?" identified 2,005 residents or 2.66% of CKL residents who identify as Indigenous.
We have practitioners within our OHT that can provide culturally and linguistically

[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.

appropriate services to patients and clients eg. French speaking family physician, Nurse Practitioner and other care staff and employees who identify as Indigenous care workers.
The COVID-19 outbreak illuminated existing health inequities and reinforced the importance of providing easily accessible, clear, and accurate information to help protect residents. In recognition of the potential for language barriers to hamper these initiatives, data on race, income, language, and household size is now collected for individuals who have tested positive for COVID-19. Data collected will help guide decisions and ensure a complete picture of the impacts of COVID-19, thus enabling Health Service Providers (HSPs) to address inequities caused by language barriers.
Other equity considerations for our OHT include variances in access to care due to rural geography and location of services predominantly in more populated communities. For example, in order to address this inequity related to COVID testing, we implemented mobile testing services for in-home testing.
An overview of the social determinants of health, for both the general and Francophone populations of the KL- OHT demonstrates similar health care needs. The KL-OHT does not include any of the 26 designated areas in Ontario where French-speaking individuals constitute more than 10% of the population. According to the 2016 Census and based on the Inclusive Definition of Francophone (IDF), the CKL is home to only 980 Francophones, representing 1.32% of the net population. Information shared by Entite4 notes that 99% of the Francophone population in the CKL do not identify as visible minorities. In terms of age ranges, 18% of the Francophone population in CKL is between the ages of 0 to 18; 56% are between the ages of 19 and 64 and 15% are 65 to 74 years of age. We know that Francophones benefit from receiving health care services in French in many ways. For instance, there is increased medication compliance, improved outcomes and higher patient and provider satisfaction when services are provided in French. The KL-OHT will provide both in-person and virtual translation services at the point of care and will continue to collaborate with Entite 4 and our HSPs to meet the needs of our Francophone population.
Information shared in this section is based on data for LHIN Sub-Regions as this data is recognized by the Ministry of Health as an acceptable proxy for specific minority populations within the population served by groups seeking to become an Ontario Health Team.

2. About Your Team

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

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

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

relationships with their Local Health Integration Networks (LHINs) to support capacity-building and the transition of critical home and community care services.

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

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

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

2.2. Confirming Partnership Requirements

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

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

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

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

Describe how existing partnerships and experiences working together can be leveraged to prepare for a potential second wave of the COVID-19 virus, and to deliver better-

integrated care to your patient population more broadly within Year 1. In your response, please identify which members of your team have long-standing working relationships, and which relationships are more recent.

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The members of the KL-OHT have a long history of working together to advance integrated care and population health. Examples of shared endeavours include:

- An innovative arrangement between Ross Memorial Hospital and Extendicare in which a specified number of Extendicare's LTC beds are reserved for RMH patients designated as ALC LTC. This arrangement freed up acute care beds, thereby reducing hallway medicine and facilitating access and flow.
- Home and Community Care (CELHIN), the Kawartha North Family Health Team, Ross Memorial Hospital and CCCKL's Community Health Centre have collaborated to enhance system navigation for clients by sharing staff across settings including care coordinators, PCCT navigators and the BSO RN to enable more seamless integration of care and services to vulnerable seniors and their caregivers.
- To facilitate access to COVID-19 testing, CKL's Paramedic Services teamed up with HSPs including Ross Memorial Hospital and CCCKL to provide COVID tests in the homes of clients and in long term care facilities. This mobile service meant individuals did not have to find transportation and venture out of their homes/residences to be tested.
- A pilot community paramedicine (CP) program funded by the municipality until December 31, 2020 whereby paramedics are performing home visits to support high risk patients for readmission. CP conducts pro-active, scheduled home visits and wellness assessments to high need patients following discharge until such time that the patient regains their ability to safely and independently remain at home or until community supports are accessed and in place. Since program inception in September of 2019 the program has demonstrated an impact on the following:

•Linking patients with community supports
•Reduce 911 calls
•Reduce number of emergency department re-visits
•Reduce the number of hospital re-admissions
•Reduce the number of alternate level of care (ALC) days
•Improve patient satisfaction
•Improve patient outcomes by decreasing risk associated with falls, medication compliance and nutrition
•Decrease social isolation

- During the pandemic, a region-wide Infection Prevention and Control table was hosted by Ross Memorial Hospital that was attended by Public Health, Paramedic Services, Family Health Teams, CCCKL and other HSPs. This mechanism facilitated up to date and shared understanding of trends, issues and approaches to manage the pandemic.

- On June 11, 2020 the City of Kawartha Lakes (municipal government) convened a virtual COVID-19 Town Hall with invited representatives from Ross Memorial Hospital, Paramedic Services, CCCKL, Kawartha Lakes Family Health Team, and HPKR Public Health District. Provided on the Zoom platform, the town hall informed residents about the status of the pandemic, promoted best practices in infection prevention and control for COVID-19 and demonstrated an integrated approach to COVID-19 management in CKL.
- Throughout the pandemic HSPs in CKL shared PPE supplies as able, with Ross Memorial Hospital taking the lead in generously providing supplies including gowns, N-95 masks and other items to Paramedic Services, CCCKL and others as needed.
- Items needed by Ross Memorial Hospital to equip its inaugural COVID-19 testing centre were contributed by CCCKL and other HSPs. Additionally the City of Kawartha Lakes (municipal government) provided the drive-thru space for the inaugural centre on its Fair Grounds.
- Regular collaboration amongst HSPs in CKL is evident in other ways. For example, members of the Ross Memorial Hospital senior leadership team serve on CCCKL's Board of Directors and Quality Management Committee. Ross Memorial has included numerous local HSPs in its current master planning process. HSPs regularly attend each other's Annual General Meetings; support fundraising initiatives and meet together to share information and trends. They also provide meeting space when feasible, for example the inaugural KL-OHT planning meeting was hosted by the Kawartha Lakes Family Health Team.
- COVID-19 testing services will continue to be pivotal in monitoring ongoing infection rates and flagging a second wave. Ross Memorial Hospital has involved KL-OHT leads in discussing ongoing sustainability for the testing centre and there is openness to contributing resources as needed.
- Involvement of many of the OHT partners in the CELHIN sub-region planning table and were involved in the Trent University Homelessness research.
- Some OHT partners attend monthly Situation Table meetings which provide an integrated approach to reduce crime, emergency room visits and calls for service by addressing the needs of individuals and families at risk.
- CCCKL Hospice service provides volunteers to the RMH palliative care unit to support clients 365 days of the year.
- Collaborative program delivery eg. specialized transportation program to support regular patient transfers enabled by hospital provided pagers carried by CCCKL drivers. This program facilitates bed flow and reduces hallway healthcare. This vital service continued throughout the COVID pandemic.

These long-established relationships provide a solid foundation to further evolve and enhance integrated care for our year-one population, and ultimately for all CKL residents. Shared understanding of the range of health services and population health needs has been established and there is a mutual commitment to KL-OHT goals and priorities. For example, it is envisioned that individuals employed by different HSPs in

roles encompassing navigation will come together to re-design navigation with the aim of achieving more seamless integration of services along with warm hand-offs. There is also a strong platform to expand shared initiatives including joint procurement; back office functions and shared positions. There is enthusiasm amongst KL-OHT partners to explore these possibilities in pursuit of quadruple aim outcomes.

3.0. Leveraging Lessons Learned from COVID-19

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

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

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The COVID-19 Virtual Assessment Centre (AC) through collaborative partnerships provided an opportunity to offer an effective public testing strategy for our community. The hospital-led program included key partnerships with: (a) EMS who provided mobile service for in-home testing for house restricted patients, (b) LTC, Retirement Home & Congregate Care Settings for IPAC and environmental services support, surveillance and outbreak testing; (c) Lindsay Exhibition who provided the physical infrastructure to house the drive-thru centre; (d) primary care who provided on-site physician assessments; (e) Public Health who provided the ongoing supply of swabs and initial resulting; and (f) Kingston Regional Lab for 24-36 hour testing turnaround times. The AC has been a successful program in diverting ED and primary care visits for patients that are both symptomatic and asymptomatic.
The Testing & Assessment Centre will continue into the fall and as needed. The KL-OHT partners are working on a sustainable model as one of the early initiatives. Partnerships as noted above will continue to expand including relocating inside a location, use an appointment-based model and a shared staffing model which includes primary care and virtual care.
During the pandemic, many organizations adapted to providing care in a pandemic situation.
For example the FHTs implemented screening for the limited face-to-face visits and virtual care. During the COVID-19 check-in, patients were asked:
1. Do you have family, friends or neighbours that are keeping in contact with you? If no, encouraged to call us with questions, etc.
2. Have you had any symptoms? If yes, appropriate course of action was provided.

3. Do you feel like you have all of the information you need about the coronavirus? Give examples and provide information where needed (social distancing, hand and coughing hygiene…)
4. Provide ways to find additional information
5. Provide numbers for Telehealth, Health Unit and assessment centre.

CCCKL implemented new approaches to care delivery. For example, new programs were created for adult day clients when in-person were services stopped due to the COVID-19 pandemic. These included grocery and medicine deliveries, in-home caregiver relief, virtual groups.
H&CC evolved provision of the chronic disease self-management program by shifting to virtual delivery platform.
Primary care providers evolved from face-to-face to virtual visits by an increase of 60% (OCFP data). Many now will continue with blended delivery models. In addition, many services within the KL-OHT partners moved to virtual care models in some capacity. For example, the diabetes, cardiac rehab, COPD and mental health clinics leveraging existing OTN infrastructure.
We have heard from patients/clients that virtual care is convenient and efficient.

4.0. How will you transform care?

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

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

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

- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Potentially avoidable emergency department visits for long-term care residents

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

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

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

Performance Measures	Purpose/Rationale	Method of Collection/Calculation
1.		
2.		
3.		
4.		
5.		

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

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

In the context of COVID-19, increasing the availability of digital health solutions, including virtual care, has been critical for maintaining the provision of essential health care services for patients, while respecting public health and safety guidelines to reduce transmission of the virus. Please describe how virtual care was implemented and used to support a response to COVID-19 and your plans to continue providing virtual care. Please also describe what digital health solutions and services are either currently in

place or planned for imminent implementation to support equitable access to health care services for your patient population and what your plans are to ensure that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery. Please demonstrate how the proposed plans are aligned and consistent with the directions outlined in the Digital Health Playbook. Responses should reference digital health solutions that both predate COVID-19 (where applicable) and any that have arisen as a result of the pandemic response[4].

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The Kawartha Lakes OHT (KLOHT) is well positioned to expand virtual care across the community as all of the KLOHT partners have risen to the challenges COVID has presented. Ross Memorial Hospital (RMH) has been leveraging Ontario Telemedicine Network (OTN) for over 10 years with a multi-room based system and a number of PCVC users. Other HSPs e.g. CCCKL have also dedicated staff and resources to OTN services. Other virtual tools are also in use including MS Teams, Webex and Zoom each of which enable patients and staff to conduct virtual encounters or support with administrative and collaborative needs. Areas for expansion include consults in mental health, ambulatory clinics, pre-surgical MSK education, disease education and home dialysis. RMH is adding devices for its EPIC implementation where Zoom is integrated to provide virtual consultations.

•Community Care City of Kawartha Lakes (CCCKL), the Kawartha Lakes Family Health Team (CKLFHT) and the North Kawartha Family Health Team (KNFHT) are providing virtual care through telephone visits and virtual platforms such as Webex and OTN. CCCKL also provides virtual care using "EMR Virtual Visit" embedded within the PS Suite Electronic Medical Record. All three organizations use provincial information sharing digital assets including Hospital Report Manager (HRM), Ontario Laboratory Information System (OLIS), Connecting Ontario and OLIS. Additionally, the three organizations as well as EPIC have the potential to enable patient portal capability through their EMRs.

•HCC has implemented a remote surgical monitoring program in partnership with Lakeridge Health (LH) for thoracic, orthopedic (same day total joint arthroplasty), gyne/onc. There is potential opportunity to expand to all CELHIN hospitals with surgical capacity. Also in the works is a COVID-19 remote monitoring program in partnership with LH and SHN with possible expansion to all CELHIN hospitals and public health units.

•HCC provides remote monitoring of patients with COPD and CHF. Patients receive an equipment kit (computer tablets, oximeters & scale). There are opportunities in both hospitals and community (primary care sites and CHCs) to increase referral volumes for this program which successfully reduces ED utilization and admissions by over 50%.

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

The CE LHIN is now holding Self-Management Program workshops for chronic disease management using Zoom. The CELHIN has Rapid Response Nurses using Vivify video for virtual visits. A Telewound Care program is being explored in its pilot phase using Swift Medical devices. HCC's provincial EMR, CHRIS can be integrated with EPIC to allow for electronic referrals and eNotification. A common landing space for information sharing for all partners is planned.

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Daniel Meraw
	Title: Integrated ICT Director
	Organization: Ross Memorial Hospital
	Email: dmeraw@rmh.org
	Phone: 705-328-6166 or mobile 705-826-6200

4.3. How will you address diverse population health needs?

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

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

4.3.1. How will you work with Indigenous populations?

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

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

If there is a First Nations community in your proposed population base, what evidence have you provided that the community has endorsed this proposal? If

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

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156/1000
KL-OHT lead members and partners are committed to providing culturally safe and appropriate care to all individuals. The number of Indigenous individuals in the Kawartha Lakes is less than 3% of the population and the area does not encompass a designated First Nations band. Over the past two years, several KL-OHT lead members and partners have taken the San'yas: Indigenous Cultural Safety Training program offered through the CELHIN to build capacity for providing culturally safe care. Policies in place amongst KL-OHT members to support for Indigenous patients include enabling smudging on-site. One of our OHT partners hosts Indigenous-led mental wellness counseling on-site. Although the Indigenous population is relatively small in our OHT region, we have resources and the ability to leverage existing resources to meet care needs appropriately. For example, we are in close proximity to the Curve Lake First Nation which provides consultation and support to OHT residents who have a cultural affiliation with them.

4.3.2. How will you work with Francophone populations?

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

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

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399/500
An overview of the social determinants of health, for both the general and Francophone populations of the KL- OHT demonstrates similar health care needs. The KL-OHT does not include any of the 26 designated areas in Ontario where

French-speaking individuals constitute more than 10% of the population. According to the 2016 Census and based on the Inclusive Definition of Francophone (IDF), the CKL is home to only 980 Francophones, representing 1.32% of the net population. Information shared by Entite4 notes that 99% of the Francophone population in the CKL do not identify as visible minorities. In terms of age ranges, 18% of the Francophone population in CKL is between the ages of 0 to 18; 56% are between the ages of 19 and 64 and 15% are 65 to 74 years of age. We know that Francophones benefit from receiving health care services in French in many ways. For instance, there is increased medication compliance, improved outcomes and higher patient and provider satisfaction when services are provided in French. The KL-OHT will provide both in-person and virtual translation services at the point of care and will continue to collaborate with Entite 4 and our HSPs to meet the needs of our Francophone population.

We will continue to collaborate with Entité 4 through community consultations, to ensure that we are engaging with the Francophone community.

The Kawartha Lakes OHT will seek to address issues specific to our Francophone patients, clients and their families. An important first step would be to clearly identify FLS capacity to better serve the Francophone community. We understand the importance of the availability of FLS to be actively offered, to be communicated clearly, visibly, readily accessible, and equivalent to the quality of services offered in English.

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

We have practitioners within our OHT that can provide culturally and linguistically appropriate services to patients and clients eg. French speaking family physician, Nurse Practitioner and other care staff and employees who identify as Indigenous care workers.

H&CC has language specific case load so care coordination can be provided in a preferred language. French speaking care coordinator in Lindsay branch.

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

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

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(433/500)
KL-OHT lead members and partners offer a diversity of health and community support services including specialty care in areas such as mental health and geriatrics. Our Year One OHT Population has been identified as those individuals 65 years of age and older who are frail, vulnerable, isolated and have had recurrent hospitalizations. Accordingly, individuals within our target population are likely to have health needs related to their socio-demographic factors and our objective is to wrap care and services around them in a more seamless, comprehensive and coordinated way. Sub-groups within our year one target population include individuals with mental health challenges, addictions, or dementias; and their caregivers/family members. We will leverage the expertise and experience of OHT lead members and partners to work with and support those groups through customized, client driven care plans, education, training, support and follow-up. These services will be expanded and modified on the basis of user feedback as the OHT matures.
COVID-19 has also highlighted the value of the diversity in partners around the OHT table. For example, throughout COVID-19 while many in-person services were not were available as needed, OHT partner members ensured that primary care visits could happen, meals were delivered to the community's most vulnerable, transportation continued to be provided to essential appointments like dialysis, and much more. The strengths of the partners around the table position the OHT well to ensure our year one priority population is well supported, while continuously working to enhance our working relationships and approach.
COVID-19 has highlighted the strain on caregivers. For example COVID-19 restrictions have revealed the increased strain on caregivers both for those caring at home and those who were attending their loved ones in a congregate setting. Accordingly, our OHT initiatives will include a focus on supporting caregivers.
The OHT remains aware and responsive to the needs of additional distinct populations such as LGBTQ, Mennonite and Amish community, those with mental health and addiction care needs. For example, Mennonite and Amish family still travel into care centre by horse and carriage. Recently, the relocation of dental services required installation of a hitching post to accommodate those families. LGBTQ population needs specific to our Year 1 population will also be accommodated. Our year 1 population encompasses those with dementia needs and our GAIN clinic has been set up to specifically support those individuals.
Our rural population faces unique challenges related to their urban counterparts including access to public transportation (eg. Only the city of Lindsay has a public bus service). Additionally, severe weather across rural terrain at times prevents care providers to access those requiring home care.

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

Describe how your team intends to deliver supports and coordinated care

to communities and settings in which social distancing and other infection prevention and control practices are a challenge.

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(253/500)
The team recognized that many of the vulnerable population in CKL are elderly and have no means of transportation to travel to the assessment centre. We established a mobile paramedic community testing service. The paramedic drives to any location in CKL to provide in home assessment and testing for COVID-19. Throughout the COVID-19 pandemic, CCCKL has continued to provide both specialized (wheelchair/stretcher) and volunteer transportation to clients travelling to and from the hospital or assessment centre.
The assessment centre will provide pop-up mobile assessment centres to remote communities in CKL.
The assessment centre will continue to support the shelters, homeless populations and congregate living facilities with assessments and mobile testing. The centre is able to set up pop-up and/or mobile testing to support schools as they reopen provincially.
The assessment centre will support LTC/RH with IPAC assessments, environmental cleaning services and/or coaching, and surveillance testing and auditing as required. The team will work with the facility to develop an action plan.
People that are identified during the assessment as high risk will be referred to primary care and Home and Community Care.
All mobile care providers will continue to have access to the appropriate PPE to ensure their safety. Screening is adaptable and can include provisions for flu or other testing.
We will explore opportunities to offer influenza vaccination to those attending the assessment centre. In past years mobile influenza clinics have been provided in locations such as supportive housing buildings and we will identify opportunities to expand mobile clinics to other settings.

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

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

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(675/1000)
The overall objectives for the community engagement process are:
- To provide information about how healthcare is currently provided within the community, including known gaps and opportunities, what the process of change involves, and the role that the community, patients, clients and families/caregivers will play in the realization of a more connected healthcare system.
- To create opportunities where residents can provide input into improving performance

across a range of outcomes linked to the 'Quadruple Aim': better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.

- To engage in dialogue that encourages thoughtful consideration of person and family/caregiver-centered care through a holistic, equitable and inclusive approach.

Methods of engagement

Community engagement is often most powerful when done in person, and every effort will be made to gather input from our Year 1 population, families/caregivers and service providers in face-to-face forums. However, given pandemic-related precautions, we are prepared to move our engagement tactics to virtual methods, and when face-to-face meeting is possible, to follow all Public Health guidance on safe gatherings. Virtual methods may include online surveys and video/teleconference meetings. For some groups (e.g., marginalized/vulnerable, Francophone or Indigenous populations, etc.), engagement will require specific outreach strategies that will be identified. The Engagement Working Group will conduct a regular review to determine if additional strategies are required.

We will partner with agencies such as the Alzheimer's Society to reach patients/families for engagement. The AS specifically has a large support group which is a large part of the year one target population.

Engagement Tactics

A Combined Patient Family Advisory Committee (PFAC) will meet throughout the community engagement process for the purpose of:

- Providing feedback and advice on a variety of items related to both the engagement process and the care transformation projects; and
- Bringing forward issues and concerns related to items under discussion on behalf of the community or the organization they represent

The patient/family advisors represent the voice of the patient and families/caregivers. Their experience, insights, expertise and perspectives are invaluable to improving care.

A Physician Advisory Committee (PAC) will be newly convened and meet throughout the community engagement process. The physician advisors represent the voice of the primary care providers. Their experience, insights, expertise and perspectives are invaluable to improving care and provider experience.

A Community Workshop will be held in 2021 (ideally in person, dependent on pandemic-limitations, and with safety precautions in place) for the purposes of outlining the process, the project and the community engagement, as well as gathering input from participants about their aspirations and concerns about connecting local care.

Focus Group Sessions in 10 local communities within the City of Kawartha Lakes, and one each with the PFAC and PAC to learn more about the challenges, opportunities and observations around their care experiences.

Public Information Sessions where the working groups will present their work, and preliminary approach for connecting local care. Feedback received will be considered by the working groups and committees in the development of the final models.

Online surveys or other digital tools will be used to gather feedback at key milestones throughout the process, giving those who may not be able to participate in any of the above scheduled events an opportunity to participate in the process.

Other engagement strategies will be utilized, such as experience-based co-design methods, in-depth interviews, or patient journey mapping, especially for marginalized patients who may not

have access to online or in-person methods of engagement.
We will conduct a thorough evaluation of engagement activities to identify areas for improvement. We will evaluate the following metrics:

- # of emails gathered to contact list
- # of attendees at each engagement session (adjusted for scale/community size)
- # of surveys completed
- Ensuring balance of groups represented (age, gender, marginalized populations)

We will survey patients/families at the end of year one to determine if care/services are meeting their expectations.
Success will include reduced complaints, increased #s of residents if desired accessing primary care through providers in CKL, reduced unattached patients if desired to local primary care providers and positive patient and provider experiences.

5.0. Implementation Planning

5.1. What is your implementation plan?

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

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

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(661/1000)
Based on the population health data provided, initiatives undertaken to serve our year one population will inform decisions regarding scaling up the projects, and applying lessons learned.
Initiatives:
1.Care Navigation: We will pilot test a redesigned navigation function geared to our year 1 population. The goal is to break down existing siloes across all care sectors including transitioning H&CC to the OHT. KPI #4, 5, 6, 7
2.Reduce Wait Time for Primary Care Providers: We will explore mechanisms to expand collaboration across our primary care provider groups in order to reduce wait times for those needing a primary care provider. KPI #1, 2
3.COVID-19 Assessment Centre: We will secure a sustainable location as the hub for COVID-19 testing and assessment and evolve the spokes in reaction to our community's pandemic needs. As COVID-19 testing methodologies rapidly evolve, we anticipate greater opportunity for all partners to play a role in ensuring testing and

assessment is accessible and reliable throughout our region. KPI #3
4.Community Paramedicine Program: We will identify sustainable funding and expand the reach of this innovative program which conducts pro-active, scheduled home visits and wellness assessments to high need patients following discharge until such time that the patient regains their ability to safely and independently remain at home or until community supports are accessed and in place. KPI #1, 2, 3
5.Patient Access to their Digital Health: We will expand the use of existing digital platforms to assist the public in navigating the health system to meet their needs. For example, implement patient portals of existing platforms as well as collect all resources in a single page of the KL-OHT website such as Connecting Care, Pockethealth, etc. KPI #1

1.Navigation
3 mos:
Complete research on navigation models e.g. Renfrew County's Virtual Triage and Assessment Centre.
Design the navigation model including identifying the first group of recipients to receive the redesigned navigation model
Develop the evaluation plan.
6 mos:
Implement the navigation model and evaluation plan
12 mos:
Evaluate the outcomes of the new model and recommend next steps.
Develop the plan to scale up the model

2.Reduce Wait Times for Primary Care Provider
3mos:
A network has been established inclusive of Health Care Connect representatives, primary care provider organizations & individuals newly attached to primary providers (client input)
One or more ideas are identified to reduce wait times for a primary provider
6 mos:
One or more ideas to reduce wait times for primary providers is implemented
12 mos:
Initiatives are evaluated including impact on wait times and satisfaction with the process from client and primary provider perspectives

3.COVID Centre
3 mos:
Assessment centre is successfully relocated to a sustainable location
A collaborative staffing model is designed and implemented
Explore opportunities to add influenza vaccination at testing site

6 mos:
Volume of testing meets demand
Staffing model is sustained
Testing methods are evolved in keeping with new techniques
Uptake of influenza vaccine is tracked
12 mos:
Potential for consolidation of procurement/purchasing such as PPE

4.Community Paramedicine Program:
3 mos:
secure permanent funding for ongoing program delivery
6 mos:
explore feasibility of expansion of team size and higher patient caseloads
12 mos:
evaluate outcomes and implement enhancements

5.Digital - Patient Portal Access
3 mos:
Research is completed to identify available patient portals
An inventory is developed of patient portals currently in place in OHT organizations
A common set of patient portal requirements is developed for the OHT
Barriers and enablers to expansion of patient portals are identified
6 mos:
A roadmap for patient portal implementation is established including outcome evaluation metrics
Additional patient portals are implemented
Patient/client teaching resources to support access and use of the portals are sourced and implemented
12 mos:
Outcomes associated with patient portals are measured and reported

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

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

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(111/1000)
•Project manager
•Experienced facilitator for community engagement - maybe from Change Foundation (to aid in patient co-design models, patient interviews and how to properly engage

people in our geography and demographic)
•Ability to deploy Home and Community Care resources including home nursing services
•Design and implement processes to collect system level data on community support services eg. Meals on wheels, adult day program, transportation to enable evaluation and benchmarking
•NP service delivery data collection is lacking
•A method to share data between provider sectors – platform to make HSP data visible
•Data and/or research to demonstrate the social determinants of our residents (eg. Scale up the Trent University research project on Homelessness)

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

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

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(344/1000)
•Lack of access to high-speed digital connections may impact virtual care delivery
•Labour relation issues (grievances, contracting out language) when organizations begin to implement initiatives - will there be work done on harmonization of salaries/employment terms?
•Guidance on transitioning LHIN (H&CC/CCAC) to the OHT
•General lack of public transportation in the rural environment continues to cause care delays or inability to access care. This includes challenges faced by care providers driving to patients' homes - in our rural area, this often presents as a barrier to patients receiving home care and so patients end up in the hospital as ALC LTC
•Guidance on reach out to visible minorities and other groups such as LGBTQ, Indigenous populations especially when these groups are small in the geography.
•Better understanding of how FHTs will fit into the OHT model in terms of their funding arrangements.
•Better understanding of how local public services (Public health, Long-term care and paramedicine) fit into the OHT model in terms of their funding arrangements
•The Connecting People to Home and Community Care Act, 2020, will significantly change home and community care for all. Virtual and digitally enabled care will allow Francophones to access bilingual health care professionals, which sometimes may be challenging at the local level. Connecting Francophone patients and clients to French-speaking providers reduces inequities in accessing care in French, one of the two official languages.
•The Connecting People to Home and Community Care Act, 2020 will empower Ontario Health Teams to coordinate and deliver home and community care services. Previously, oversight for home and community care services was provided almost exclusively by the 14 Local Health Integration Networks (LHINs) across the province.
•Receiving care in a patient's official language of choice is essential in building trust and comfort particularly for individuals obtaining care directly in their homes. When

providing care for seniors, the language of care is crucial. Often, as people age their ability to speak a second language deteriorates. Up until now, Francophones receiving home and community care services from the LHINs were guaranteed access to French language care.

Membership Approval

Please have every member of your team sign this application. For organizations, board chair sign-off is required. By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	Andy Letham
Position	Mayor
Organization (where applicable)	City of Kawartha Lakes
Signature	Andy Letham Andy Letham (Sep 12, 2020 12:06 EDT)
Date	Sep 12, 2020
Please repeat signature lines as necessary.	

Cathie Ritchie
City Clerk
City of Kawartha Lakes
Cathie Ritchie
Cathie Ritchie (Sep 14, 2020 08:12 EDT)
Sep 14, 2020

cody bowen
Lead Physician
CKL FHO
cody bowen
cody bowen (Sep 15, 2020 16:19 EDT)
Sep 15, 2020

Jacquelyn Choi
Dr Jacquelyn Choi
Asssociate lead CKL FHO
Jacquelyn Choi
Jacquelyn Choi (Sep 15, 2020 16:40 EDT)
Sep 15, 2020

Peter Anderson
FHO Board chair
CKL FHO
Peter Anderson (Sep 16, 2020 19:37 EDT)
Sep 16, 2020

Barbara Mildon
CEO
Community Care City of Kawartha Lakes
Barbara Mildon (Sep 17, 2020 08:23 EDT)
Sep 17, 2020

Linda Coles
CEO Board Chair
Community Care City of Kawartha Lakes
Sep 17, 2020

Jim armstrong
Board chair
Kawartha north family health team
Jim armstrong (Sep 17, 2020 12:45 EDT)
Sep 17, 2020

Marina Hodson
Executive Director
Kawartha North FHT
Sep 17, 2020

Wanda Percival
Chair
Ross Memorial Board of Governors
Wanda Percival
Wanda Percival (Sep 17, 2020 17:08 EDT)
Sep 17, 2020

Kelly Isfan
Kelly Isfan, President & CEO
Ross Memorial Hospital
Kelly Isfan (Sep 17, 2020 18:24 EDT)
Sep 17, 2020