Northwestern Ontario Integrated Care Working Group

June 28, 2021
2:00 – 4:00 PM EST (1:00 – 3:00 PM CST)
Webex details: CLICK HERE | Meeting # 173 687 8680 or dial: 647-484-1598

Meeting objectives:

1. Debrief on recent stakeholder engagement sessions and key takeaways
2. Confirm next steps based on stakeholder feedback
3. Obtain approval on Engagement Summary document (Attachment 3) for distribution to engagement session participants and posting on website

Agenda:

Timing	Item	Detail	Lead
2:00 – 2:05 PM	1. Welcome, objectives and approval of agenda	• Review and consider approval of agenda • Review and consider approval of previous meeting notes (May 10) [Attachment 1] • Reference 'key messages' document (May 10 meeting) [Attachment 2]	J. Christy/ J. Logozzo

2:05 – 2:45 PM	2. Stakeholder Feedback	• Debrief on engagement sessions [see Section 2.0 of Attachment 3]
		• Other engagement updates:
		  ○ Indigenous stakeholders
		  ○ MOH/Ontario Health/Ontario Health North
		  ○ Ontario Health – North East Engagement Session [Attachment 4]
		• Roundtable sharing of feedback from stakeholder networks and other engagement activities – hot spots? [Attachment 5]
			J. Logozzo & All

2:45 – 3:30 PM	3. A (proposed) Plan Forward!	[see Section 3.0 of Attachment 3]
		• Defining priorities – regional and local
		  ○ Patient Declaration of Values
		• Confirm work plan
		• Further engagement:
		  ○ July 20: Primary Care
		  ○ Indigenous engagement - confirm approach and Working Group Leads to champion
			J. Christy/ J. Logozzo

3:30 – 3:40 PM	4. Digital Health	• Update on regional digital work, including Health Information System renewal • Next steps for alignment to regional NWOIC work – as regional strategic enabler	C. Fedell
3:40 – 3:55 PM	5. Other	• Home and Community Care Legislation – feedback [Attachment 6] • OHT Impact Fellowship – update and next steps [Attachment 7] • Resources – Project Management, Facilitation, Clinical Leadership	J. Logozzo
3:55 – 4:00 PM	6. Wrap up and Next Steps	• Next meeting: September 13, 2021 • Upcoming webinars/resource ○ Webinar [Attachment 8]	J. Christy/ J. Logozzo

[A1]

Minutes: Northwestern Ontario Integrated Care Working Group

May 10, 2021 | 2:00 – 4:00 PM EST (1:00 – 3:00 PM CST)

Meeting objectives:

1. Discuss stakeholder feedback
2. Discuss updated Communications and Engagement Plan – specifically, content for stakeholder/community-level webinars
3. Discuss next steps

Attendees: Jessica Logozzo, Jack Christy, Adam Vinet, Alice Bellavance, Chantal Chartrand, Dan McCormick, David Newman Deb Hardy, Diane Walker, Henry Wall, Jorge VanSlyke, Juanita Lawson, Karen Lusignan, Lee Mesic, Marcia Scarrow, Nancy Chamberlain, Nathanial Izzo, Rhonda Crocker Ellacott, Shannon Cormier, Sue LeBeau, Tracy Buckler, Wayne Gates

Regrets: Bill Bradica, George Saarinen, Rob Kilgour

Agenda:

Lead	Item	Detail
J. Christy/ J. Logozzo	1. Welcome, objectives and approval of agenda	Jessica called the meeting to order at 2:02 PM EST. The agenda and previous minutes were approved as presented.
J. Logozzo & All	2. Stakeholder Feedback	Jessica asked Working Group members to provide updates on who they engaged and if there were any hot spots that arose. All feedback received to date continues to be supportive of the directions of the Working Group. Stakeholders look forward to more focused engagement. Further feedback is incorporated into the stakeholder matrix. Following each of our Working Group meetings, Jessica and Jack are meeting with David Newman and Ontario Health to review our work to date. Ontario Health has committed to attending all of the engagement sessions to hear feedback and questions, which is a good sign of partnership. Jack added they seemed a bit cautious of the number of people that would be attending and noted they are supportive of the direction we are taking.
J. Logozzo/ C. Chartrand/ K. Lusignan G. Saarinen	3. Communication and Engagement	Jessica provided an updated on Indigenous engagement explaining she has had a number of conversations over the last month with Dilico, Ontario Native Women's Association, Thunder Bay Indigenous Friendship Centre, Fort William First Nation, Mushkiki, Tikinagan and Sioux Lookout First Nation Health Authority. The purpose of this engagement to ensure we are building and fostering relationships with our First Nations partners. At each of the meetings systemic racism has been raised, this needs to be addressed before discussion process or integration. Based on previous engagements there is opportunity to do things better. Other opportunities that have come up are around transportation, expanding Indigenous navigators, which we may want to look into in the future. Jessica briefed the group on the work the Communications and Engagement Sub-Group has completed and highlighted the invite and details they worked out for the upcoming engagement sessions. The first portion of the sessions will be recorded and posted to the NWOIC website so those unable to attend will have access to view after. The Working Group agreed with this approach. Invitations to LHIN funded stakeholders tomorrow with the ask that the invitation be shared broadly.
J. Logozzo	4. Ontario Health Team Fellowship Opportunity	Jessica noted there is an opportunity provincially for an OHT fellowship where a PhD or masters level research can support some of the approved OHTs. Ontario Health noted we would still be able to partake in the program

		as a potential OHT. Jessica will work on the application and share with this group. The Working Group agreed this was a good opportunity.
J. Christy/ J. Logozzo	5. Wrap up and Next Steps	Jessica proposed an additional meeting in June to discuss the engagement sessions and next steps and then reconvening in September. The Working Group agreed, Kaleigh will set June and September meetings. Jessica adjourned the meeting at 2:43 PM EST.

Northwestern Ontario Integrated Care Working Group
Key Messages Document

Summary of May 10, 2021 Meeting:

1. The 'Northwestern Ontario Integrated Care Working Group' met on May 10. The objectives of the meeting were to:
   - Discuss ongoing stakeholder feedback
   - Discuss updated Communications and Engagement Plan – specifically, content for stakeholder/community-level webinars in May and June, as well as feedback from ongoing Indigenous stakeholder engagement

2. Members that were in attendance provided an update on the engagement and communication they have completed since the last meeting. All feedback received to date continues to be supportive of the directions of the Working Group. Some questions have been raised related to governance. Stakeholders look forward to more focused engagement.

3. The Working Group endorsed the details for engagement with community-level stakeholders. Sessions will be led by Working Group members and Co-Chairs and will include representation from Ontario Health.

   The following (virtual) engagement sessions have been scheduled:
   - Patient Family Advisors – May 19 (6:30 – 7:30 CST; 7:30 – 8:30 PM EST)
   - Red Lake/Dryden/Sioux Lookout stakeholders – May 25 (3:00 – 4:00 CST; 4:00 – 5:00 EST)
   - Kenora stakeholders – May 26 (3:00 – 4:00 CST; 4:00 – 5:00 EST)
   - Thunder Bay/Nipigon stakeholders – May 27 (3:30 – 4:30 CST; 4:30 – 5:30 EST)
   - Marathon/Terrace Bay/Manitouwadge/Geraltdon stakeholders – May 31(3:30 – 4:30 CST; 4:30 – 5:30 EST)
   - Fort Frances/Emo/Rainy River/Atikokan stakeholders – June 3 (3:00 – 4:00 CST; 4:00 – 5:00 EST)
   - Francophone stakeholders – June 9 (11:00 – 12:00 CST; 12:00 – 1:00 EST)
   - Primary Care stakeholders – TBD

   The goals of the sessions are:
   - To share information regarding the work that is underway by the North West Regional Integrated Care Working (and broader partners)
   - To provide the opportunity for stakeholders to ask questions, provide feedback and begin a meaningful process of co-design
   - To talk about next steps to improve care across our region – including ideas for ongoing engagement and communication

4. Engagement with Indigenous stakeholders is ongoing. The following feedback has emerged (in addition to that shared at the previous Working Group meeting):
   - Need to address systemic issues first – equity, treatment of Indigenous individuals within the health care system, racism, etc. "Racism gets in the way of patient care"
   - If it's about systemic change, need to ensure there is engagement of non-status Indigenous individuals and urban Indigenous; this has been a gap
   - Previous engagement has been sub-optimal – first need to build trust
   - Opportunities noted:
     - Support for homeless population – can health services and housing working together to support client needs
     - Traveling health teams – to serve off reserve and homeless populations
     - Expansion of Indigenous Navigators
   - Need to acknowledge existing integrated specialized providers for Indigenous people; these need to 'interface' with other parts of the system, including any OHTs that emerge

5. The Working Group supported the completion of application to have an Ontario Health Team (OHT) Fellow support the Northwestern Ontario Integrated Care work and deliverables.
   - The OHT Impact Fellows program places skilled evaluators and researchers directly within OHTs. During a year-long embedded fellowship, OHT Impact Fellows will support the implementation and evaluation of local priority projects and contribute to rapid learning and improvement.
   - Ontario Health has confirmed that the North West would be uniquely positioned to benefit from this opportunity. Applications are due in late May.

6. The Working Group will meet again in June to discuss the findings from the engagement sessions. The evolved Working Group will begin their regional support work in September 2021.

Key Messages – May 10, 2021:

- The 'Northwestern Ontario Integrated Care Working Group' (Working Group) met on May 10, 2021 to discuss stakeholder feedback and finalize details of the stakeholder engagement sessions.
- The goals of the sessions are: to share information regarding the work that is underway by the Working Group (and broader partners); to provide the opportunity for stakeholders to ask questions, provide feedback and begin a meaningful process of co-design; and, to talk about next steps to improve care across our region.
- Engagement sessions (virtual) are scheduled for late May and June with Francophone individuals, Patient/Client & Family Advisors, and partners within the proposed OHT/model groups. A session with Primary Care stakeholders is being scheduled. Engagement with Indigenous stakeholders is ongoing.
- The Working Group will meet again in June to discuss the findings from the engagement sessions. The evolved Working Group will begin their regional support work in September 2021.

[A3]

Northwestern Ontario Regional Integrated Care

Engagement Summary

June 2021

DRAFT – FOR DISCUSSION AND APPROVAL BY WORKING GROUP ON JUNE 28, 2021

Outline

1.0 Overview and Approach

Beginning in December 2020, the 'North West Regional Integrated Care Working Group' – consisting of approximately 30 cross-sectoral and cross-geography system partners – have worked together to develop recommendations on:

- A local Ontario Health Team (or other more culturally appropriate model of care) coverage model for the North West;
- A coordinated approach to planning for regional specialized services; and,
- What regional-level resources/supports may be required going forward.

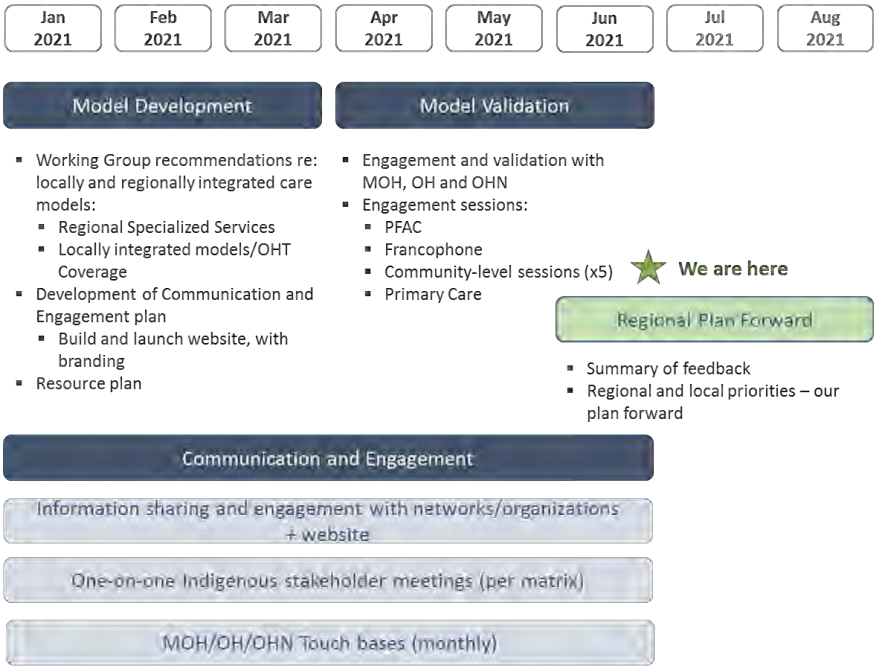
Over April – June 2021 a number of engagement sessions were held with the following objectives:

- To share information regarding the work that is underway by the Northwestern Ontario Integrated Care Working Group (and broader partners)
- To hear from stakeholders on what they think
- To talk about next steps to improve care across our region – including ideas for ongoing co-design, engagement and communication

While engagement throughout the pandemic continued to be a challenge, valuable feedback was gathered.

The feedback has been consolidated within this report (Section 2.0) and has been used to inform next steps related to integrated care/OHT advancement in the North West. The proposed next steps ('A Plan Forward', Section 3.0) is presented as a strategic roadmap to advance integrated care across the North West, both locally and regionally.

The image below provides an overview of the North West Regional Integrated Care Working Group planning approach to date:



2.0 Engagement Themes

Engagement Overview:
7 Engagement Sessions - **101** Participants
22 Working Group members involved/leading - **13** communities represented

2.1 Summary Themes

The following overall themes emerged from the engagement sessions:

- Overall, **proposed model and Vision is 'directionally right'** – no objections to the proposal model or Vision, though, still many outstanding questions that will need to be answered as the work proceeds
- **Continued engagement is necessary** and **getting more partners engaged will be key to success**
    - Need to get local stakeholders to the table – utilize existing structures (i.e. local service delivery/planning tables to get people engaged) and leverage local leaders so it is meaningful
    - Physician and clinician engagement will be critical
- Need a **parallel Indigenous-led process**, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way
- **Local care delivery and autonomy needs to be protected** in a regionally integrated model
- There are **many areas where we can work together as system partners to improve the system** – locally and regionally
    - Regionally, we need to **begin working together to address key system enablers and priorities**, including: digital, data & information sharing, transitions between regional and local care, Mental Health and Addictions, transportation, etc.

2.2 Session Themes

The key takeaways/themes from each session are summarized below.

Session/ Stakeholder Group	**Key Takeaways**
Patient Family Advisors (May 19)	1. Participating patient, resident, client, family and caregiver Advisors **want to continue to be involved in this important work**. As a next step, a follow up session will be scheduled to focus on the development of a *Patient Declaration of Values* to guide this work. 2. Need to **respect the important role of care delivery in small communities, and ensure that care is delivered as close to home as possible**. 3. Key **areas for improvement** include: better continuity of care between regional and local services (including better information sharing); improved transportation system/services; and, better access to mental health and addictions services. Opportunities to support this may include: EMR integration; exploring mobile models of care; and, expansion of regional programs/services to meet the needs of the population as close to home as possible.
Red Lake, Dryden & Sioux Lookout	1. **Broader engagement is necessary**. Agreement to leverage existing Working Groups and stakeholder groups to continue to advance discussions on the topic.

(May 25)	2. Need to **acknowledge, learn from and build on previous and existing work**. Examples include Regional Wound Central Intake/Referral, NAN transformation, etc. 3. Need to **acknowledge the unique needs of individual communities and articulate how local service delivery models fit with the proposed integrated models at a local, district and regional levels**. Also, need to ensure that small communities (i.e. Ignace, Macchin, Vermillion Bay) do not get lost in this planning.
Kenora (May 26)	1. All Nations Health Partners OHT is advancing their work at a local level. The OHT will also be **connected regionally to plan for regional specialized services** – this includes planning with regional providers in Thunder Bay, as well as Winnipeg/Manitoba as a regional service hub. 2. **Regional approaches to key enablers** such as data and a Health Information System (HIS), as well as advocacy, will be helpful and necessary to enable the All Nations Health Partners OHT. Need to consider regional infrastructure so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'. 3. Key challenges we must work on as a region/system include: discharge planning, transportation and regional capacity planning to address service gaps (i.e. home and community care).
Thunder Bay & Nipigon (May 27)	1. Need **meaningful engagement with Indigenous peoples** – to envision and plan for a parallel Indigenous-led process, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way. 2. As providers in Thunder Bay and Nipigon work together, must **ensure that Nipigon as a smaller community is not 'lost'**. The needs, autonomy, nimbleness and local successes must be recognized and built upon. 3. **Regional work should focus on advancing key enablers**, including: data, technology infrastructure, transformation resources, etc.
Marathon, Terrace Bay, Manitouwadge & Greenstone (May 31)	1. **Need further engagement** – local partners needs to be engaged in a meaningful way. Physicians are critical stakeholders and partners in this work. 2. Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense. 3. **Further discussion is needed with partners in Greenstone** to understand where partnerships and integration makes sense to support patient care.
Rainy River District (June 1)	1. Need to **ensure linkage between regional providers and work being done locally**, so regional providers truly understand needs and can be part of solutions. 2. **Regional approaches to key enablers** such as data and digital technologies/infrastructure, as well as advocacy for an all government approach (including municipal) will be necessary to enable the Rainy River District OHT. 3. Key challenges we must work on as a region/system include: health human resource planning.
Francophone (June 9)	1. Need to **ensure the Francophone voice is heard**, not only in the planning phases, but all the way through implementation to ensure that needs are being met. There needs to be follow through and accountability to needs being met. 2. Need to be **culturally sensitive to Francophone patients who may or may not request FLS services**. Language barriers can be harmful and cause added stress. 3. Specific gaps/challenges related to Francophone needs need to be addressed: services for sexual assault/domestic violence, psychiatry services in French and access to

	qualified translation services through the continuum of care. These can be addressed by providers thinking creatively and beyond their organizational walls/mandates.

3.0 A Plan Forward

3.1 Our Regional Vision

Feedback supports advancement towards a regional Vision:

To be a leading integrated care (health and human services) system, where partners work together to achieve the best outcomes and care experience for the people of Northwestern Ontario.

3.2 Values

A number of values/principles have guided our work to date, including:

1. **Status quo is not an option**
2. **Acknowledge the importance of local care delivery in a regional system**

- Any models we pursue must support: integrated delivery of care at the local community level; what is already working well locally; and, improved connection to the broader regional system

3. **Data is important, but it's not everything**

- Our models need to be supported by a reasonable level of data – however, it's not only about existing referral or utilization patterns – it's also about how to do things better and readiness and willingness of partners

4. **We will use an ongoing and evolutionary process – guided by co-design**

- We need to start somewhere – we won't get it perfect, and we may not even get it right at the start
- Iterative and flexible process

The Patient Family Advisory engagement session identified the need and opportunity to develop a *Patient Declaration of Values*, developed by Patients, Clients, Residents and Caregivers.
RECOMMENDATION: As a next step, it is recommended that another PFA Engagement Session be scheduled for the Fall 2021 to develop a Patient Declaration of Values that will guide ongoing system integration work.

3.3 Regional priorities

Engagement sessions confirmed that we need to begin working together across the system and region to address key enablers, including:

- Digital strategies and technology
- Data and information sharing
- Transitions in care; particularly between regional and local care
- Transportation, etc.

As well, from a service perspective, Mental Health and Addictions was identified as a common priority (and one that aligns with the priority populations of the two approved OHTs in the North West region).

RECOMMENDATION: As a next step, it is recommended that the North West Integrated Care Working Group evolve to focus on advancing the following key regional priorities:

1. Indigenous engagement (advancing a parallel process of engagement and system development)
2. Data & information (immediately, includes: service mapping and data needs mapping; over time, will evolve to population health data management)
3. Improving transitions in care; particularly between regional and local care
    - Mental Health and Addictions as a regional service planning priority

NOTE: digital strategy and Health Information System renewal is being advanced through an existing regional structure (Digital Health Council) that includes hospital and broader system representation.

RECOMMENDATION: It is recommended that the Digital Health Council Lead (Regional Chief Information Officer, Cindy Fedell) join the North West Integrated Care Working Group to provide regular updates and leverage the Working Group to ensure broader system alignment (across approved and emerging OHTs).

Additionally, the North West Integrated Care Working Group will support the following objectives/functions:

- Communication and engagement
- Information sharing across OHTs
- Facilitating connection between regional specialized providers and OHTs, to ensure effective planning and service provision (where necessary in early stages of model implementation/refinement)
- *With additional resources and funding, regional resources can support project management and facilitation to emerging OHTs to ensure regional alignment, efficiencies and economies of scale. .*

3.4 Community-level priorities

Engagement sessions confirmed that the proposed integrated models/OHTs were 'directionally right' (at least as a starting point). Though, further engagement is necessary and getting more partners engaged will be key to success.

RECOMMENDATION: As a next step, it is recommended that OHT Planning Tables be formed around the proposed integrated models/OHT:

1. Dryden/Red Lake/Sioux Lookout
2. Thunder Bay/Nipigon
3. Marathon/Terrace Bay/Manitouwadge
4. Geraldton – TBD

NOTE: further local (community-level) engagement may need to precede the formal development of these Tables.

The focus of their work will be to advance OHT planning, with the aim to identify tactical steps to improve patient care for their shared population; as well as align to provincial directions and leverage associated funding opportunities. Key deliverables will include identification of OHT:

- Vision
- Population focus (Year 1 and at maturity) *NOTE: It is recommended that each OHT focus on Mental Health and Addictions as a Year 1 population, to support a shared purpose and efforts regionally.*
- Team/partners
- Collaborative Decision Making Models
- Transformation opportunities and implementation plans

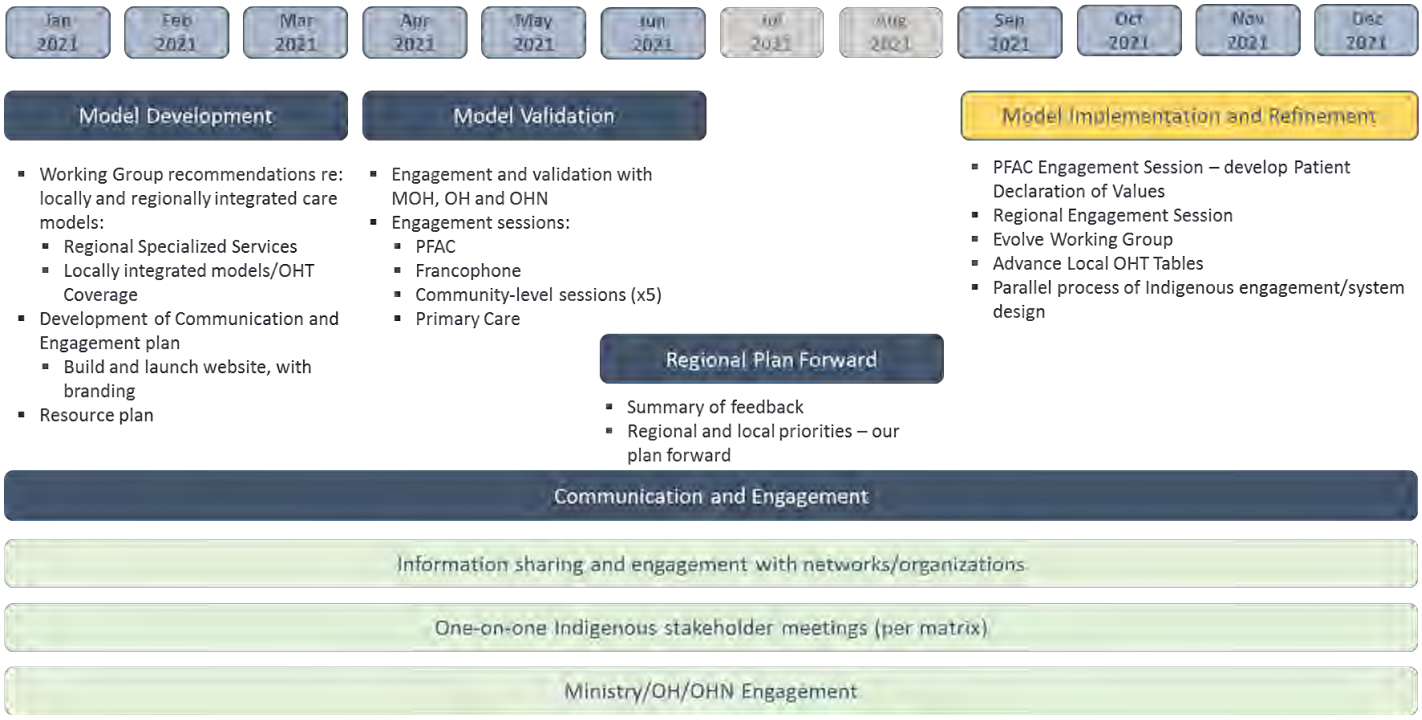
OHT Leads are asked to sit on the Northwestern Integrated Care Working Group to ensure alignment.

3.5 A Proposed Roadmap and Next Steps

Based on engagement feedback and work to date, the following next steps are proposed:

1. **PFAC Engagement Session to develop draft *Patient Declaration of Values (September 2021)***
2. **Regional Engagement Session (September 2021)**
    - Share engagement session themes and next steps
    - Confirm our shared principles and the *Patient Declaration of Values* to guide regional efforts
    - Launch regional and local work
3. **Launch region-wide parallel Indigenous-led process (September 2021)**
    - Invite all Indigenous stakeholders to engagement session (need to determine facilitation lead) to determine *"what does a parallel process looks like that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way?"*
4. **Renew Northwestern Ontario Regional Integrated Care Working Group (October 2021)**
    - Advance regional system priorities:
        i. Indigenous engagement (advancing a parallel process of engagement and system development)
        ii. Data & information (includes service & data mapping, and eventual population health data management)
            - Include HIS renewal and regional digital strategy as a standing item for information and system alignment
        iii. Transitions in care; specifically between regional and local care *can leverage HQO Quality Standards as a guiding approach
            - Mental Health and Addictions (as a regional service planning priority)
    - Support the following objectives/functions:
        i. Communication and engagement
        ii. Information sharing across OHTs
        iii. Facilitating connection between regional specialized providers and OHTs, to ensure effective planning and service provision (where necessary in early stages of model implementation/refinement)
        iv. Pending resources/funding, Project Management, Facilitation and Clinical Leadership

5. **Launch local integration/OHT work (October 2021)**
    - Develop OHT Planning Tables around the proposed integrated models/OHT:
        - Dryden/Red Lake/Sioux Lookout
        - Thunder Bay/Nipigon
        - Marathon/Terrace Bay/Manitouwadge
        - Geraldton – TBD
    - Locally led engagement
    - Key deliverables will include identification of OHT:
        - Vision
        - Population focus (Year 1 and at maturity) *Mental Health and Addictions as an overarching regional priority
        - Team/partners
        - Collaborative Decision Making Models
        - Transformation opportunities/plans
        - Implementation plans



4.0 Appendix: Engagement Session Notes (with participants)

4.1 Engagement Session Summary: **Patient and Family Advisors** – May 19, 2021

Attendees:

Session Leads: Jack Christy, Jessica Logozzo, George Saarinen

1. Dan Pieroz - Fort Frances
2. Donna Brown - TBRHSC
3. Linda Ballentine – NOSH
4. Jules Tupker – TB health coalition
5. Carol Ann Brumpton – TBRHSC
6. Wendy Petersen – Kenora
7. Becky Johnson – Marathon
8. Katherine Smith – PFA NW LHIN
9. Diane Clifford – PFA
10. Mirim – Marathon
11. Paul Carr – TBRHSC
12. Jan – TBRHSC PFA and CFP SJCG
13. Lesley Ryan – Marathon
14. Rita Boutette – Kenora PFA LWDH
15. Chantal Chartrand – FLS NW Ontario
16. Theresa Bowen – Kenora
17. Marg Arnone – Thunder Bay
18. Marge Porieir – Kenora
19. Joan Duke – LHIN PFA
20. Keith Taylor – Chair PFAC TBRHSC
21. Dana Lamminmaki – PFA TBRHSC
22. Jessica Saunders
23. Heather Woodbeck – PFA TBRHSC PFAC
24. Maleeha – Red Lake PFAC
25. Debbie Ruuska – Kenora
26. Cindy Cole – PFAC Fort Frances
27. Chief Lorraine Cobiness PFAC in Kenora
28. Wayne – Kenora
29. Craig Kozlowski – OH North
30. Joanna de Graaf Dunlop

Discussion notes:

- Acknowledgement of **great work to date**, and **excitement to be engaged in the process**
    - Appreciate bringing PFAs together across the region.
    - Felt that the example of hospitals working together on a shared leadership role focused on integration is a positive sign.
- Request for **continued patient, resident, client, family and caregiver involvement**
    - It was raised that a **patient declaration of values** from this group to help guide decision makers would be helpful. All agreed. **Agreement that a follow up session will be scheduled to advance this work.**
- Need to **respect the important role of care delivery in smaller communities** – Thunder Bay cannot be seen as the 'centre of healthcare' and **care needs to continue to be delivered as close to home as possible**.
- A participant shared that work underway through All Nations Health Partners OHT has led to better collaboration and innovation. Some key learnings include:
    - Common Vision – all partners are on the same page
    - Ability to leverage existing resources, both federal and provincial, allows them to meet the needs of the population
    - Courage – need to honest about what the challenges are
- <u>Challenges/issues that need to be addressed</u> to improve care for people across the region:
    - **Continuity of care and information** – when patients are discharged out of Thunder Bay and back to community, there are challenges with information being shared with providers/family and there is a lack of follow up care in the community.
    - **Integration** – story shared where a patient from a small community in the North West region was scheduled for three tests in Thunder Bay on three separate days. Noted that

there needs to be more integration/coordination so that patient appointments "make sense".
    - **Transportation** – lack of transportation options in the region; can lead to missed appointments. Two specific examples provided:
        - Ambulance services in the North West being look at for "rationalization" which may mean service to some communities is likely to become limited.
        - Closure of Greyhound bus routes with only limited service provided by Casper and Northland means transport to appointments for medical care has may be (or has been) significantly compromised.
    - **Mental health and addictions** – access is an ongoing challenge, which has been worsening due to the pandemic. Consider ideas such as: safe drug program; services available through school board.
- Opportunities noted:
    - **Electronic Medical Records (EMR) integration** to support better information sharing. *Presenters noted that this is a priority for the region – all hospitals are currently working together to renew the current Health Information System, and are looking at integration/interoperability with the broader health and human services system.*
    - Consider **mobile models of care** to ensure access to services – for example, mobile MRI for the region.
    - Build on **successful regional programs** to address needs – for example, regional stroke prevention team (look at mobile models for ECG, bone density, etc.)
    - Opportunity to look to best practices (i.e. Registered Nurses Association of Ontario Best Practice guidelines) to learn from other organizations/models to advance our work.
- Questions raised:
    - Will hospitals that currently deliver babies still do so in an integrated model?

Key take-aways:

1. Participating patient, resident, client, family and caregiver Advisors want to continue to be involved in this important work. As a next step, a follow up session will be scheduled to focus on the development of a *Patient Declaration of Values* to guide this work.
2. Need to respect the important role of care delivery in smaller communities, and ensure that care is delivered as close to home as possible.
3. Key areas for improvement include: better continuity of care between regional and local services (including better information sharing); improved transportation system/services; and, better access to mental health and addictions services. Opportunities to support this may include: EMR integration; exploring mobile models of care; and, expansion of regional programs/services to meet the needs of the population as close to home as possible.

4.2 Engagement Session Summary: **Red Lake, Dryden & Sioux Lookout** – May 25, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Marcia Scarrow, Sue LeBeau, Henry Wall

1. Doreen Armstrong-Ross
2. Heidi West
3. Joanna de Graaf Dunlop
4. Linda McNaughton
5. Heather Lee
6. Kieran McMonagle
7. Michael McBride
8. Alice Bellavance
9. Cherie Kok
10. Jennifer Urosevic
11. Daniel McGoey
12. Adam Day
13. Randi
14. Davlin

Discussion notes:

Red Lake Breakout Session:

- Overall, no objections to the proposed model.
- We need a **mechanism to address small volumes** – persons living in small communities matter as much as those living in more populated centers. Care as close to home as possible is important.
- **Technology is a critical enabler**
    - Allows service providers to meet clients where they are at; also allows opportunity to potential reduce stigma
    - In some cases, may result in fewer no shows
- **Primary care needs to be integrally involved** – not at an arms distance
- Need to build a model of care where there is **no wrong door** – to ensure that the care people need is there when they need it
    - Regional Wound Care Central Referral Model could be something to consider translating to other issues
- We **need to address wait lists** so people can access care.
- We **need to look at the broad determinants of health** – activity, income security, housing, etc.
- We **need to be creative.**

Sioux Lookout Breakout Session:

- Need to ensure we **build upon and learn from previous work** (both good and bad) – i.e. existing blueprints and many regional initiatives/programs that are being worked on as we move this forward
- In Sioux Lookout there is both health transformation work taking place, as well as OHT work, which are **very separate systems**. How do we support this work?
- Progress will be developed at the **speed of trust**.

Dryden Breakout Session:

- **Need to engage more broadly** – acknowledged that there are many community partners that need to be engaged in this discussion (only one provider from Dryden and one provider from Ignace in the session/breakout group)

    - Engagement should be led locally and should leverage local work already underway – **agreement to bring Dryden Integrated Health Care Organization (DIHCO) Working Group back together to engage in discussion and advance work**
    - Need to **acknowledge the local work that is already being done, build on that and articulate where it fits**
- Overall, felt that the **model makes sense** and is moving in the right direction; though, **many questions remain**:
    - Where do local services fit with district services?
    - How will we ensure that smaller communities do not get lost? (Ignace, Macchin, Vermillion Bay)
    - How will we ensure that the unique needs of all of the communities are not lost?

Key take-aways:

1. Broader engagement is necessary. Agreement to leverage existing Working Groups and stakeholder groups to continue to advance discussions on the topic.
2. Need to acknowledge, learn from and build on previous and existing work. Examples include Regional Wound Central Intake/Referral, NAN transformation, etc.
3. Need to acknowledge the unique needs of individual communities and articulate how local service delivery models fit with the proposed integrated models at a local, district and regional levels. Also need to ensure that small communities (i.e. Ignace, Macchin, Vermillion Bay) do not get lost in this planning.

4.3 Engagement Session Summary: **Kenora** – May 26, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Henry Wall

1. Alice Bellavance
2. Rob Kilgour
3. Daniel McGoey
4. Kevin Queen
5. Sara Dias
6. Deborah Everley
7. Rossana Tomashowski
8. Kieran McMonagle
9. Ryan Bhopalsingh
10. Lynn Moffatt
11. Cynthia Stables
12. Marc Demers
13. Jenn Urosevic
14. Call in – Patricia Garden Supportive Housing – Dryden

Discussion notes:

- All Nations Health Partners OHT is well established and is advancing important work at a local level. Following the path of the patient, the OHT will also be connected regionally to plan for regional specialized services to ensure that people receive the care they need, and that it is seamless as they transition through the system.
    - When thinking about regional services and regional integration, need to think not just about Thunder Bay, but also **Winnipeg/Manitoba as a regional service hub**.
- While All Nations Health Partners OHT work happens locally, there are also components we can/should begin to build capacity around regionally. Need to consider **regional infrastructure** so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'.
- <u>Opportunities noted</u>:
    - **Data** – need to look at data and information regionally, to show where inequities exist so we can plan together and put forward business cases on how to fill those gaps.
        - Most of the data that is readily available in the system relies on OHIP billing. As such, this excludes important services offered through FHTs, CHCs, Nurse practitioner led clinics, etc., that do not utilize these billing models.
        - Collecting data that represents the full continuum of services and needs is something that should be worked on regionally.
        - Opportunity to identify quality indicators for the region.
    - **Regional advocacy** – opportunity to utilize our collective regional voice to advocate to the Ministry to ensure appropriate funding models for OHTs in Northwestern Ontario; to address existing inequities and to ensure that OHTs are funded sufficiently to get the work done (clinically and administratively). Also need to advocacy to remove barriers related to existing "mandates" and eligibility criteria – need to be able to focus on the client and provide services without mandates/criteria getting in the way.
    - **Regional Health Information System** – needs to consider not only hospitals, but the broader system.
- More direction/definition is needed on what is 'regional'.
- <u>Challenges/issues that need to be addressed</u> to improve care for people across the region:

- **Discharge planning and transitions in care (regional)** – story shared regarding a patient that was discharged from TBRHSC without a wallet or identification. Need to do better in supporting people in getting back to their home community. Key to this is ensuring that proper discharge plans are in place and information is shared with local service providers.
- **Transportation** – those coming from rural or remote communities need medical transport and not every patient has access.
- **Inappropriate usage of LTC** – noted that there are significant social admissions (with light behavioural issues) in LTC that should more appropriately be placed in supportive housing – we need to ensure the right people are receiving the right care in the right place.
- **Local service capacity** – need to address gaps in local community resources. Key gaps is in **home care service capacity** in communities. Need to ensure that appropriate local services exist – regional services can be provided, but if there aren't services in place locally when transitioned back to community, it all falls apart.

Key take-aways:

1. All Nations Health Partners OHT is advancing their work at a local level. The OHT will also be connected regionally to plan for regional specialized services – this includes planning with regional providers in Thunder Bay, as well as Winnipeg/Manitoba as a regional service hub.
2. Regional approaches to key enablers such as data and a Health Information System (HIS), as well as advocacy, will be helpful and necessary to enable the All Nations Health Partners OHT. Need to consider regional infrastructure so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'.
3. Key challenges we must work on as a region/system include: discharge planning, transportation and regional capacity planning to address service gaps (i.e. home and community care).

4.4 Engagement Session Summary: **Thunder Bay & Nipigon** – May 27, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Nancy Chamberlain, Diane Walker, Alice Bellavance, Rhonda Crocker Ellacott, Bill Bradica, Juanita Lawson, Nathanial Izzo

1. Joanna de Graaf Dunlop
2. David Newman
3. Daniel McGoey
4. Cathy Eady
5. Deborah Dika
6. Randi
7. Tiffany Stubbings
8. Jennifer Wintermans
9. Ken Ranta
10. Dan Levesque
11. Nicole Lator
12. Kerrie
13. Jodie
14. Trish Malmborg
15. Joanne Lent
16. Bobbi Jo Smith
17. M M
18. Michael Dawthorne
19. Diane Lajambe
20. Natalie P
21. Kiirsti Stilla
22. Tina B
23. Shannon Cormier
24. Megan Waque
25. Lisa Tyrrell
26. Melanie Maunula
27. Pam
28. Terry Tilleczek
29. James Anderson

Discussion notes:

Thunder Bay Breakout Session:

- **Everyone needs to be included in the planning and delivery of the plan**.
  - Need to determine who 'everyone' is (group didn't feel it was clear)
- What would the Vision look like if it included **Indigenous system partners**?
  - Indigenous partners have communicated with Ontario Health that they have not been consulted in a meaningful way and are still waiting for this dialogue. They want a separate process.
- **System partners need to service our demographics** which includes a large Indigenous population.
- How do we understand what a **culturally sensitive**, integrated system would look like?
  - Start with knowledge to build capacity.
  - Non-Indigenous need to step up and recognize that our current health system is a Western, colonial system.
- **Equity is paramount**. We need to rethink our health service design. **Engage with Indigenous partners in a parallel process.**
- **Technology** will be really important and may in fact, make it hard to move ahead.
- We need to **recognize and resolve the tension between the city and the District**.
- **Non-health care partners have value to be added to the planning and delivery**. They are often connected to the people using the health care system and whatever happens to the healthcare system will also impact non health care providers
- **Community based services are key to an inclusive, equitable, health care system.**

Nipigon Breakout Session:

- Need **meaningful engagement with Indigenous peoples** – to envision and plan for a **parallel Indigenous-led process**, that respects the integrated specialized services role that Dilico, and other

Indigenous providers, have. Need to ensure that the needs of Indigenous people are met in a culturally appropriate way.

- Need to ensure that the **autonomy, nimbleness and efficiency** that exists in Nipigon is not lost. Need to respect and build on it. This is not about losing services, but **improving services and building on partnerships**.
- Regionally, the following opportunities exist:
    - Building a proper **data and technology infrastructure** to support local and regional service planning and population health management. Needs to focus on the **determinants of health** and look at data on those that do not access services.
- Recognition that we cannot transform the system off the side of our desk. We **need to invest in the resources/capacity for transformation** so we are successful.
    - System planning structures need to acknowledge that partners cannot be part of various groups
- Overall, partners feel the proposed model is **moving in the right direction**. Some questions remain:
    - How will provincial services (i.e. Canadian Hearing Services) be engaged with local OHTs and ensure needs are being met?

Key take-aways:

- Need **meaningful engagement with Indigenous peoples** – to envision and plan for a **parallel Indigenous-led process**, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way.
- As providers in Thunder Bay and Nipigon work together, **must ensure that Nipigon as a smaller community is not 'lost'**. The needs, autonomy, nimbleness and local successes must be recognized and built upon.
- **Regional work should focus on advancing key enablers**, including: data, technology infrastructure, transformation resources, etc.

4.5 Engagement Session Summary: **Marathon, Terrace Bay, Manitouwadge & Greenstone** – May 31, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Bill Bradica, Jocelyn Bourgoin

1. Joanna de Graaf Dunlop
2. Alice Bellavance
3. Daniel McGoey
4. Darryl Galusha
5. Anne Harrison
6. Cori Watson
7. Donna Jaunzarins
8. Ryan Bhopalsingh
9. Roland Smith
10. Kerrie
11. Valerie
12. Randi Doggett
13. Peter Ruel
14. Adam Brown

Discussion notes:

<u>Manitouwadge/Marathon/Terrace Bay Breakout Session:</u>

- It is important, as this discussion moves forward, to **not lose sight of the good work that has been done in each local area** to improve services.
    - Many efficiencies have already been found at the local level.
    - Already gained on IT and red tape efficiencies.
    - Partnership between Peninsula Manor in Marathon and TBDSSAB in providing rent supplements was noted by Marathon participants as a positive partnership
- Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense.
- Need to **ensure physician engagement** in this work going forward.
    - Physicians must be supportive of horizontal integration; or it will not work.
    - No physicians in attendance at the session which may signal this lack of support.
    - Physicians have been supportive of vertical integration at the local level. There is currently no perceived incentive for physicians to buy into horizontal integration.
- There did not appear to be clear support for Manitouwadge to be included in an OHT with Marathon/Terrace Bay.
- If we proceed, there is **concern about a negative impact on the work that has already been done and potential impact on small communities**.

<u>Greenstone Breakout Session:</u>

- Need to do **more engagement** and have focused discussion with the stakeholders in the Greenstone/Long Lac area given they were not at the table. Only one local Greenstone provider was in attendance.
- Noted that there is **good cooperation among providers in the community** already. This works needs to build on that, and **must not negatively impact**.
    - Also need to build on the virtual/remote models/successes that have been achieved through the pandemic.
- Noted that **natural referral patterns and travel patterns are towards Thunder Bay** (not associated with Manitouwadge/Marathon/Terrace Bay). This should be considered in proposed OHT model.

Key takeaways:

1. **Need further engagement** – local partners needs to be engaged in a meaningful way. Physicians are critical stakeholders and partners in this work.
2. Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense.
3. **Further discussion is needed with partners in Greenstone** to understand where partnerships and integration makes sense to support patient care.

4.6 Engagement Session Summary: **Rainy River District** – June 3, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Dan McCormick, Karen Lusignan, Jorge VanSlyke

1. Rob Kilgour
2. Alice Bellavance
3. Kristan Miclash
4. Shanna Weir
5. Joanna de Graaf Dunlop
6. Kiirsti Stilla
7. Raiili Pellizarri
8. Deb Ewald
9. Char Strain
10. Lloy Schindler
11. Jenn Osesky
12. Andrew Hallikas

Discussion notes:

- Rainy River District OHT is advancing work locally to improve care. While this work advances locally, **need to ensure linkage between regional providers and work being done locally, so regional providers truly understand needs and can be part of solutions**. Feedback on this included:
    - "Working separately is not working" – need local insights to inform regional services.
    - Example shared – how do we ensure that referrals are getting through and needs will be met?
    - **Opportunity to work together to address HHR challenges and meet population needs**. Regional providers are often challenged to recruit and retain staff due to the regional nature of jobs (i.e. travel) and wage disparities. May be opportunities to work with contract service providers locally to fill gaps closer to home.
    - **Regional providers need to be 'part of' every OHT in the North West.** *Noted that the regional structure of the Northwestern Ontario Integrated Care Working Group can support regional providers in staying connected and accountable to the needs of each OHT/community.*
- **Need active engagement of physicians** in this work. *Rainy River District OHT has developed a Primary Care Advisory Council to engage physicians.*
- **Need active engagement of Indigenous partners.** *Rainy River OHT has been co-led by Indigenous partners.*
- A number of opportunities on how we need to work together regionally include:
    - **Digital technologies** – need to get all of our programs/organizations 'speaking' to each other to support seamless and connected patient care
    - **Data** – need to look at data and information regionally, to show where inequities exist so we can plan together to address needs and gaps.
        - Data needs to be balanced and interpreted based on the needs of the organization/sector/provider.
- Questions to be answered include:
    - From a municipal perspective – how do you get an all of government approach to care everywhere? Discussed housing supports and need for advocacy to get support in these areas.

Key takeaways:

1. Need to ensure linkage between regional providers and work being done locally, so regional providers truly understand needs and can be part of solutions.
2. Regional approaches to key enablers such as data and digital technologies/infrastructure, as well as advocacy for an all government approach (including municipal) will be necessary to enable the Rainy River District OHT.
3. Key challenges we must work on as a region/system include: health human resource planning.

4.7 Engagement Session Summary: **Francophone Partners** – June 9, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Chantal Chartrand

1. Angele Brunelle
2. Jodie Quesnel
3. Denyse Herry
4. Alexandra Mauro
5. Elodie Grunerud
6. Anita Jean
7. Diane Breton
8. Rose Viel
9. Laila Faivre

Discussion notes:

- **Need to ensure voices are heard, there is follow through and there is an end result**.
    - The Francophone voice and needs to be considered not only in the planning phases, but all the way through implementation to ensure that needs are being met.
    - Previous initiatives have ended engagement and consultation once programs were off the ground, with no follow through.
    - Providers and partners need to be willing and ready to think outside of their organizations/mandates; need to be supported by removing barriers and silos. Success story shared where a FLS resource was hired that moved across multiple organizations/agencies. Funded by a number of providers to provide services across the continuum.
- **Need to be culturally sensitive to Francophone patients who may or may not request FLS services**. Language barriers can be harmful and cause added stress.
    - Cannot make assumptions that Francophone who speak English are fluent. In healthcare situations specifically, many Francophones are not comfortable with English slang/terminology and this can affect their experience and outcomes.
- <u>Challenges/gaps noted:</u>
    - **Lack of services for sexual assault/domestic violence** survivors in French
    - **Accessing psychiatry services** in French has always been a challenge; however, with increased capacity in Thunder Bay as well as the possibility to now access psychiatry virtually has been incredibly helpful with language and wait times.
    - Access to **qualified translation services**. Example shared where patient was contacted by oncology nurse re: diagnosis and treatment options, in English. Patient was experiencing stress due to the nature of the conversation and the nurse offered to have them speak to a nurse that was able to communicate in French (conversational level, though not adept in clinical terminology). Unfortunately, incorrect translation was given which caused additional stress to patient.
- <u>Opportunities/questions noted:</u>
    - How can we better capture existing resources/capacity (i.e. physicians or other HHR) that speak French in the system?
    - OHTs should be required to do active training, as well as have resources and staff embedded to support patients through each part of their care journey. *Centrelles noted that Social Work services are provided for first 12 months of service, but if no follow up care in community/OHT then it falls apart.*

    - How will this be different from previous transformation initiatives? Have seen many initiatives to streamline/improve care – what is different this time? Need to incentivize providers to transform and integrate.
- Need to make sure that if a patient receives care in Thunder Bay, that their care plan follows them back home to the region and their specific community. Concern that if hubs are created (grouping of communities) that the patient's care plan is still shared with his or her local medical professionals.

Key takeaways:

1. Need to ensure the Francophone voice is heard, not only in the planning phases, but all the way through implementation to ensure that needs are being met. There needs to be follow through and accountability to needs being met.
2. Need to be culturally sensitive to Francophone patients who may or may not request FLS services. Language barriers can be harmful and cause added stress.
3. Specific gaps/challenges related to Francophone needs need to be addressed: services for sexual assault/domestic violence, psychiatry services in French and access to qualified translation services through the continuum of care. These can be addressed by providers thinking creatively and beyond their organizational walls/mandates.

[A4]

Sharing Our Work

Working Together to Improve Care for People in Northern Ontario!

June 15, 2021

Jack Christy, Northwestern Ontario Integrated Care Working Group, Co-Chair
Jessica Logozzo, Northwestern Ontario Integrated Care Working Group, Co-Chair & EVP, Regional Transformation and Integration

NORTHWESTERN ONTARIO
Integrated Care
Working Group

Starting with WHY…

- First and foremost, **to improve care for the people within our region!**
- With two Ontario Health Teams approved in the North West region, there is question regarding **what the rest of the region looks like related to integrated models**, both locally and regionally – this **must be co-designed with many partners**.
- A **coordinated approach** will ensure equity across the region; ensure patient care and experience is not unduly impacted (rather, will be improved); allow efficiencies to be realized; and, leverage lessons learned and common work.
- We are a highly **interconnected system in the North West**

Why co-design?

- It's the only way to be able to integrate care
- Each partner holds a piece of the puzzle…especially the patient!
- The whole is greater than the sum or our parts…

NORTHWESTERN ONTARIO
Integrated Care
Working Group

What is the end goal?

Our Regional Vision:

To be a leading integrated care (health and human services) system, where partners work together to achieve the best outcomes and care experience for the people of Northwestern Ontario.

NORTHWESTERN ONTARIO
Integrated Care
Working Group

How…

- **Patient-leadership** – Patient Family Advisor (PFA) as Co-Chair to guide this work and provide input
- **Co-design** with system partners
  - The ‘Northwestern Ontario Integrated Care Working Group’ – 30 cross-sectoral and cross-geography system partners
  - Continuous, broad and transparent engagement on proposed directions (engagement sessions, one-on-one relationship building)
- **Shared Vision and principles**

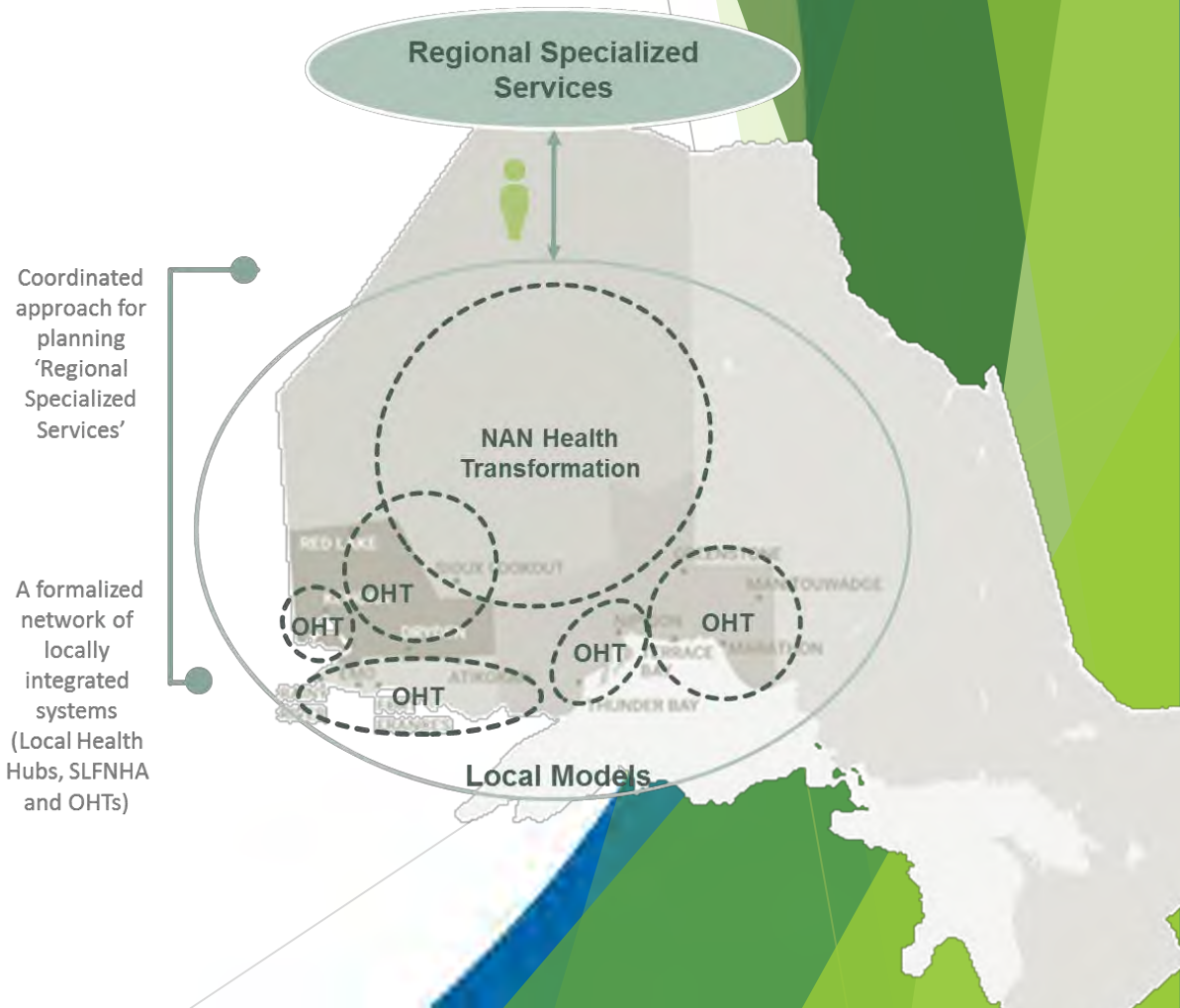
Principles that guide our work…

1. **Status quo is not an option**
2. **Acknowledge the importance of local care delivery in a regional system**
   - Any models we pursue must support: integrated delivery of care at the local community level; what is already working well locally; and, improved connection to the broader regional system
3. **Data is important, but it’s not everything**
   - Our models need to be supported by a reasonable level of data – however, it’s not only about existing referral or utilization patterns – it’s also about how to do things better and readiness and willingness of partners
4. **It will be an ongoing and evolutionary process – guided by co-design**
   - We need to start somewhere – we won’t get it perfect, and we may not even get it right at the start
   - Iterative and flexible process

Some Lessons Learned to Date…

1. Patient leadership and engagement helps ensure we never lose sight of the WHY – the patient
2. Meaningful engagement takes time and flexibility – and it is the most important part!
   - Need parallel, Indigenous-led process of co-design
   - Primary Care and clinical leadership
3. There are clear enablers we must work on together, regionally – data, technology, advocacy…transitions in care
4. Losing ‘local identity’ is a common concern
5. Progress over perfection

NORTHWESTERN ONTARIO
Integrated Care
Working Group



Feedback Form: Proposed Home and Community Care Regulations

As part of the regulation development process, the ministry is seeking feedback on proposed new home and community care regulations.

As you review the proposed regulations, you may wish to consider the following questions:

- Would the proposed regulations create any unintended disruption or risk to current care delivery?
- Would the proposed regulations create any barriers to improving care delivery?
- Would the proposed regulations impose new costs, or enable new cost savings?
- Should there be different or additional requirements in the regulations?
- What lessons from COVID-19 should be applied in the new regulations?

We appreciate your feedback!

Please submit this completed form to HCCB.Modernization@Ontario.ca by July 15, 2021

Your Organization's Name: Click or tap here to enter text.

Representative First and Last Name: Click or tap here to enter text.

1. Scope of Services, Service Maximums (slides 9 – 11)

- Do you have feedback on any aspects of the proposed approach set out on slide 10?

  Click or tap here to enter text.

2. Client/Patient Eligibility Criteria (slides 12 - 13)

- Do you have feedback on any aspects of the proposed approach set out on slide 11?

  Click or tap here to enter text.

- For the proposed new services of Traditional Healing and Indigenous Cultural Supports:
  - Do you have feedback on whether client/patient eligibility criteria should be defined provincially in regulations, or left to be determined more locally (and if they should be defined provincially, what they should be)?

    Click or tap here to enter text.

  - Do you have any other feedback on these proposed new services?

    Click or tap here to enter text.

Feedback Form: Proposed Home and Community Care Regulations

3. **Care Coordination (slides 17 – 20)**

   - Do you have feedback on the proposed requirements for care coordination functions on slide 17?

   Click or tap here to enter text.

   - Do you have feedback on the factors to be considered when planning care on slide 18?

   Click or tap here to enter text.

   - Are there any rules or parameters in addition to what is set out on slide 19 that the ministry should consider regarding an HSP or OHT's assignment of care coordination functions?

   Click or tap here to enter text.

4. **Bill of Rights, Locations of Service, Eligible Providers, Methods of Delivery (slides 21 -25)**

   - Do you have any feedback on the proposed items on slides 21-25?

   Click or tap here to enter text.

5. **Charges for Services (slide 26)**

   - Do you have any feedback on the proposed items on slide 26?

   Click or tap here to enter text.

6. **Plans to Prevent Abuse, Complaints, Appeals, Patient Ombudsman (slides 27-30)**

   - Do you have any feedback on the proposed items on slides 27-30?

   Click or tap here to enter text.

7. **Self-Directed Care, Residential Congregate Care, Other Related Amendments (slides 31 - 35)**

   - Do you have any feedback on the proposed items on slides 31-35?

   Click or tap here to enter text.

8. **Other feedback**

   - Do you have any other feedback on the proposed regulations?

   Click or tap here to enter text.

Update on Proposed Home and Community Care Regulations under the *Connecting Care Act, 2019*

June 2021

Ministry of Health

Ontario

Your feedback is invited

- The Ministry of Health (MOH) is seeking feedback on proposed updates to regulations for home and community care services.
  - These updated regulations under the *Connecting Care Act, 2019* are targeted for finalization later this year.
- To support your feedback, this document sets out:
  - an overview of the MOH's broader plan and timeline for home and community care modernization; and
  - a description of MOH's proposed new home and community care regulations.
- Attached to this document is a fillable form for submitting your feedback on the proposed regulations.
- The ministry has scheduled several question-and-answer sessions in June and July.
  - The intention of these sessions is to provide an opportunity to clarify any of the content in these materials in order to support you in developing written feedback to MOH before regulations are finalized later this year.

Review updated summary of the regulations (this document) → Attend Q&A session → Submit written feedback to the ministry by July 15, 2021

This is an opportunity for stakeholders to ask questions about the proposed regulations.

Ontario

Home and Community Care Modernization – Overview

Transformation Priorities for HCC

The Ministry has been advancing home and community care modernization in five key areas:

Bolster Capacity to Support COVID Response

Fund and implement targeted initiatives in HCC as part of the government's broader COVID-19 response plan.

Modernize Legislation and Regulations

Create a new and modernized legislative framework for home and community care to enable Ontario Health Teams and Health Service Providers to assume responsibility for the delivery of home and community care within an integrated and person-centred service model.

Improve Accountability in Delivery

Review and update home care service provider organization procurement and contracting model.

Establish Transitional and Permanent Governance

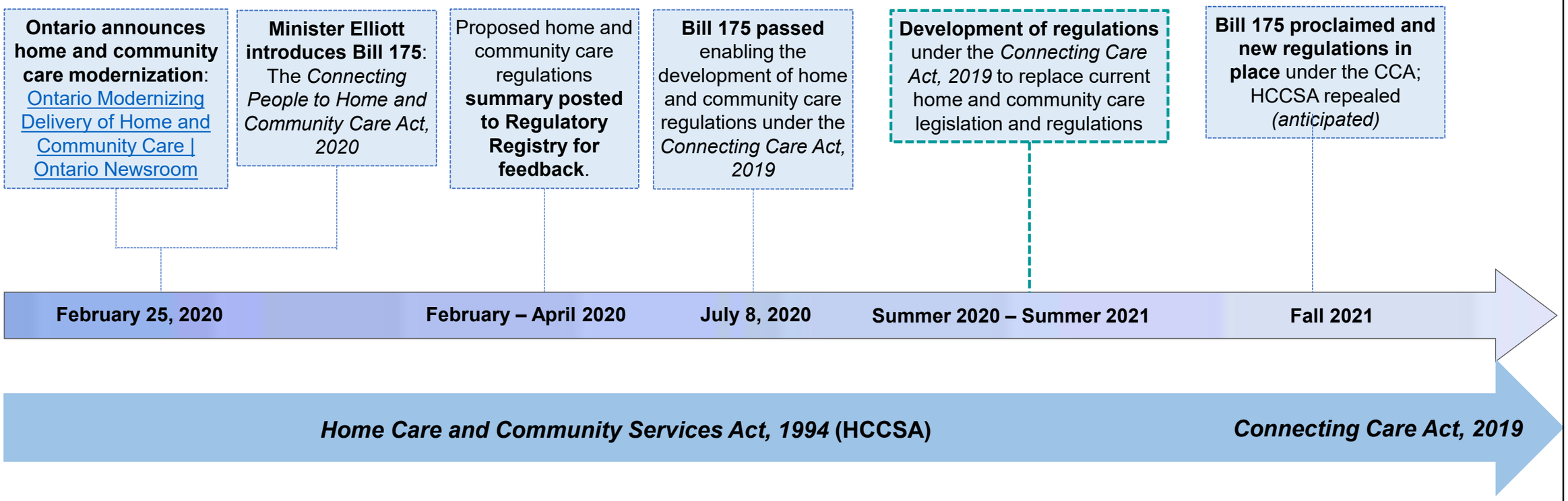
Refocus LHINs as interim organizations responsible for maintaining home care delivery and long-term care placement functions. New name: Home and Community Care Support Services (HCCSS). Plan for end state Ontario Health takes accountability for HCC, and services are delivered through Ontario Health Teams.

Develop a Framework for HCC Transition

With a strong foundation for service continuity with Home and Community Care Support Services, set parameters for the phased transition of HCC to Ontario health Teams and establish clear roles and responsibilities for the ministry, Ontario Health and Ontario Health Teams during transition. Evaluate tests of change to prepare for full provincial scale.

Ontario

Modernizing Home and Community Care – timeline for new regulations



Ontario

Modernizing Home and Community Care Legislation and Regulations

- On February 25th, 2020, the government introduced Bill 175, the *Connecting People to Home and Community Care Act, 2020*. It received Royal assent on July 8th, 2020. It will be proclaimed into force once regulations are ready – expected later in 2021.
- The legislation embeds provisions regarding the funding and delivery of home and community care in the *Connecting Care Act, 2019,* signaling that home and community care is part of an integrated health care system.
- The new legislation and regulations would enable Ontario Health to fund Health Service Providers (HSPs) and Ontario Health Teams (OHTs) to provide more person-centred home and community care services in more flexible, locally-determined ways.

CURRENT FRAMEWORK

Home Care and Community Services Act, 1994 (HCCSA)

- Care coordination model that creates barriers to responsive, integrated care.
- Service maximums
- Dated Bill of Rights

NEW FRAMEWORK

Amend the *Connecting Care Act, 2019*

✓ Add provisions to enable integration of home and community care with OHTs and the broader health system.

Create New Regulations

- Create regulations that build and improve on the current framework, including to:
  - define an expanded scope of home and community care services that Ontario Health may fund,
  - create more flexibility for HSPs and OHTs to coordinate and deliver services at points of care, and
  - establish a more modern Bill of Rights and robust client/patient and caregiver complaints process.

Create New Guidance and Policies

- Working with Ontario Health and experts and providers, update and develop guidance and direction for HSPs, OHTs, and contracted service providers regarding care coordination arrangements, care planning considerations, and other aspects of home and community care provision.

Ontario

Proposed home and community care regulations under the *Connecting Care Act, 2019*

Highlights

The proposed regulations would enable more modern, comprehensive, flexible, and client/patient-focused home and community care.

- The full range of services currently included in home and community care would be **carried forward**, and new **services would be added**.
- Client/patient **eligibility criteria for most services would be retained**, and **additional flexibility would be introduced** for some services **to support access and transitions**.
- **Service maximums would be removed**, and **factors to be considered in care planning would be expanded**.
- Health Service Providers and Ontario Health Teams funded for home and community care would have **flexibility, within defined parameters, to assign required care coordination functions** to their contracted front-line service providers and/or to other HSPs and OHTs – while **remaining responsible for ensuring all regulatory requirements for care coordination continue to be met**.
- The **Bill of Rights would be modernized**, including to reflect the full range of human rights set out in the Human Rights Code, and to affirm a right of persons who identify as First Nation, Metis, or Inuk to culturally appropriate care.
- Current **restrictions related to co-payments would continue**.
- Requirements for providers regarding **plans against abuse and complaints processes would be enhanced**, and **rights of appeal** to the Health Services Appeal and Review Board (HSARB) **would continue**.
- The **Patient Ombudsman's authority** to help resolve complaints about home care services would be **expanded** to include HSPs and OHTs, along with Home and Community Care Support Services.
- Self-Directed Care would continue to be available, with program parameters set out more in policy than in legislation or regulations.
- Legislative provisions supporting **quality and safety in congregate residential care settings** would be enabled, when appropriate.

Home and Community Care Services

- Traditional Healing
- Indigenous cultural support services

- Meal services.
- Transportation services.
- Caregiver support and respite services.
- Adult day programs.
- Home maintenance and repair services.
- Friendly visiting services.
- Security checks or reassurance services.
- Social or recreational services.
- Client intervention and assistance services.
- Emergency response services.
- Foot care services.
- Home help referral services.
- Independence training.
- Palliative care education and consultation services.
- Psychogeriatric consulting services relating to Alzheimer disease and related dementias.
- Public education services relating to Alzheimer disease and related dementias.
- Services for persons with blindness or visual impairment.
- Services for persons with deafness, congenital hearing loss or acquired hearing loss
- Bereavement services
- Behavioural supports
- Education, prevention, and awareness services pertaining to home and community care services, mental health and addictions, chronic disease management, aphasia and communication disorders, and vocational training and education

- Nursing services.
- Occupational therapy services.
- Physiotherapy services.
- Social work services.
- Speech-language pathology services.
- Dietetics services.
- Diagnostic and laboratory services.
- Providing medical supplies, dressings and treatment equipment necessary to the provision of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services or dietetics services.
- Pharmacy services.
- Respiratory therapy services.
- Social service work services.
- Psychological services
- Training a person to provide any of these services

- Personal hygiene activities.
- Routine personal activities of living.
- Assisting a person with any of the above activities.
- Training a person to carry out or assist with any of the above activities.

- Housecleaning
- Doing laundry.
- Shopping.
- Banking.
- Paying bills.
- Planning menus.
- Preparing meals.
- Caring for children.
- Assisting a person with any of the activities referred above
- Training a person to carry out or assist with any of the activities referred above

Blue text = proposed new listed services

Ontario

What would be included in Home and Community Care Services

- The ministry is proposing **to build on the current scope of home and community care services.**

Current state	Proposed Approach
• Home and community care services (which are called 'community services' under HCCSA) comprise four groups of services: ○ professional services ○ personal support services (PSSs) ○ homemaking services ○ community support services (CSSs)	• The ministry is proposing to: ○ refrain from sorting services into 'home care' and 'community care' categories *in regulation* ★ ○ keep the four current groups of services (professional, personal support, homemaking, and community support services), and the individual services currently listed under each group (e.g. nursing, assisting a person with activities of daily living, etc.) ★ ▪ Two legacy homemaking services would be discontinued: ironing and mending. ○ introduce a new group (Indigenous Services) that includes Traditional Healing and Indigenous Cultural Support Services. ★ ▪ Indigenous Cultural Support Services would replace Aboriginal Support Services, a current community support service. ○ add psychological services as a new professional service ○ add new community support services: bereavement services; behavioural supports; and education, prevention, and awareness services pertaining to home and community care services, mental health and addictions, chronic disease management, aphasia and communication disorders, and vocational training and education services ★ ○ rename "caregiver support services" as "caregiver support and respite services" ○ retain "security checks or reassurance services" as a community support service • Services previously identified as potential new services (aphasia services, diabetes education, and pain and symptom management) have now been confirmed as being within the scope of other listed services, e.g. the new education, prevention, and awareness services. • Under the new regulations, Health Service Providers could be funded to provide any combination of these services, and Ontario Health Teams, once mature, would be funded for all of them.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

★ New approach since Feb 2020 posting based on feedback to date

Ontario

Service Maximums

- The ministry is proposing to remove service maximums from regulations and provide service allocation guidance in policy.

Current state	Proposed Approach
• Home and Community Care Support Services and other approved agencies may provide no more than a prescribed maximum number of hours of certain services. • HCCSSs may provide service volumes above the service maximums under extraordinary circumstances to persons in the last stages life, persons on a waitlist for Long-Term Care Home placement, persons with complex needs, or for no more than 30 days in any 12-month period, to any other person.	• Service maximums would be removed from regulations. • The ministry is reviewing options for providing updated policy guidance on service allocation to support equity of access.

Ontario

Client/Patient Eligibility Criteria

- The ministry is proposing to maintain current client/patient eligibility criteria for most services and introduce additional flexibility for some services.

<table>
<tr><th>Current state</th><th>Proposed Approach</th></tr>
<tr><td>Eligibility criteria are set out for each category of home and community care services except for community support services, where providers determine eligibility locally.

Additional eligibility criteria are set out for in-home physiotherapy and pharmacy services, among others.</td><td>

The ministry is proposing to retain current eligibility criteria for all home and community care services (please see next slide), with additional flexibility as follows:

expanding the list of ‘purposes’ for which professional services may be provided to include all end-of-life care (not only palliation)
allowing home and community care-funded personal support services to be provided in long-term care homes for a transitional period to newly admitted persons with behavioural issues ★
changing the eligibility criteria for in-home pharmacy and physiotherapy services to:

remove the requirement that a person be ‘unable to access the service outside the home due to their condition’ , and
replace it with a requirement that the person ‘have difficulty accessing the service outside the home due to their condition or other circumstances’

The regulations would not set out client/patient eligibility criteria for the three proposed new community support services.
The other proposed new services would have the following service-specific client/patient eligibility criteria:
<table>
<tr><td>• Psychological services</td><td>• person has a long-term mental health disability or responsive behaviours</td></tr>
<tr><td>• Traditional healing
• Indigenous Cultural Supports</td><td>• Input is requested on whether the regulations should set out client/patient eligibility criteria for either or both of these services, and if so, what those criteria should include</td></tr>
</table>
For persons needing home and community care services as part of end-of-life care, the ministry would propose new regulations to waive the requirement for Ontario Health Insurance Plan (OHIP) coverage for newcomers to Ontario who were insured by another province or territory.

</td></tr>
</table>

Blue text = proposed new content for regulations (not currently in/under HCCSA)

★ New approach since Feb 2020 posting

Client/Patient Eligibility Criteria (continued)

- Current 'baseline' eligibility criteria for each of group of home and community care services would be maintained, as follows:

<table>
<tr><th>Professional Services</th><th>Personal Support Services</th><th>Homemaking Services</th><th>Community Support Services</th><th>Indigenous Services</th></tr>
<tr><td colspan="3">• Person is OHIP-insured</td><td rowspan="5">Eligibility is determined by the HSP/OHT</td><td rowspan="5">Feedback is requested</td></tr>
<tr><td>• Person needs the service to return home from hospital or another institution, or to remain in their home</td><td colspan="2">N/A</td></tr>
<tr><td>• Service is reasonably expected to result in progress of the person towards rehabilitation, maintenance of functional status, or palliation or other end of life care (not applicable to pharmacy services)</td><td colspan="2">N/A</td></tr>
<tr><td colspan="3">• Place where services are to be provided has all the necessary features for the services to be provided</td></tr>
<tr><td colspan="3">• There is no significant risk of serious physical harm to provider</td></tr>
</table>

- In addition to the criteria for each group of services shown above, individual professional services would retain their current eligibility criteria (if any), e.g.:
  - For physiotherapy services provided in a congregate or group setting, the person must have been recently discharged from hospital and the services must be directly connected to the reason for admission, or the person must be 65 years of age or older.
  - For pharmacy services, the person must be taking three or more prescription medications and be at risk of medication complications due to complex medical needs and (as proposed) have difficulty accessing the service outside the home due to their condition or other circumstances.
  - For respiratory therapy services, the person must be ventilator-dependent, have artificial airways, or be receiving home oxygen services under the Ministry of Health's Assistive Devices Program.
  - For diagnostic and laboratory services, the person must be in need of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services, or dietetics services.
- For physiotherapy services provided in the home, current service-specific eligibility criteria would be made more flexible, as noted on the prior slide.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Highlight: Care Coordination for Home and Community Care Services

- Care coordinators work with patients/clients to develop care plans based on an individual's needs and goals, and they ensure patients/clients have the ongoing care they need. Care coordinators go beyond the functions articulated in regulation.
- The new regulations would:
  - keep care coordination at the centre of home and community care
  - further enable integration of home and community care with primary care and other types of care by removing care coordination from current silos
  - maintain and modernize regulatory standards regarding fundamental care coordination activities, including assessing and re-assessing needs, developing and updating care plans, and initiating and coordinating services
  - enable HSPs and OHTs to implement new models of care that coordinate and provide care more responsively and effectively for patients and families, and more efficiently for providers and the broader health care system

Current State	Future State
• Home and Community Care Support Services and other approved agencies are funded to coordinate and provide home and community care. • Home and community care is often siloed from other types of care, including care assessments and records. • An approved agency cannot delegate or contract out these functions.	• Ontario Health Teams and non-profit Health Service Providers are funded to coordinate and provide home and community care. • Care coordination is more integrated with primary care and other health providers through integrated care records, integrated care delivery and improved referral networks. • Ontario Health Teams and Health Service Providers can assign care coordination responsibilities differently among care partners, including to contracted service providers or other HSPs, within specified parameters, and remain accountable for spending and outcomes.

Ontario

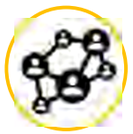
Highlight: Care Coordination for Home and Community Care Services (continued)

Regulations will lay the foundation for more integrated home and community care coordination and care delivery by OHTs and HSPs.

- Assessments and care plans that consider the client's wholistic needs for services across the OHT, using a teams-based approach that includes primary care, home and community care, and hospital care.

- Enabling changes to client care plans by front-line care providers and other members of the care team within accountability parameters.

- Care plans are responsive to client needs in real time to reduce emergency department visits.



- Coordination supports the circle of care, patient and family to actively participate in an integrated care plan that they can access and contribute to digitally.

Implementation Example

- Ontario Health funds a Health Service Provider in an Ontario Health Team to provide home and community care services to high-needs clients discharged from hospital partners in the Ontario Health Team.
- The Health Service Provider procures some of those services from external service providers.
- Working within parameters set by its Ontario Health Team, the Health Service Provider:
  - Assigns a degree of care coordination responsibilities for re-assessing needs and revising care plans to its contracted providers to ensure care remains responsive to the client's needs
  - Works with service provider staff work to monitor client outcomes.
- The Ontario Health Team monitors the quality and value of services provided, including to ensure the patient/client and their caregivers experience seamless, person-centred care.
- Health Service Providers and their contracted service providers leverage digital tools to share information, leverage remote monitoring to manage high risk patients, and respond effectively to the person's changing needs.

Future of Care Coordination

- Care coordination functions will continue to play a vital role in ensuring Ontarians receive high quality home and community care services
- While new regulations would enable new and innovative models of care, the responsibility of care coordination will transfer to Health Service Providers (HSPs) and OHTs carefully, deliberately, and over time.
- As with any new model of home and community care, models that allocate care coordination functions differently will be carefully considered and consider the capacity of partners to deliver in alignment with objectives for the health system, including accountability for system resources.
- To support this transition, the ministry will work with Ontario Health, HSPs, OHTs, and Home and Community Care Support Services to develop a staged implementation plan, including complementary policies and management tools for care coordination (e.g., service allocation, wait listing).

Related Upcoming Work

- Review of home care contract templates and accountability requirements to support new models of integrated care delivery.
- Development of parameters for tests of change and transition of home care functions to Ontario Health Teams.

Proposed Approach: Care Coordination

- The ministry is proposing to **retain current care coordination functions** and **enable more flexibility in care planning requirements** to support delivery that is **more efficient and responsive to changing client/patient needs** and more **oriented to client/patient outcomes**.

Current state	Proposed Approach

Care coordination functions and requirements:
• **assess** the person's requirements, taking into account other assessments and information provided.
• **determine eligibility** for services required.
• **develop a care plan**, setting out amounts of service and taking into account the person's preferences.
• **review the person's requirements** when appropriate, and **revise the care plan** when requirements change.
• **provide services in a reasonable timeframe**, and **wait-list** the patient if services are not immediately available.
• **assist the person in coordinating multiple services** (e.g. scheduling nursing and personal support visits at different times)
	• Care coordination would include the same functions: assessing needs, determining eligibility, planning care, reviewing needs and revising care plans as appropriate, providing home and community care services in a reasonable time or wait-listing, and coordinating multiple services.
	• Requirements for the care coordination would be updated to support and enable more responsive and integrated care, including as follows:
	  ○ The care coordinator would be required to actively seek to obtain assessment information already collected by other providers, with appropriate authority, and assessments would have to include consideration of social determinants of health.
	  ○ Care plans would have to set out care goals, including intended clinical and functional client/patient outcomes, and planned amounts, duration, and modalities of service.
	  ○ Assessment results and the contents of care plans would have to be provided in an accessible format to the person receiving services.
	  ○ Organizations providing multiple HCC services to a person would be required to ensure the services are coordinated in accordance with the person's wishes.
	  ○ Health Service Providers and Ontario Health Teams funded for any home and community care service would be required to refer persons to other providers if the person requests or requires a home and community care service the organization is not funded to provide.
	  ○ HSPs and OHTs would be required to ensure that French language care coordination and care services are actively offered in line with the current obligations of Home and Community Care Support Services, including their obligations under the *French Language Services Act.*

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Proposed Approach: Care Coordination (continued)

Current state	Proposed Approach
• When a care plan is developed, evaluated, or revised, the care coordinator must consider the person's preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.	• When a care plan is developed, evaluated, or revised, the following factors would have to be considered: ○ the person's preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors ○ clinical best practices ○ the effective and efficient management of human, financial and other resources ○ the availability of family and other informal caregiver supports ○ equitable access to services within available funding ○ the relative costs and benefits of providing the service inside and/or outside the home and in-person and/or virtually, and ○ opportunities for referrals to providers of non-health services related to social determinants of health.
• Service providers must ensure there is a written plan of care for persons receiving professional services, and if the care involves controlled acts, providers must ensure the plan has been developed or reviewed by the appropriate regulated health professional.	• There will be one care plan for the patient/client that includes all their home and community care services. • Providers will continue to be required to ensure that any plans for professional services involving controlled acts are developed, updated, or reviewed by the relevant regulated health professionals.
	• Providers would be required to: ○ seek to coordinate their care delivery with other providers to avoid duplication and ensure quality of care ○ work with the person, their caregivers, and other providers to develop and implement a transition plan prior to terminating a person's home and community care services.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Ontario

Proposed Approach: Care Coordination (continued)

- The ministry is proposing to **allow Health Service Providers and OHTs flexibility to assign care coordination functions to contracted providers or other organizations** to improve system navigation, reduce transitions, and eliminate duplication in assessments and care planning.

Current state	Proposed Approach

Care Coordination must be done directly:
 	
Home and Community Care Support Services and other approved agencies must *directly (i.e. with their own employees)* carry out care coordination functions set out in legislation (i.e. assess and re-assess needs, determine eligibility, plan and revise care, coordinate multiple services) – they *cannot* have their service providers or other organizations carry out those functions.
	Care coordination functions could be carried out directly by Health Service Providers and Ontario Health Teams funded to provide care, and/or by their contracted service providers, within defined parameters:
	• Health Service Providers and Ontario Health Teams could choose to assign some or all care coordination functions (assessments and re-assessments, care planning and revisions, etc.) to one or more contracted service providers and allow each of those contracted service providers to update the person's care plan as required.
	• If assigning care coordination functions to a contracted service provider, the HSP/OHT must ensure that:
	  ○ the organization meets provincial requirements for care coordination;
	  ○ there is effective oversight of the organization's performance of care coordination functions;
	  ○ the arrangement supports equitable access to care and the appropriate use of public resources;
	  ○ the arrangement includes processes for reviewing a person's needs and adjusting their care plan, as appropriate, to support responsive care provision; and
	  ○ appropriate digital resources, data sharing arrangements, and infrastructure are in place to enable secure and effective information exchanges between the HSP/OHT and the organizations, and otherwise as required.
	• Care coordination functions would not be permitted to be further assigned or sub-contracted.
	• HSPs and OHTs funded to provide home and community care services would remain accountable for ensuring all care coordination requirements are met in relation to those services, whether care coordination is performed directly by the HSP/OHT and/or indirectly by their contracted service provider(s).

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Proposed Approach: Care Coordination (continued)

- The ministry is proposing to set out **detailed expectations and guidance on care coordination in policy**

- Additional requirements and guidance would be set out **in policy as terms and conditions of funding**, and **templates, tools, and other resources** would be developed, e.g. regarding:
  - use of the Client Health and Related Information System (CHRIS) for care planning, management, and reporting
  - use of evidence-based assessment tools, other provider assessments, and reassessment requirements
  - form and content of care plans
  - factors to consider when planning care, including the availability of the service on a publicly-funded basis from other providers
  - guidance on care planning to ensure equity of access across the province
  - system navigation, coordination of services, and information and referral services
  - assignment of care coordination functions
  - worker qualifications for assessments and planning

Ontario

Bill of Rights

- The ministry is proposing to **enshrine in regulations a Bill of Rights for all persons receiving any HCC service,** modelled on the current Bill of Rights but updated to be more inclusive and comprehensive.

- All Health Service Providers and OHTs, and all their contracted and subcontracted providers, would be required to fully respect and promote these rights.
- Persons receiving home and community care services would have the right to be dealt with:
  - in a respectful manner, and to be free from physical, sexual, verbal, emotional and financial abuse
  - in a manner that respects the person's dignity and privacy, and promotes the person's autonomy and participation in decision-making
  - in a manner that is free from discrimination, as set out s.1 of the Human Rights Code*
  - in a manner that recognizes the person's individuality and is sensitive to and responds to the person's needs and preferences, including those based on ethnic, spiritual, linguistic, familial, and cultural factors
- Persons receiving home and community care services would have the right to:
  - clear and accessible information about the services provided to them
  - actively participate, in the presence of whomever they choose, in assessments of their care needs
  - participate in the development of their care plan and in any subsequent changes to the care plan, and have access to their care plan
  - give or refuse consent to the provision of any home and community care service

Continued next slide

* Human Rights Code s.1: Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Please see also slide 17 regarding French Language Services.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Ontario

Bill of Rights (continued)

- *(cont'd)* Persons receiving home and community care services would have the right to:
  - raise concerns or recommend changes in connection with the service provided and with policies and decisions that affect the person's interests, to the provider, government officials or any other person, without fear of interference, coercion, discrimination or reprisal
  - be informed of the laws, rules and policies affecting the operation of the provider
  - be informed in a clear and accessible manner of the procedures for initiating complaints
  - have their records kept confidential in accordance with the law
  - receive care in accordance with the requirements of the *Connecting Care Act, 2019* and all accompanying regulations
  - be informed of the Bill of Rights and that it could be used as grounds to submit a formal complaint should any rights be violated
- Persons who identify as First Nations, Métis or Inuk have the right to receive services in a culturally safe manner.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Locations of Service

The ministry is proposing:

- to allow the provision of home and community care-funded personal support services in Long-Term Care Homes to support transitions of persons admitted with behavioural issues
- not to allow the provision of home and community care services in hospital to clients/patients with complex needs who were receiving the services prior to admission

Current state	Proposed Approach
• Home and community care services may be provided in a person's home, in group or congregate settings, and in schools, and certain professional services may be provided in long-term care homes, all within parameters set out in regulation.	• Existing locations of services outlined in *Home Care and Community Services Act*, 1994 would be maintained. • The ministry is proposing to allow the continued provision of HCC-funded PSSs for a transitional period to persons with behavioural issues who have been admitted from home care to a long-term care home. • The ministry is no longer proposing to allow home and community care services to be provided in hospital ★

Blue text = proposed new content for regulations (not currently in/under HCCSA)

★ New approach since Feb 2020 posting

Ontario

Eligible Providers

- The ministry is proposing to allow Health Service Providers and OHTs to provide home and community care services directly and/or through contracted providers, and to prohibit contracting with for-profit providers for community support services.

Current state	Proposed Approach
• Home and Community Care Support Services and other Approved Agencies that are funded to provide home and community care services may deliver those services directly through HCCSS/Approved Agency employees, and/or indirectly through contracts with not-for-profit and/or for-profit service provider organizations.	• Once relevant provisions of the *Connecting Care Act, 2019* are proclaimed into force, Ontario Health would be able to fund OHTs and not-for-profit Health Service Providers to provide home and community care services. • The ministry is proposing to: ○ allow Health Service Providers /OHTs to provide professional services, personal support services, homemaking services, and Indigenous Services directly through employees and/or indirectly through contracts with not-for-profit and/or for-profit providers ○ prohibit Health Service Providers/OHTs from delivering Community Support Services through contracts with for-profit providers, with an exception for transportation services, security checks and reassurance services, and any current contracts.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Ontario

Methods of Delivery

- The ministry is proposing to allow home and community care services to be provided in person and/or virtually using electronic means.

Current state	Proposed Approach
Home and community care services may be delivered in-person and virtually.	• The ministry is proposing to **continue to affirm that home and community care services may be delivered in-person or virtually** using digital means, as long as the services support quality care, are appropriate, are based on assessed needs, and are in line with the person's preferences. • The ministry is proposing to modify the current requirement (for professional, personal support, and homemaking services) that a place have the 'physical features' necessary to enable the services to be provided the ministry would clarify that the requirement applies to services provided *in person* rather than virtually. • The ministry would outline guidance on virtual services in policy and/or terms and conditions of funding to support appropriate use, equity, access, and quality.

Ontario

Charges (co-pays) for Services

- The ministry is proposing to maintain a **prohibition against charges for professional and personal support services for all clients/patients** and is proposing to **prohibit charges for homemaking services for persons meeting *any* current eligibility criteria for homemaking provided by a HCCSS/HCCSS.**

Topic	Current state	Proposed Approach
Charges for Services	Charges for *personal support services* and *professional* services are prohibited, regardless of the provider. Home and Community Care Support Services are prohibited from charging for homemaking services if a person meets the eligibility criteria set out under HCCSA, but CSS agencies are able to charge for homemaking services. HCCSA allows non-HCCSS approved agencies (e.g. CSS agencies) to charge fees for homemaking services and community support services.	• Charges for *professional services* and *personal support services* would continue to be prohibited, and charges for *community support services* would continue to be allowed. o Charges would be prohibited for security checks and reassurance services provided to a person who is also receiving: o professional services, o personal support services, or o homemaking services, if the person meets the criteria below for 'no-charge' homemaking services. • The ministry is proposing to maintain current state and not allow charges for homemaking from any organization if the client meets any of the follow criteria: o the person also requires personal support services (PSS); o receives PSS and homemaking from a caregiver who requires assistance with the homemaking services in order to continue providing the person all required care; or o requires constant supervision as a result of a cognitive impairment or acquired brain injury and the person's caregiver requires assistance with homemaking. • Charges would be prohibited for the proposed new services of Traditional Healing and Indigenous Cultural Supports.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Ontario

Plans to Prevent Abuse

- The ministry is proposing to maintain a requirement for providers to have a plan to prevent abuse.

Topic	Current state	Proposed Approach
Plan Respecting Abuse	Home and Community Care Support Services and approved agencies are required to develop and implement a plan for preventing, recognizing and addressing physical, mental and financial abuse. Contractors and sub-contractors are not required under the *Home Care and Community Services Act*, 1994 to have plans respecting abuse.	The ministry would require Health Service Providers and Ontario Health Teams to: • have a plan in place to prevent, recognize and address abuse; • have plans to address training and education of employees and volunteers in methods of preventing and recognizing physical, sexual, verbal, emotional and financial abuse; and • ensure that any contracted providers have a plan for meeting the same requirements as above.

Blue text = proposed new content for regulations (not currently in/under HCCSA)

Ontario

Complaints

- The ministry is proposing to maintain current requirements for responding to complaints, except it is proposing enhanced requirements for responding to complaints alleging abuse, harm, or risk of harm
- The ministry is proposing not to set out a list of complaint topics; instead, all complaints would require a response.

Current state	Proposed Approach
Home and Community Care Support Services and other approved agencies must have processes for reviewing client/patient and caregiver complaints on a list of complaint topics set out in regulations. Clients/patients can appeal to the Health Services Appeal and Review Board (HSARB) if they are unsatisfied with an approved agency's decisions in response to certain complaints (e.g. regarding service amounts) Clients/patients and caregivers can also make complaints to the Long-Term Care ACTION Line about a HCCSS's provision or arrangement of services. Clients/patients may also complain to the Patient Ombudsman about HCCSS-delivered professional, personal support, and homemaking services.	• Once relevant provisions of the *Connecting Care Act, 2019* are proclaimed into force, Health Service Providers and OHTs funded to provide home and community care services would be required to establish a process for reviewing complaints. • The ministry is proposing to require Health Service Providers and OHTs to: ○ have processes for recording, monitoring, and analyzing complaints data; ○ engage clients/patients and caregivers in designing and updating the complaints processes; ○ ensure their contracted and subcontracted providers have complaint processes; and ○ ensure information about a provider's complaints process is made available to the public. • To better align other health sectors, complaints requiring a response would no longer be limited to certain topics. ★ • Providers would be required to respond to complaints within 60 days, but if a complaint alleged abuse, harm, or risk of harm, the provider would be required to: ★ ○ respond within 10 business days. ○ immediately investigate the complaint ○ immediately disclose the complaint to the relevant Health Service Provider/OHT if the provider is a contracted provider • Providers would be required in their response to: ○ set out how the complaint has been addressed or why it has not been addressed; ○ for appealable topics, give notice of the response to the person to whom the decision relates or their substitute decision-maker and inform the person that the decision can be appealed to the Health Services Appeal and Review Board.

Blue text = proposed new content for regulations (not currently in/under HCCSA) ★ New approach since Feb 2020 posting

Appeals

- The ministry is proposing to **maintain current rules about appeals**.

Topic	Current state	Proposed Approach
Appeals	After making a complaint, clients/patients can appeal to the Health Services Appeal and review Board (HSARB) any of the following decisions by an HCCSS or other approved agency: • decisions about **ineligibility** to receive service • decisions to **exclude a service** • decisions related to the **amount of service**, and • decisions to **terminate service** Notice requirements and other details about appeals are set out in HCCSA.	Clients/patients would continue to be able to appeal the same HSP/OHT decisions to HSARB, and current notice requirements and other parameters would be maintained.

Ontario

Patient Ombudsman

- The ministry is proposing to maintain the Patient Ombudsman's current jurisdiction over services provided by Home and Community Care Support Services, and expand that jurisdiction to include HSPs and OHTs providing those same services.

Current state	Proposed Approach

Under the *Excellent Care For All Act* (ECFAA), 2010, the Patient Ombudsman is responsible for receiving and responding to complaints, facilitating the resolution of complaints, undertaking investigations of complaints, and making recommendations to health sectors organizations following the conclusion of investigations from clients/patients or former clients/patients of a health sector organization and their caregivers, and by any other prescribed persons.
 	
Currently, 'health sector organizations' that fall under the jurisdiction of the Patient Ombudsman include: public hospitals, long-term care homes, and home and community care services with respect to:
• professional services, personal support services and homemaking services arranged and coordinated by the HCCSS;
• placement of a person into:
  ○ a long-term care home
  ○ supportive housing programs
  ○ chronic care or rehabilitation beds in a hospital
  ○ adult day programs
	Upon proclamation of the new HCC legislation and amendments to ECFAA, there will be an updated definition of a 'Health Sector Organization' to include:
	• a health service provider or OHT that is **provided for in the regulations and that provides a prescribed home and community care service** pursuant to funding under section 21 of the *Connecting Care Act, 2019*
	
	The regulations being developed now would specify that the jurisdiction of the Patient Ombudsman with respect to home and community care services would:
	• continue to apply to the same services (professional, personal support, and homemaking services)
	• continue to apply to Home and Community Care Support Services
	• newly apply to Health Service Providers and OHTs with respect to those same services
	
	This approach will ensure that the Patient Ombudsman's jurisdiction over home and community care services 'follows the services' as their provision transitions over time from Home and Community Care Support Services to Health Service Providers and OHTs.

Ontario

Self-Directed Care

- The ministry is proposing to continue Self-Directed Care, with program parameters set out more in policy than in legislation or regulations.

Current state	Proposed Approach

• Home and Community Care Support Services may provide funding to a person to purchase professional, personal support, and homemaking services.
• The care coordination and funding process for Self-Directed Care is set out in legislation: the person's needs are assessed, their eligibility for services determined, a plan of care is developed, funding is provided to eligible persons based on their plan of care and with terms and conditions, and care plans are reviewed and funding is adjusted as appropriate.
• Regulations set out that self-directed care funding is available to certain persons: children with complex medical needs, adults with acquired brain injuries, home-schooled children eligible for school health personal support or professional services, and persons in extraordinary circumstances.
• Additional program parameters are set out in program specifications.
	• Once relevant provisions of the *Connecting Care Act, 2019* are proclaimed into force, Ontario Health would have authority to fund OHTs and not-for-profit Health Service Providers to provide funds to a person to use to purchase home and community care services and manage their own care.
	• Regulations would set out that:
	  ○ HSPs and OHTs funded for Self-Directed Care would be responsible (through its own employees and/or an assigned organization) for assessing a person's care needs, determining their eligibility for services, and planning their care, as well as for re-assessments and revisions to care plans as appropriate (as they would for persons/clients outside of Self-Directed Care)
	  ○ Persons receiving Self-Directed Care funding would have the same rights of appeal to the Health Services Appeal and Review Board as persons receiving home and community care services outside Self-Directed Care, i.e,. to appeal decisions about eligibility for services, service amounts, exclusions of services from a plan, and terminations of services
	• Additional program parameters would be set out in updated policy documents.

Ontario

Residential Congregate Care Services

- The ministry is proposing t**o consult on bringing residential congregate care settings under the CCA.**

Current state	Proposed Approach
Residential accommodation is not explicitly listed as an HCC service that the Home and Community Care Support Services can fund, so the provision of HCC services in congregate or group settings that have an accommodation component (e.g. residential hospices and transitional care beds) are funded and regulated through a variety of mechanisms	• The *Connecting Care Act, 2019* includes provisions: ○ authorizing Ontario Health to assign an investigator to report on the quality of an HSP or OHT's management, or on the care and treatment it is providing, or on any other matter when in the public interest (except that for hospitals and OHTs that include hospitals, investigators may only be assigned by the Lieutenant Governor in Council (LGIC) on the Minister of Health's advice). ○ authorizing the Minister to appoint a supervisor of an HSP (other than a Long-Term Care Home) or OHT funded to provide home and community care services (except that for hospitals and OHTs that include hospitals, supervisors may only be appointed by the LGIC on the Minister's advice) • The Act also includes unproclaimed provisions, that would, once the relevant regulations are in place and the provisions are proclaimed: ○ authorize Ontario Health to fund HSPs and OHTs to provide defined home and community care services that include residential accommodation ○ authorize investigators to enter premises where such services are being provided if consent of the occupier cannot be obtained after making reasonable efforts and 24 hours' written notice has been provided to all occupiers ○ waive the usual requirement for 14 days' notice of the appointment of a supervisor to an HSP or OHT providing defined home and community care services that include residential accommodation where, in the Minister's opinion, there is an immediate threat to the health, safety or well-being of persons receiving those services. • The Ministry is planning to undertake further engagements on bringing the funding and regulation of the provision of accommodation and health care services in residential congregate premises under the *Connecting Care Act, 2019.*

Other Related Amendments

- The ministry is planning to update references in various pieces of legislation and regulation that now refer to the *Home Care and Community Services Act* (HCCSA), 1994 and terms used in HCCSA

Topic	Current state	Proposed Approach
References in other regulations	The *Home Care and Community Services Act*, 1994 is referenced in numerous regulations.	The ministry is proposing to replace current references in regulations to HCCSA with new references to the *Connecting Care Act, 2019,* including in regulations under the following acts: • *Connecting Care Act, 2019* (CCA) • *Long-term Care Homes Act, 2007* (LTCHA) • *Health Insurance Act* (HIA) • *Ontario Drug Benefit Act* (ODBA) • *Retirement Homes Act, 2010* (RHA) • *Ontario Infrastructure and Lands Corporation Act, 2011* • *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*
Subrogation	Under the *Home Care and Community Services Act*, 1994 the government can indirectly recover costs through subrogation for the provision of home and community care services that an individual requires as a result of a personal injury due to the negligence, other wrongful act or omission of another. If an injured person is including healthcare costs that include publicly funded home and community care services as part of a claim or legal action for personal injury, the province can recover these costs. The recovery of costs through subrogation enables the government to ensure fiscal responsibility and accountability of public funding.	• The ministry has continued the Minister's right to subrogate and recover costs related to HCC and long-term care by amending the *Ministry of Health and Long-Term Care Act* to adopt the scheme outlined in the *Health Insurance Act*, and by substituting references to HCCSA in Regulation 498/20 (Subrogated Claims) of the *Class Proceedings Act, 1992,* replacing them with references to the *Ministry of Health and Long-Term Care Act.* Further regulations may be made under the *MOHLTC Act* regarding subrogation.

Other Related Amendments (continued)

- The ministry is planning to update references in various pieces of legislation and regulation that now refer to the *Home Care and Community Services Act* (HCCSA), 1994 and terms used in the HCCSA

Topic	Current state	Proposed Approach
Public Vehicles Act (PVA)	Providers of transportation services as a community support service under HCCSA are currently exempted from provisions under the PVA that would otherwise require them to have an operating permit, obtain a permit to tow a trailer, and have emergency exits or push-out windows.	• The *Public Vehicles Act* is to be repealed. Regulations under the Highway Traffic Act would regulate the sector, and exemptions currently under HCCSA would be continued. • MOH is working with the Ministry of Transportation to ensure planned changes to transportation legislation continue to support the provision of HCC transportation services and avoid unnecessary administrative burdens for providers.
Home and Community Care Support Services as HSPs	Under HCCSA, Home and Community Care Support Services are approved agencies. Some provisions under HCCSA have applied to all approved agencies, but there are also specific requirements for Home and Community Care Support Services providing or arranging community services.	• The Ministry is proposing to make regulations under the *Connecting Care Act, 2019* to make certain provisions of the Act and its regulations apply to Home and Community Care Support Services as providers of home and community care services – this would ensure that all clients/patients receive equitable care, regardless of whether the care is provided by a HCCSS, HSP, or OHT.

Other Related Amendments (continued)

- The ministry is proposing to maintain the current status of First Nations and urban Indigenous organizations that provide home and community care as Health Information Custodians under the *Personal Health Information Protection Act, 2004* (PHIPA)

Topic	Current state	Proposed Approach
Indigenous organizations that provide HCC services are Health Information Custodians (HICs)	• First Nations communities are funded to provide HCC services under section 4(d) of HCCSA, and urban Indigenous organizations are Approved Agencies under the *Home Care and Community Services Act*, 1994 for the purposes of delivering HCC. • Under the *Personal Health Information Protection Act, 2004*, Health Information Custodians include 'service providers' as that term is defined under HCCSA, and the term 'service providers' includes Approved Agencies and entities funded directly under section 4 (d) of HCCSA. • First Nations and urban Indigenous organizations funded directly by the Ministry to provide HCC do not fall under any other existing HIC definitions within PHIPA , so it is necessary to update the definition of a HIC under PHIPA to continue to include Indigenous organizations that will continue to be funded to provide HCC services after the repeal of HCCSA.	• The ministry is proposing amendments to regulations under *Personal Health Information Protection Act*, 2004 (PHIPA) to replace references to the *Home Care and Community Services Act*, 1994 (HCCSA) and Approved Agencies with updated terminology to set out that Indigenous organizations funded under the *Ministry of Health and Long-Term Care Act*, 2007 (MOHLTCA) remain Health Information Custodians (HIC). • After the repeal of HCCSA, the ministry would continue its funding of Indigenous organizations for home and community care services on the same terms as today, but using its funding authority under the MOHLTCA, 2007, instead of its funding authority under HCCSA, 1994. • This approach will maintain government-to-government funding of Indigenous organizations and their current status as HICs under PHIPA, 2004. • There would be no impact on Indigenous organizations with respect to their funding for home and community care services or their Health Information Custodian status. • Please see Regulatory Registry posting here : https://www.ontariocanada.com/registry/view.do?postingId=37228&language=en

Ontario

From: Patrick Feng <patrick.feng@utoronto.ca>
To: Jessica Logozzo <logozzoj@tbh.net>
CC: Angela Del Monte <angela.delmonte@utoronto.ca>, "G. Ross Baker" <ross.baker@utoronto.ca>, "McMahon, Meghan" <mmcmahon.ihspr@ices.on.ca>, "Soo, Stephanie D. (MOH)" <Stephanie.Soo@ontario.ca>, "Bulpitt, Cheryl (MOH)" <Cheryl.Bulpitt@ontario.ca>, OHT Impact Fellows Program <ohtfellows@utoronto.ca>
Date: 2021-06-04 2:23 PM
Subject: Re: OHT Impact Fellowship - confirmation of North West submission

Hi Jessica,

I'm responding to your email regarding the OHT Impact Fellowship. As you know, the fellowship program is aimed at the 42 OHTs<https://health.gov.on.ca/en/pro/programs/connectedcare/oht/#meet> that have been approved by the MOH. Regional models such as yours were not included in the initial program design. When we received your EOI, we checked with our colleagues in the Ministry regarding eligibility. Unfortunately, I must inform you that your application is not eligible at this time.

I understand that this is disappointing news. Innovative models such as yours offer interesting fellowship opportunities. The issue at this point is twofold:

1. Complexity: the impact fellows program was designed with a certain OHT model in mind (i.e., a group of providers covering a defined geographic population). The work you are doing is great but your model is different from the "standard" one and placing an impact fellow in a model such as yours would add extra complexity to the program.

1. Funding: we currently have funding to support around 12 fellows in cohort 1, with a second cohort coming in 2022. That's around 24 fellows in total. We received EOIs from 30 OHTs this round so demand is definitely higher than supply. That makes it hard to justify broadening the eligibility criteria.

Moving forward, I am hopeful we can broaden the program criteria to include different OHT models in cohort 2. There is definitely interest in supporting innovative models such as yours. However, for this round at least, your application is not considered eligible.

Thank you for your understanding. Happy to chat further should you have questions.

Regards,

Patrick
--
Patrick Feng
Co-lead, OHT Impact Fellows Program

From: Jessica Logozzo <logozzoj@tbh.net>
Sent: June 4, 2021 10:20 AM
To: Angela Del Monte <angela.delmonte@utoronto.ca>
Cc: G. Ross Baker <ross.baker@utoronto.ca>
Subject: OHT Impact Fellowship - confirmation of North West submission

EXTERNAL EMAIL:
Good Morning Angela,

I am reaching out in regards to the OHT Impact Fellowship opportunity. We had submitted an application for this opportunity on behalf of the North West region. We are advancing a unique approach in our region that looks at both locally and regionally integrated care. Our submission acknowledges our collaboration with our two approved OHTs (All Nations Health Partners and Rainy River District OHT) that have also submitted applications, as we planned to work collaboratively in this Fellowship opportunity.

One of our academic partners at the Northern Ontario School of Medicine reached out this week as she has two post-docs interested in applying to support us but did not see our application in the list to be able to rank. I wanted to confirm if our application is being considered. If you are able to provide an update that would be greatly appreciated, and I can be sure to loop back with our partners to clarify.

Thanks so much,
Jessica

Jessica Logozzo
Executive Vice President
Regional Transformation and Integration

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LinkedIn (http://www.linkedin.com/company/tbrhsc)

Kaleigh Demeo - Fwd: OHT Virtual Engagement Series Issue #4: Register for June 28th Webinar on OHT Learnings Through COVID-19

From: Jessica Logozzo
To: Northwestern Ontario Integrated Care Working Group
Date: 2021-06-21 7:13 PM
Subject: Fwd: OHT Virtual Engagement Series Issue #4: Register for June 28th Webinar on OHT Learnings Through COVID-19

Please see below link to an upcoming OHT webinar.

The Ministry of Health (ministry) and Ontario Health (OH) are hosting the third session of the "*OHT Virtual Engagement Series*" on **June 28, 2021, from 12:00 – 1:30 p.m.** This session will be focused on OHT learnings through COVID-19 and how these experiences can shape OHTs' future work as they transform patient care.

>>> "Ontario Health Teams (MOH)" <ONTARIOHEALTHTEAMS@ontario.ca> 2021-06-21 5:38 PM >>>
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Issue #4

June 21, 2021

Please share this event notice across your team membership.

The Ministry of Health (ministry) and Ontario Health (OH) are hosting the third session of the "*OHT Virtual Engagement Series*" on **June 28, 2021, from 12:00 – 1:30 p.m.** This session will be focused on OHT learnings through COVID-19 and how these experiences can shape OHTs' future work as they transform patient care.

This session will feature a facilitated panel discussion and question and answer period with a number of OHTs who will share their experiences responding to COVID-19 in their local communities, including lessons learned that can be applied to the delivery of better integrated and coordinated care, in an equitable, population-health focused way. In addition, ministry and Ontario Health leaders will share reflections on an equitable, patient-centred health system recovery and the role of OHTs as enablers of that recovery.

Ontario Health partners scheduled to speak include:

- Dr. Sacha Bhatia, Executive, Population Health and Values Based Health System, Ontario Health
- Anna Greenberg, Chief, Strategy and Planning, Ontario Health
- Dr. Chris Simpson, Executive Vice President, Medical, Ontario Health

This session will also include remarks from Deputy Premier of Ontario and Minister of Health Christine Elliott (planned).

Register here: https://zoom.us/webinar/register/WN_qcHTH8YYQqSPUvT9a5hQiQ

Please note that the webinar will be recorded and made available for future viewing.

Please add OntarioHealthTeams@ontario.ca to your safe senders list to ensure that you receive future updates.

About the OHT Virtual Engagement Series

The *OHT Virtual Engagement Series* is part of a renewed approach to communications with teams. Working together with OH and partners in the Central Program of Supports, the ministry is looking to expand opportunities for teams to learn, ask questions, and share successes or challenges about areas of common interest. Through ongoing engagement and learning opportunities, teams will be better supported to achieve key milestones and advancement of the OHT model.

Future webinars will continue to highlight leading OHT initiatives across key elements and building blocks of the OHT model. **Please contact your ministry point of contact if you would like your OHT's activities to be highlighted through an "OHT Spotlight" in a future webinar.**

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Numéro #4

juin 21 2021

Veuillez faire part de cet avis aux membres de votre équipe.

Le ministère de la Santé (ministère) et Santé Ontario tiendront la troisième séance de « *La Série de participation virtuelle des ESO* » le **28 juin 2021, de 12 h à 13 h 30**. Cette séance mettra l'accent sur les leçons tirées de la COVID-19 et la façon dont les expériences vécues peuvent orienter la transformation des soins dispensés aux patients par les équipes Santé Ontario.

Cette séance comportera un débat d'experts dirigé et une période de questions avec un certain nombre d'ESO qui parleront de leurs expériences liées à la COVID-19 dans leur communauté locale, y compris les leçons tirées qui peuvent être appliquées à la prestation de soins mieux intégrés et coordonnés, d'une manière équitable et axée sur la santé de la population. En outre, des dirigeants du ministère et de Santé Ontario feront part de leurs réflexions pour rétablir un système de santé équitable et axé sur le patient et le rôle des ESO pour favoriser ce rétablissement.

Les partenaires de Santé Ontario suivants prendront la parole :

- Dr Sacha Bhatia, directeur, Santé de la population et système de santé axé sur la valeur, Santé Ontario
- Anna Greenberg, chef, Stratégie et planification, Santé Ontario
- Dr Chris Simpson, vice-président directeur, services médicaux, Santé Ontario

La séance englobera aussi une allocution de la vice-première ministre de l'Ontario et ministre de la Santé, Christine Elliott (planifiée).

Pour vous inscrire : https://zoom.us/webinar/register/WN_qcHTH8YYQqSPUvT9a5hQiQ

Veuillez prendre note que le webinaire sera enregistré et pourra être visionné à une date ultérieure.

Veuillez ajouter OntarioHealthTeams@ontario.ca à votre liste d'expéditeurs sûrs pour vous assurer de recevoir de futures mises à jour.

À propos de la série sur l'engagement virtuel des ESO

La Série de participation virtuelle des ESO s'inscrit dans le cadre d'une approche renouvelée des communications avec les équipes. En collaboration avec SO et les partenaires dans le programme central de mesures de soutien de l'équipe Santé Ontario, le Ministère cherche à multiplier les occasions pour les équipes d'apprendre, de poser des questions et de partager leurs succès ou leurs défis dans des domaines d'intérêt commun. Grâce à un engagement continu et à des possibilités d'apprentissage, les équipes seront mieux soutenues pour franchir les étapes clés et faire progresser le modèle des ESO.

> Les prochains webinaires mettront en lumière les principales initiatives d'équipes Santé Ontario en fonction des éléments clés et des composantes du modèle d'ESO. **Communiquez avec la personne-ressource de votre Ministère si vous souhaitez que les activités de votre ESO bénéficient des « Pleins feux sur les ESO » lors d'un prochain webinaire.**