Ontario Health Team: Full Application

Preamble

It is important to note that our Full Application does not reflect the full scope of what we would consider a meaningful and necessary partnership with local Indigenous organizations and communities. Although preliminary conversations have occurred, we all agree that we have not addressed the important issues discussions that will need to take place to ensure meaningful and reciprocal partnership between Indigenous and non-Indigenous organizations. These conversations will form a foundation as we work collectively to meet the needs of the people we serve; and, concurrently take appropriate steps towards addressing systemic racism and Truth and Reconciliation.

In engagement with Indigenous organizations to date, including members of the Indigenous Primary Health Care Council (IPHCC), we acknowledge that the current OHT planning process has not allowed for meaningful collaboration between Indigenous and non-Indigenous organizations. More specifically, we see it as reflective of colonial practices that need to be examined and addressed at the organizational level going forward. While our proposal outlines proposed leadership structures and priorities, it must be noted that these are draft and will be evolved based on ongoing discussions with Indigenous organizations to ensure fair and equitable representation, and that they are appropriate and reflective of reciprocal and equitable partnerships.

As we advance our OHT, we commit to addressing the following:

- **Authority and voice** - it is important to understand who has authority and a voice in decision-making. This process needs to be spelled out clearly and in a transparent way before decisions are made regarding resources and money (not after). It is also important to respect and validate Indigenous Health in Indigenous Hands.
- **Governance** - Indigenous organizations cannot participate meaningfully and equally when governance has not yet been decided. Indigenous organizations must at minimum have proportional representation at the leadership level on the governance council – this provides inclusion in decision-making and makes room for the Indigenous voice to be embedded on a continuous basis. For example, if Indigenous people represent 25% of the population then Indigenous organizations should have at minimum 25% of the voice/seats that represent decision making; however, we know that this number is low and requires further validation. OHT leadership/governance structures must reflect the diversity of the population and communities they serve.
- **Jurisdictions and complexity** - there is currently a lack of understanding of the complexity of the systems and context Indigenous organizations work within as they are often caught between provincial and federal governments having to advocate and navigate unfair, complicated and racist systems. There needs to be a commitment by the province, the region, and local non-Indigenous organizations/partners to understand and advocate with Indigenous partners where and when Indigenous partners decide it will be helpful.

- **Priorities** - Often priorities identified by OHTs and non-Indigenous organizations are not reflective of Indigenous priorities and needs – for example, much of OHT focus at this present time relates to seniors but in reality for the Indigenous people, half of the population is below the age of 30 years and many individuals experience health complexities at much younger ages than 65 years. This again shows that realities are different, and priorities need to be adjusted from a population health management lens so that it is inclusive of equity needs. We commit to ensuring the voice and priorities of Indigenous people are reflected in the OHT decisions regarding priority programming.
    - Anti-Racism and Cultural Safety: It is well documented that racism continues to be rampant within the City of Thunder Bay, the North region and health systems that serve Indigenous people. We commit to and prioritize working with Indigenous partners to address racism and build trust at the organizational level and create safer spaces for Indigenous people in the health care system.
    - Data: It is acknowledged that there is significant work required to collect and analyze current, accurate information on the Indigenous segment of the population and health inequities. We are committed to working with Indigenous organizations to invest in data collection and the development of performance indicators that reflect Indigenous needs and health outcomes.

We acknowledge that discussions amongst our organizations are ongoing, and the necessary engagement is comprehensive and will take time and resources to continue to advance beyond current stages. We commit to ensuring that our OHT processes and governance structures respect First Nation jurisdiction and sovereignty as well as urban Indigenous people who live on territory and off territory (reserve), who are status, non-status, Inuit, and Métis. We commit to being flexible to and supporting any parallel Indigenous-led health transformation processes.

We acknowledge that through an agreement with the Ministry, IPHCC members are developing regional models for inclusion within the OHT framework that do not interfere with or dismantle Indigenous-governed health systems, partnerships, funding models, or service delivery models.

Prior to the formal advancement of our OHT, we commit to coming together in ceremony as Indigenous and non-Indigenous organizations to commit to meaningful, inclusive and reciprocal relationships based on trust and transparency, governance, and commitments to addressing systemic racism and Truth and Reconciliation.

Further details on how each OHT plans to work together as Indigenous and non-Indigenous partners are described in Section 4 of the respective OHT applications.

B. City and District of Thunder Bay OHT

Ontario Health Team: Full Application – Adapted for In Development Teams in Northern Ontario (February 2022)

Introduction

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

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

The following Full Application form has been adapted to reflect the Ministry of Health's (ministry) ongoing work with local providers and Ontario Health to support the advancement of Ontario Health Teams in Northern Ontario.

The Full Application form consists of two parts.

Part A, to be completed by each of the proposed Teams individually, is intended to provide assessors with a comprehensive understanding of each Team and its capabilities, including proposed implementation plans. This information is used to assess each Team's ability to meet the readiness criteria, as set out in *'Ontario Health Teams: Guidance for Health Care Providers and Organizations'* (Guidance Document).

Part B of the application, to be completed regionally (e.g., by the regional planning/working group or its equivalent in collaboration with the proposed Teams in the region), is intended to provide assessors with key information about the regional plan for all Ontario Health Teams in the region, including how the regional structures and functions will connect individual Teams across the region.

OHT Implementation & COVID-19

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

Additional Notes

- Details on how to submit your application will be provided by the ministry.
- Word limits are noted for each section or question.
- The costs of preparing and submitting a Full Application are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).

- The ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The ministry is bound by the *Freedom of Information and Protection of Privacy Act (*FIPPA) and information in applications submitted to the ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

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

PART A: TO BE COMPLETED BY EACH TEAM

(City and District of Thunder Bay OHT)

With this application, your Team demonstrates interest and commitment to serve the population attributed your Team and to work collaboratively within the proposed regional plan set out in Part B.

Part A of the Full Application form is adapted from both the original 2019 Full Application Form to become an Ontario Health Team and the revised 2020 version. It consists of eight sections:

1. About your population
2. About your Team
3. Leveraging lessons learned from COVID-19
4. How will your Team work together?
5. How will you transform care?
6. Implementation planning & risk analysis
7. How will your Team collaborate across the region?
8. Membership approval

Information about Patient Attribution

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

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

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

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

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

For more information about attribution, please refer to the *'Ontario Health Teams: Data Supports Guidance Document'*.

To complete this application, please use information available to you about your patient population. If your Team is approved, the ministry will provide your team with additional information about your attributed population to support your Team in serving the needs of your attributed population.

Participation in Central Program Evaluation

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Jessica Logozzo
	Title: Executive Vice President, Regional Transformation and Integration (also, Co-Chair of the Northwestern Ontario Integrated Care Working Group)
	Organization: Thunder Bay Regional Health Sciences Centre (role works on behalf of the 12 hospitals in the North West Region; also, works on behalf of OHT Members in Working Group Co-Chair role)
	Email: logozzoj@tbh.net
	Phone: (807) 684-6015
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Jessica Logozzo
	Title: Executive Vice President, Regional Transformation and Integration (also, Co-Chair of the Northwestern Ontario Integrated Care Working Group)
	Organization: Thunder Bay Regional Health Sciences Centre (role works on behalf of the 12 hospitals in the North West Region; also, works on behalf of OHT Members in Working Group Co-Chair role)
	Email: logozzoj@tbh.net
	Phone: (807) 684-6015

1. About Your Population

In this section, you are asked to demonstrate your commitment and understanding of the populations that your Team intends to focus on initially (also referred to as "Year 1" or initial target population) and at maturity.

1.1. Who will you be accountable for at maturity?

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

The ministry will assign your Team an attributed population using data about who the members of your Team serve. Based on the population health data available to you, please describe how you intend to work toward caring for this population at maturity.

NOTE: the Ontario Health Team (OHT) descriptor of "City and District of Thunder Bay OHT" is not a final Team name, but rather a placeholder. An appropriate name and branding will be selected by OHT Members once approved.

At maturity, our OHT will be accountable for the entire attributed population of the City and District of Thunder Bay, which is inclusive of approximately 157,000 people (based on data provided by the Ministry of Health). The land area in square kilometres is 102,895.48, which is over 11% of Ontario's land area. With those two factors combined, the population density per square kilometer in this area is very low at 1.4 in comparison to all of Ontario, which is 15.9.

When comparing the Public Health Unit Ontario Marginalization (ON-MARG) index for this area to other Public Health Unit areas it is noted that this population experiences greater residential instability, material deprivation and dependency, which demonstrates that there are factors that undermine individual and community health within our OHT.

Statistics Canada census data from 2016 reports 15.2% of the population as identifying as Aboriginal (Indigenous). This statistic is likely underreported due to some communities not participating in census data collection. This reported rate is five times higher than the provincial rate of 2.8%. From the Well-Living House research study conducted in partnership with Anishnawbe Mushkiki, the findings indicate there are likely 23,080 to 42,641 Indigenous adults living in Thunder Bay, 2.5 to 4 times more than estimated by Statistics Canada. Many of those individuals are from communities outside the Thunder Bay hub area.

Our OHT has an aging population with 19.4% of the population over the age of 65 and 2.7% of the population over the age of 85. The average age in comparison to Ontario is also slightly older with the average age being approximately 43.1 in comparison to Ontario at 41.

Using census data from 2016, 85% of the population identify English as their mother tongue, which is much higher than Ontario and 3.4% identify French, which is similar to the rest of the province. The 10.3% of the population that have identified non-official languages as their mother tongue include 1.3% (likely underreported) identifying Aboriginal (Indigenous) languages as their mother tongue. This area has a very high rate of 95.3% of the population identifying that they speak one of the two official languages most often at home.

The communities served by our OHT include:

- Animbiigoo Zaagi igan Anishinaabek (Lake Nipigon)
- Aroland First Nation
- Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay)
- Bingwi Neyaashi Anishinaabek (Sand Point First Nation)
- Conmee
- Dorion
- Anemki Wajiw (Fort William First Nation)
- Gillies
- Ginoogaming First Nation - Long Lake #77
- Greenstone
- Kiashke Zaaging Anishinaabek (Gull River, Gull Bay First Nation)
- Lac des Mille Lacs
- Long Lake No. 58 First Nation
- Manitouwadge
- Marathon
- Neebing
- Nipigon
- O'Connor
- Oliver Paipoonge
- Pawgwasheeng (Pays Plat First Nation)
- Netmizaaggamig Nishnaabeg i (Pic Mobert First Nation)
- Biigtigong Nishnaabeg (Pic River First Nation)
- Opwaaganisining First Nation (Red Rock -- Lake Helen First Nation)
- Schreiber
- Ashkibwaanikaang First Nation (Seine River 22A2)
- Shuniah
- Terrace Bay
- Binesii Wiikwedong (Thunder Bay)
- Thunder Bay Unorganized (Armstrong, Fowler, Upsala, Nolalu, Lappe, Gorham, Kaministiquia)
- Whitesand First Nation

It must be noted that these City and District of Thunder Bay "boundaries" do not align with First Nations. For example, Matawa has nine First Nations – Aroland, Constance Lake, Eabametoong, Ginoogaming, Long Lake # 58, Marten Falls, Neskantaga, Nibinamik and Webequie First Nations.

1.2. Please identify your initial target population(s).

Over time, Ontario Health Teams will work to provide care to their entire attributed population. However, to help focus initial implementation, it is recommended that Teams identify initial population groups on which to focus care redesign and improvement efforts. This initial target population(s) should be a subset of your attributed population.

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

Our proposed OHT has selected Mental Health and Addictions (MH&A) as the year one priority population. In addition to the population health data supporting this decision, all signatories identified that this aligns to support cross-continuum (health and social services), cross-lifespan and cross-region solutions which will set a strong foundation for the OHT efforts and improvement of population health. It also aligns to provincial priorities. While the efforts to improve care transitions, patient navigation and continuity of care will initially be focused on this population, the initiatives will be foundational and scalable to support the entire population at maturity.

PHO (Public Health Ontario) Data using Thunder Bay District Health Unit (TBDHU) to reflect the proposed OHT:

Snapshot	Rank among PHUs (highest to lowest)	Measure/ Rate/ Percentage	Trend	Comparison to Ontario
Alcohol Harms[2]	2nd	3014	Increasing	514.6
Alcohol-Attributable Hospitalizations[3]	1st	1036.58	Stable to Increasing	209.34
Cannabis Harms[4]	17th	101.3	Increasing	87.4
Mental Health Emergency Department Visits[5]	1st	9294.01	Increasing	2006.42
Stimulant Harms[6]	1st	11	Increasing	2.2
Youth Self-Harm Emergency Department Visits Health Inequities[7]	1st	1278.63	Increasing	159.96

[2] Alcohol Harms Snapshot | Public Health Ontario
[3] Alcohol-Attributable Hospitalizations Health Equity Snapshot | Public Health Ontario
[4] Cannabis Harms | Public Health Ontario
[5] Mental Health Emergency Department Visits Health Equity Snapshot | Public Health Ontario
[6] Stimulant Harms Snapshot | Public Health Ontario
[7] Youth Self-Harm Emergency Department Visits Health Inequities Snapshot | Public Health Ontario

From the Well Living House research study in partnership with Anishnawbe Mushkiki, 30% of Indigenous adults in Thunder Bay have been told by a healthcare worker that they have a psychological or mental health disorder. The accrual rates of mental health diagnoses may be much higher than reported due to issues accessing professionals able to make these diagnoses. 43% of Indigenous adults in Thunder Bay have harmed themselves on purpose.

67.5% of the population within the TBDHU area report that their perceived mental health is very good or excellent, in comparison to 71.1% of Ontarians[8].

Numerous enablers have been identified in order to support the year one priority of MH&A, including:

- Human health resources; specifically primary care
- Access to data - data needs to be focused on this specific area, available through the care continuum and comparable to other sectors
- Digital health; specifically integrated health records and data sharing across the continuum

In addition to MH&A as a Year 1 population focus, the following priorities have been identified:

- Addressing systemic racism, Truth and Reconciliation
- Addressing Health Human Resource challenges
- Standardized transitions in care/pathways; including transitions between children and adult systems

1.3. Are there specific equity considerations within your population?

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

Where known, provide information (e.g., demographics, health status) about the following populations within your initial target population group(s) and within the full attributed population. Please use and cite data sources that are available to you.

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

[8] Self-Reported Overall Health Snapshot | Public Health Ontario

Indigenous populations

With census level data not portraying the Indigenous population accurately, the service providers within the OHT have turned to other data sources to highlight considerations. Well Living House is a group of Indigenous health researchers, health practitioners and community grandparents who are working together to improve the health and well-being of Indigenous infants, children, and their families in Canada and around the world through applied knowledge work. This group completed an inclusive community-driven health survey[9] for Indigenous peoples of Thunder Bay - in partnership with Anishnawbe Mushkiki who has ownership of this data, and much more detailed results as well if needed - which highlighted the following statistics:

- 50% of Indigenous adults in Thunder Bay have a regular family doctor or nurse practitioner. In comparison, 90% of adults in Ontario have a regular medical doctor.
- Over 1 in 4 Indigenous adults in Thunder Bay had unmet health needs in the past 12 months. Reasons why these were not met include: lack of trust in the health care provider, long waiting lists and inability to get transportation. In comparison, 1 in 10 Ontarian adults reported unmet health needs in the past 12 months.
- 46% of Indigenous adults in Thunder Bay self-reported accessing emergency care in the past 12 months, compared to an estimated 19% of Ontarians. Of people who accessed emergency care, 49% rated the quality of care as fair or poor.
- 48% of Indigenous adults in Thunder Bay self-reported having spent one night or more in a hospital in the past 5 years. Of people who accessed hospital care, 41% rated the quality of care as fair or poor.
- 39% of Indigenous adults reported they have been treated unfairly by health care professionals because of their Indigenous identity. 26% of Indigenous adults in London and 28% of Indigenous adults in Toronto were treated unfairly by health care professionals because of their Indigenous identity. Of adults in Thunder Bay that experienced unfair treatment, 67% indicated that it occurred more than once in the past 5 years.
- 66% of Indigenous adults in Thunder Bay said that experiences of racism from health care professionals prevented, stopped or delayed them from returning to health services.
- 46% of Indigenous adults felt that there were inadequate community resources serving Indigenous people in Thunder Bay for primary health care (family doctors, nurse practitioners).

Francophone populations

It is important to acknowledge the lack of data on health outcomes and status for Francophones. Taking this into consideration, the Francophone population experiences health inequities due to lack of health services available in French. According to the 2013-2014 Canadian Community Health Survey, only 49.8% of the Francophone population in the North West self-perceive their health as very good/excellent in comparison to 56.4% non-Francophone and 60.2% of the Francophone population provincially. Self-perceived mental health as very good/excellent is another area where the Francophone population within the North West differs from non-Francophone and the province. In the North West, 60% self-perceive their mental health as very good/excellent in comparison to 65.3% of the non-Francophone population in the North West and 72.1% provincially.

[9] General Health Fact Sheet (welllivinghouse.com)

The OHT members will work together with respect to culturally sensitive, equitable and readily accessible services in French to meet the unique needs of the Francophone population and to improve their experience and health outcomes. By actively offering French Language Services to the Francophone population, we will help health care professionals provide quality services that are safe, ethical and fair.

Other unique health needs

Utilizing ON-MARG data[10], this OHT also needs to be aware of the following social determinants of health that are most prevalent within the Thunder Bay District Health Unit PHU area:

- Percent of the population without a high school diploma
- Percent of the labour force population who are unemployed
- Percent lone parent households

Other notable risk factors that have been identified through multiple sources include tobacco use, alcohol consumption, physical inactivity and unhealthy eating. Higher rates of these risk factors are common among disadvantaged socioeconomic statuses that are prevalent throughout this proposed OHT.

Black People

- In Thunder Bay there are less than 700 people or .63% who identify as Black.
- Black people, similar to Indigenous people, when compared to white, struggle more with poverty, racism, criminalization, housing, addictions, employment, housing and access to health care.

Immigration

- About 10% of the population are immigrants whom have come to Canada before 1981; there continues to be an increase of less than 1% per year. Our area receives between 500-1000 people out of the 500,000 who immigrate to Ontario, about 70% are under the age of 24.

Children and the Social Determinants of Health (SDH) and Health Inequalities – these are key environmental factors that influence individual and group difference in health status and overall quality of life. Poor SDH often result in people having insufficient access to resources to live, learn and thrive. Examples include poverty, racism, education, employment, housing, food, access to healthcare to name a few. Key SDH include:

- Income & Poverty – 10% of households in Thunder Bay and 13.8 % in the District are low income (under 20,000); 20% of children (0-17) and 30% of Indigenous children live in low-income households; low income is associated with precarious housing, food insecurity and poor health.
- Education – Thunder Bay children and youth tend to have much lower scores when compared to provincial scores across Early Development Indicators (EDI), School Achievement Tests, School attendance and Graduation rates.
- Childhood Experiences – As noted above our EDI scores across most areas are low when compared to Ontario with some neighborhoods having numerous struggles with poverty, racism, crime and addictions, which in turn are reflected in lower EDI scores.

[10] Ontario Marginalization Index (ON-Marg) | Public Health Ontario

- Domestic Violence - Thunder Bay has the highest overall rate per capita of persons accused (240 per 100,000), as well as the highest rate of male accused specifically (387).
- In 2018, the rate of police-reported family violence against children and youth was 266 per 100,000 population. Family violence increased with victim age: there were 159 victims aged 5 and younger per 100,000 population, while there were 379 victims aged 15 to 17 per 100,000 population. Thunder Bay experiences very high rates of child and youth violence when compared to other major centres.

Geography and Rurality

- Many of our District communities have some of the highest rurality scores in the province. Our population density is 1.4 people per sq/km as compared to Ontario which is 15.9 with some areas having hundreds per sq/km.
- We are home to 15 municipalities, 17 First Nations Communities and 6 School Boards, with 93% of the District being unorganized.
- Travel, although a part of our way of life in Northern Ontario, can also be challenging and at times risky; travel to some communities to provide service can take a day in total.
- Most people use vehicles to travel, with some use of public transit when available.
- In the District, transportation can be a significant barrier with more challenges noted in the winter.

Our OHT is committed to health equity and embracing diversity and building an inclusive, integrated health system.

2. About Your Team

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

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

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

In the face of the ongoing COVID-19 pandemic, teams should look at efforts to engage with public health and congregate care settings including long-term care, and other providers that support regional responses.

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

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

2.2. Confirming Partnership Requirements

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

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

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

Describe how existing partnerships and experiences working together can be leveraged for ongoing COVID-19 response and recovery, and to deliver better-integrated care to your patient population more broadly within the initial phase of implementation. In your response, please identify which members of your team have long-standing working relationships, and which relationships are more recent.

Providers within the City and District of Thunder Bay have a long history of working together to identify and implement opportunities for improving access, transitions and coordination of care. These partnerships are strong and broad – some are formal and others informal. This is evidenced through numerous collaborations, partnerships and more formal integration activities at the local and district levels. Some examples (not inclusive) to support this include:

- **Local/Rural Health Hubs** – in every community within the District of Thunder Bay, partners are working together across the continuum of care to deliver coordinated care for their population. This includes: formal and informal integration/coordination of services among Local Health Hub partners (i.e. hospital, primary care, long-term care, home and community care, etc.) and implementation of care coordination planning (previously Health Links). Each District community has a highly integrated model of

primary care, with many using the Patient Medical Home Model as a Vision for the future.
    - As an example, Santé Manitouwadge Health is a truly integrated local health system. It has external contracts/partnership to provide Home and Community Care Support Services, Public Health programs, Diabetes, and Assisted Living in collaboration with its Family Health Team. They also have North of Superior Health Counselling Programs (NOSP) in an integrated space within the campus.
- **Thunder Bay and District Mental Health and Addictions Network** – MH&A providers from across the City and District of Thunder Bay have established a formal network, serving communities, families and clients across the life span and across the continuum of care for more than 20 years. The Thunder Bay District Mental Health and Addictions Network meets monthly, has set a strategic plan and is actively advancing work to improve system integration and the quality of care for this population. Given the Year 1 focus on MH&A, this network will be foundational in the OHT's advancement of priorities and has been identified as key part of the OHT's leadership structure, (which provides opportunity to begin to align system objectives and efforts towards common goals).
- **Children's Network** – similar to the above Thunder Bay and District Mental Health and Addictions Network, Children's service providers have a formal network, with targeted goals and initiatives for improving care for youth and their families with our geographic region.
- **Strategic Alliance between Children's Centre Thunder Bay and Thunder Bay Counselling** – both organizations have entered into a formal strategic alliance designed to enhance their capacity to serve children, youth, adults, and families in the District of Thunder Bay and area. The alliance aims to increase efficiencies and maximize resources to deliver the best possible services to clients.
- **Palliative CareLink** – collaboration among partners in order to provide integrated palliative care services to residents of Thunder Bay, access to secondary and tertiary level palliative care expertise and support for providers, clients and caregivers across the North West. The Advisory Group members have all signed partnership agreements and include: Dilico, NorWest Community Health Centres, Hospice North West, Home and Community Care Support Services, St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre.
- **Centralized Chemotherapy mixing models** – through a regional planning effort, a centralized mixing model ('hub and spoke' model) has been developed where one of the hospitals in the District of Thunder Bay (North of Superior Health Care Group) has taken on a centralized mixing function for a neighbour hospital (Sante Manitouwadge Health). This model is now being evolved to have Thunder Bay Regional Health Sciences Centre take on centralized mixing for multiple sites within the District. This partnership and model has supported and alleviated pressures related to Health Human Resource pressures, increased legislature and regulatory requirements and costs.
- **Northshore District Laboratory Program** – hospitals within the District of Thunder Bay have been working together for over 10 years as a district-based laboratory program, where they share resources and expertise across their sites. The District is supported by one Laboratory Director and Administrative Lead.
- Hospice Northwest has partnerships with all funded Hospice Beds in the District of Thunder Bay – including all LTC homes and hospitals in the District (in Manitouwadge, Geraldton, Marathon, Terrace Bay and Nipigon)

- There are also numerous examples of where organizations have collaborated on back-office opportunities and resource sharing across the City and District.

It should be noted that the Thunder Bay District Health Unit and Thunder Bay District Social Services Administration Board serve the City and District communities, and have strong partnerships across this geography. This is a strength that will be leveraged by the OHT.

Additionally, the following are examples of how providers from across the City and District of Thunder Bay are currently partnering to support people with MH&A challenges:

- **Rapid Access to Addiction Medicine (RAAM**) – St. Joseph's Care Group, as a regional lead, provides support and leadership to the advancement of RAAM clinics across the region and district, in partnership with multiple service partners.
- Coordinated Housing Access Table – a community-wide system partner table offering a streamlined process for people experiencing chronic homeless to access housing and support.
- **Kwae Kii Winn, Managed Alcohol Program** – NorWest Community Health Centres works collaboratively with Shelter House Thunder Bay to offer managed alcohol service which aims to reduce harms from alcohol for individuals with unstable housing and severe alcohol related harms.
- **Consumption and Treatment Services** – NorWest Community Health Centers and Dilico Anishinabek Family Care offers the supervised injection service to reduce harms associated with individuals who consume illicit substances. The service offers safe consumption, education, harm reduction supplies and over dose response.
- **HIV collaborative** – NorWest Community Health Centres works in partnership with Elevate NWO, Thunder Bay District Health Unit and Ontario Aboriginal HIV/AIDS Strategy to enhance assessment and treatment services to individual requiring low barrier and culturally appropriate care.
- **Team Care** – NorWest Community Health Centre provides a team of professionals such as foot care, therapy, and system navigation to clients serviced by Aurora Family Health Clinic, Port Arthur Health Centres, and Superior Family Health. Team Care members work together with physicians to plan and provide health services, supports and resources to clients with more complex health and wellness needs.
- **Lifeguard Digital Health App** – NorWest Community Health Centres has led the implementation of the Lifeguard App in northwestern Ontario with over twenty community partners. This life-saving overdose prevention app. The Lifeguard App provides support to people who use drugs with a direct link to emergency responders if an overdose occurs, which could save their life.
- Hospice Northwest has Grief and Bereavement supports in place, receives referrals from and works with many agencies to support clients of all ages including children and families experiencing the loss of loved one.
- Suicide Fan Out and Tragic events coordination
- Coordinated Service Planning for Children/Youth
- Youth Concurrent Disorder Walk in Counselling Clinics
- Integrated Mental Health and Addiction Services for Youth (U-Turn)
- Complex Case Review (CCR) for hard to service, complex mental heath and addiction clients

These local and district examples, are supported by a high level of regional partnership. At a regional level, formalized regional programs provide highly-specialized services to increase access to care in local communities and improve patient outcomes, including: psychiatry,

seniors, rehabilitative care, surgeries, stroke, cancer, palliative care, critical care, diabetes, etc. This is also supported by significant efforts that are underway related to digital and virtual health services across the City and District – as described in section 5.3.

The COVID-19 pandemic has enhanced existing partnership and forged new ones. The following examples highlight only some partnership initiatives that were advanced through the pandemic:

- **Vaccination efforts** – a coordinated approach led by the Thunder Bay District Health Unit, in partnership with many partners across the OHT (hospitals, primary care, Indigenous communities, etc.) has led to high vaccination rates throughout our region. Thunder Bay District Health Unit has a rate of 89.7% fully immunized for those 12+.
- **COVID-19 Isolation Shelters** – significant efforts among partners ensured Isolation Shelters were in place for those who tested positive for COVID-19 within our vulnerable populations. In the City of Thunder Bay, St. Joseph's Care Group was the lead organization, working closely with the City of Thunder Bay, Thunder Bay District Health Unit, the District of Thunder Bay Social Services Administration Board, and Thunder Bay Fire Rescue, along with the city's Vulnerable Populations COVID-19 Planning Table. Similarly, Isolation Shelter's throughout the District of Thunder Bay were established through partnerships between many system partners.
- **Surge and Outbreak Management Tables –** hospitals, long-term care, Home and Community Care Support Services and North Region MH&A partners, met on a regular basis to understand needs across communities, identify solutions and escalate issues to Ontario Health. This group focused not only on pandemic response, but also on pandemic recovery to ensure whole system perspective on important issues such as surgical recovery.
- **Mobile Enhancement and Support Teams** - partnerships and support between LTC, public health and hospitals.

The advancement of our OHT will allow us to build on the strengths of existing relationships and partnerships, to truly enhance our pathways to deliver the best possible integrated care.

3.0. Leveraging Lessons Learned from COVID-19

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

The COVID-19 pandemic has highlighted our collective ability to work together to develop solutions that meet the needs of the population. Relationships among providers have always been strong within the City and District of Thunder Bay and the pandemic has expanded relationships to ensure the overall protection and wellbeing of the population.

Our collective response to the COVID-19 pandemic has expanded or changed the types of services offered within our community in the following ways:

- Virtual care was initiated and/or expanded across almost all settings.

- Telemedicine options were expanded across many partner settings, and existing programs such as Extension for Community Healthcare Outcomes (ECHO) were realigned to support care delivery for those that could not or would not travel for care.
- Remote patient monitoring was introduced to reduce home care visits and monitor COVID-19 positive patients that were well enough to be at home.
- Transportation solutions to support COVID-19 testing were put into place to reduce the amount of time people waited for results. As an example, in the month of April 2020, turnaround times for COVID-19 swabs for the Thunder Bay and District Health Unit were at 41% within 48 hours compared to 76% throughout the province. After incredible support of transportation solutions and the laboratory system in the North, turnaround times improved to 92% within 48 hours comparable to the rest of the province at 93% in November 2021.
- The use of some virtual applications, such as “Breaking Free”, have served as an excellent resource for people living with substance use issues who are awaiting more intensive services and providing improved access to timely care.
- Significant collaborative efforts were undertaken to ensure access to care for vulnerable populations, including implementation of Isolation Shelters, warming centres, and mobile outreach teams across the City and District of Thunder Bay.

The most significant shift was to virtual care which is appealing to many people in terms of access, privacy and eliminating the need for travel. Some providers found that they were able to develop a better connection with younger populations by expanding access to virtual services. While many of the virtual care advancements will be sustained to support access to care, providers will ensure that a blend of service access options is maintained given the importance of face-to-face interactions and supports. Additionally, our OHT recognizes the digital inequity that exists among people who are not connected due to poverty, homelessness, and bandwidth issues, particularly in rural and remote communities. This will be a key element of our OHT’s digital health plan to ensure equitable access for the entire OHT population.

Overall, there is need for flexible, nimble, mobile solutions to provide care where people who need it are located.

Additionally, the OHT will focus on various treatment strategies that are specifically designed to address unique mental health stressors associated with the pandemic, such as “lock-down”. The pandemic also illuminated specific challenges related to in-home supports, respite services and caregiver supports when caring for persons living with dementia.

4.0. How will your team work together?

4.1. What are the proposed governance (or collaborative decision-making) and leadership structures for your team?

Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. For additional guidance on the development of Collaborative Decision-Making Arrangements (CDMAs), please refer to the ‘*Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System’.* Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

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

- ***How will your team be governed or make shared decisions?*** Please describe the planned governance (or collaborative decision-making) structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?

- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.

- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***

- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?*** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

We, as OHT Members (inclusive of proposed signatories, partners and observers) have had a series of discussions in preparing this Full Application to focus on how we will come together in the OHT structure to meet the needs of our population. While we have had landed on agreement on many key items, we recognize that this is the start of our journey together and we will need to evolve and refine much of this as we begin our work together. It is important to acknowledge the preamble that has been included in this Full Application, which acknowledges the importance of a continued dialogue and engagement with Indigenous partners as we move through the development and implementation of our OHT.

As such, this section summarize the key elements of 'how we will work together'.

Principles – how we will conduct ourselves

As OHT members, we have agreed to the following principles for working together:

- Person and population focus – we will co-design a system that puts patients, clients and their families at the centre of services and addresses the holistic needs of the population we serve.
- Equity – we will improve outcomes and service experiences for equity seeking groups and will critically examine and remediate the social determinants of health and how these disproportionally affect equity seeking groups.

- Value-creation – we will make decisions that will improve outcomes, experiences, access and sustainability. We will seek to simplify the system and address the root cause of challenges, rather than building in further inefficiency.
- Collaboration – we will work together as system partners knowing that we are better together and that no one of us can (or should) do it alone. We commit to acting as a system, by putting our organizational interests aside in order to put the best interest of the people we serve at the centre of all we do.
- Acceptance – we recognize and respect that each partner may have different skills and capacity but know that each adds value to the whole. No one person or community is more important than the other. We will create space for, and listen intently to, the diversity of voices and perspectives.
- Continuous improvement – we commit to always seeking to do better for the population we serve. We will aim for progress over perfection, and will move courageously towards our vision despite fears and unknowns.

Vision and Goals – what we want to achieve

Our OHT will be guided by the following Vision and goals:

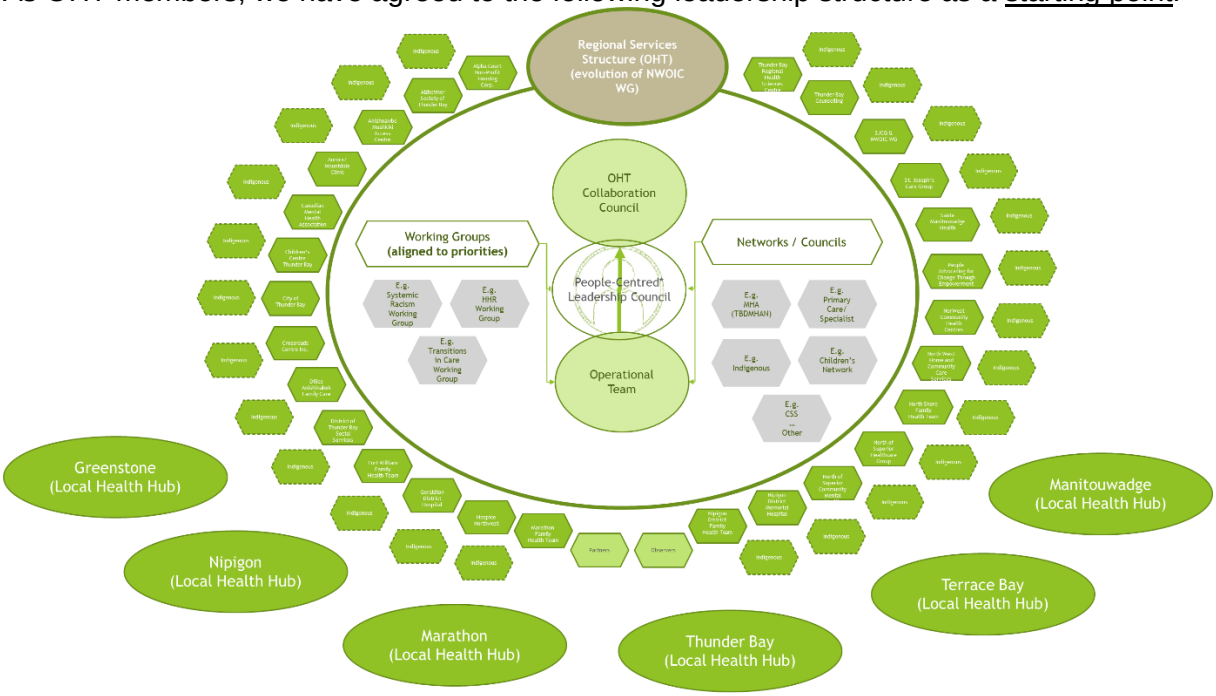
Vision: To be a leading integrated care (health and human services) system, where partners work together to achieve the best outcomes and care experience for the people of the City and District of Thunder Bay.

Goals – what we want to achieve for the population we serve:
- Work as a collective voice for the City and District of Thunder Bay to improve the health of the population
- Build upon collective strengths of the many partners to transform the system – enabled by common vision, priorities and performance measures
- Improve access to high quality care for the people of the City and District of Thunder Bay; providing care close to home and meeting people where they are at
- Ensure seamless transitions and coordination across the patient/person journey
- Shift thinking to a whole system and whole person approach
- Sustainability - reduce waste
- Prioritize, embed and fund Indigenous Traditional Healing practices in the OHT structure; ensure patient preferences for Indigenous Traditional Healing practices in health care provision are adequately met; and, ensure patients of the health care system receive culturally safe and relevant services. Recognizing the unique needs of the Indigenous population at every level of healthcare is vital.
- Collaborate for Health Human Resource Strategies and innovative service delivery models

As a starting point, the City and District of Thunder Bay has identified the following key areas of focus:
- Mental Health and Addictions (Year 1 population)
- Addressing systemic racism, Truth and Reconciliation
- Addressing Health Human Resource challenges
- Standardized transitions in care/pathways; including transitions between children and adult systems

Proposed Leadership Structure

As OHT members, we have agreed to the following leadership structure as a starting point:



*People-centred is intended to be inclusive of patients, clients, residents, caregivers, families and other relevant partners that are important to a person's care, across the continuum of care

All levels of the OHT leadership structure will utilize consensus-based decision-making. As such, OHT Members are committed to finding solutions that everyone actively supports, or at least can live with, in the interest of improving population health. Given the importance of getting this right, the OHT will build in training and education on the topic into our Year 1 operational plan.

Indigenous voice

The OHT recognizes the Indigenous organizations cannot participate meaningfully and equally when governance structures have not yet been decided. It has been agreed that Indigenous organizations should have equal voice on the Collaboration Council. We agree that our OHT leadership/governance structures must reflect the diversity of the communities we serve. As such, it has been agreed that **50% of the "seats" on the Collaboration Council will be held by Indigenous partners to have a decision-making voice (without an expectation/requirement to be a "signatory").** This would be evolved and evaluated with Indigenous partners to ensure meaningful partnerships. This may also be supported through a Memorandum of Understanding with participating Indigenous organizations. As part of this an Elder will be invited to be part of the Collaboration Council.

Conflict resolution

In the case of conflict, the following conflict resolution process will be utilized:

- The Team Members will use their best efforts to resolve any disputes in a collaborative manner through informal discussion and resolution, applying the agreed to principles.

- To facilitate and encourage this informal process, the Team Members involved in the dispute will use their best efforts to jointly develop a written statement describing the relevant facts and events and listing options for resolution. The Team Members will request help from a person or persons on whom all Team Members agree, who can support them in resolving the dispute. This person or persons may be an Elder/Knowledge-Keeper and/or mediator and/or a facilitator. Any OHT Member can request to initiate the conflict resolution process and use of supports.
- If these efforts do not lead to a resolution, any involved Team Member will refer a disputed matter to the OHT Collaboration Council. The Collaboration Council will work to resolve the dispute in an amicable and constructive manner. The Collaboration Council will request help from a person or persons on whom all Team Members agree, who can support them in resolving the dispute. This person or persons may be an Elder/Knowledge-Keeper and/or mediator and/or a facilitator.

*The OHT Members have committed to ensuring there is opportunity for Indigenous-led resolution processes. The OHT Members have identified this as an area that requires further discussion and education to get this right. It will require further meaningful discussion with an Elder/Knowledge-Keeper. This will be an activity undertaken in the first 6 months.

NOTE: we would like to acknowledge that our proposed leadership structure, consensus-based decision making and conflict resolution process is based off of Indigenous concepts and learnings. We had the great benefit to learn from the work of the All Nations Health Partners OHT process and concepts. We acknowledge and express sincere appreciation for the knowledge that has been shared and for how our OHT will benefit from this.

The following roles/responsibilities have been discussed to guide the preliminary leadership and operational structure:

Element	Role	Membership
People-centred* Leadership Council	• Guide all levels of decision making, from the "people-centred" perspective	• Patient/Client/Resident/Caregiver/Family members – from all communities • Collaboration Council Patient/Client/Resident Co-Chair *People-centred is intended to be inclusive of patients, clients, residents, caregivers, families and other relevant partners that are important to a person's care, across the continuum of care
OHT Collaboration Council	• Plan, design, implement and oversee initiatives in pursuit of shared Vision and goals • Set directions for OHT (guided by respective councils) • 'Decision-making' for OHT	• Leads (3-4): Administrative, Patient/Client/Resident, Primary Care, Indigenous • Membership: 1 individual from each OHT signatory + *partners* + *observers*
Operations Team	• Leads day-to-day operational work of OHT (i.e. project management, communications, leadership, etc.)	• TBD – resource requirements to be determined by Collaboration Council in first 6 months • Patient/Client/Resident/Caregiver/Family member
Working Groups	• Advance specific priorities and work, as set by OHT Collaboration Council (guided by respective councils)	• TBD – to be determined by Collaboration Council in first 6 months • Patient/Client/Resident/Caregiver/Family member
Networks/ Councils	• Inform all levels of decision making, from respective perspectives (i.e. Indigenous, MHA, Primary Care, Specialist, etc.)	• TBD – to be determined by Collaboration Council in first 6 months • Patient/Client/Resident/Caregiver/Family member
Regional Services Structure (OHT)	• Regional service planning and coordination + regional enablers (i.e. data, digital)	• Regional service providers • 1-2 individuals per OHT (x4) • Patient/Client/Resident/Caregiver/Family member

Membership and Onboarding

The OHT is currently utilizing the following membership categories:

- OHT signatory: Organizations that formally sign off on the Full Application and eventual formal partnership agreement which outlines the expectations and accountabilities of the OHT. OHT signatories will work together as agreed through collaborative decision-making agreements which will guide decision-making on shared priorities/initiatives, funding, resource allocation, etc.
- Partner: Organizations that choose to actively participate in OHT meetings, planning processes and collaboration opportunities, though do not identify as a formal "OHT signatory". Partners may choose to actively participle in some or all OHT/collaboration initiatives – these partnerships will be supported by agreements/MOUs outlining expectations on all parties.
- Observer: Organizations remain informed and involved, but not active in planning or delivery.

NOTE: only OHT signatories participate in consensus decision-making; with the exception of the "seats/voices" for Indigenous partners, which do not require OHT signatories. Decisions will be informed by the collective perspectives of partners and observers.

Our leadership/membership approach will enable flexibility for partners to move between levels according to their interests, demonstrated capacity to meet the requirements of their preferred membership level, and organizational circumstances.

On-boarding process:

- Partners, observers or new stakeholders are to identify to the Collaboration Council their interest to join the OHT (with indication of their desired level of involvement)
- Collaboration council will consider request (based on Vision, directions, priorities)
- When approved, member will be provided orientation (i.e. consensus decision-making, conflict resolutions, principles, overview of priorities, etc.)

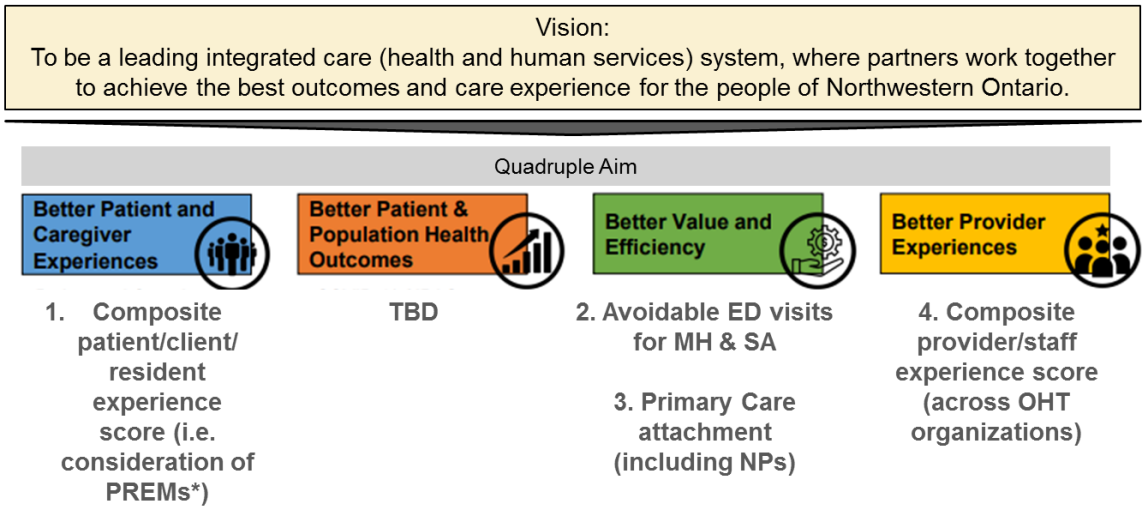
Engagement

The OHT has developed the following ways to ensure leadership, involvement and engagement with patients/clients/families/caregivers, clinicians, Indigenous and Francophone stakeholders:

Patient/Client/ Resident/Caregiver/Family Engagement	Clinician Engagement	Indigenous Engagement	Francophone Engagement	Vulnerable Population Engagement
• Patient/Client/ Resident/Caregiver/Family **Co-Leadership of Collaboration Council** • People-centred **Leadership Council** (guides all levels of decision making, from the patient/client/resident/caregiver/ family perspective) • Patient/Client/ Resident/Caregiver/Family member on all Councils, Networks and Committees • Patient/client/resident/ caregiver/family stories/experiences embedded at meetings/discussions • OHT-led survey (to inform patient/client/resident experience measure)	• Primary Care **Co-Leadership of Collaboration Council** • **Clinician Council** (guides all levels of decision making) • Ongoing engagement through **existing forums** • OHT-led survey (to inform provider experience measure)	• Indigenous **Co-Leadership of Collaboration Council** • **Indigenous Council** (guides all levels of decision making *further discussion will take place with Indigenous partners to determined appropriate and meaningful engagement approaches and mechanisms at all levels of the OHT	• Ongoing engagement sessions and collaboration with Reseaux • Involvement of Francophone individuals in People-centred Leadership Council	• Invite multi-cultural Centres to the OHT (as observer) to ensure linkages (Regional Multicultural Association) • Focus groups – meet people where they are at to engage feedback

Performance Measurement

The OHT has agreed to the following preliminary performance metrics in Year 1, aligned to the Quadruple Aim:



*consideration of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs)

Further work will be done in the first 6 months to refine and finalize measures, including the identification of an appropriate "patient & population health outcome" measure. As part of this, an assessment of performance metrics across all other OHTs in the North West will be done to seek alignment towards common measures. Performance measures will also be aligned and inclusive of provincial metrics (i.e. MH&A Centre of Excellence and other Ontario Health required metrics).

In addition to the above, the OHT will also measure key process metrics, for example:

- Achievement of OHT deliverables (e.g. CDMA, leadership structure implementation)
- Progress/achievement of projects/initiatives
- OHT relationship/trust measures

The OHT has agreed to the following high-level elements of a Performance Management Process:

- Development of Collaboration Council dashboard (system-level and OHT-level metrics)
- Review of dashboard on quarterly basis
- Annual review of plans/priorities – direction-setting for next year
- Development of common performance metrics across organizations to drive change (collaborative Quality Improvement plan)

5.0. How will you transform care?

In this section, you are asked to propose what your team will do differently to achieve improvements in health outcomes for your patient population.

At maturity, OHTs will be held to a standardized *Performance Measurement Framework* based on the internationally recognized Quadruple Aim. The Quadruple Aim is a framework for measuring the delivery of high-quality care and is focused on: Better Patient and Caregiver Experiences, Better Patient and Populations Health Outcomes, Better Value and Efficiency, and Better Provider Experiences.

5.1. Recognizing that measuring and achieving success on the Quadruple Aim will take time, the ministry is interested in understanding how your team will measure and monitor success improving population health outcomes, patient care, and integration in the short-term.

Using data available to you, please identify between 3 and 5 performance measures your team proposes to use to monitor and track success in the short term. In your response, you may consider the *Collaborative Quality Improvement* (cQIPs) indicators.

Please complete section 5.1 in the full application supplementary template.

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

Seamless and effective transitions, 24/7 access to coordination of care, and system navigation services are key components of the Ontario Health Team model. Care

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

5.2.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your initial target population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings. Identify whether your Team has plans to organize care coordination resources differently from how they are currently deployed in order to better serve your population.

NOTE: This italicized section serves as an overall preamble to questions 5.2.1, 5.2.2 and 5.2.3.

Preamble
OHT Members are committed to transforming the system to better meet the needs of our population. To truly answer the questions on how we will coordinate care, improve transitions in care and help individuals navigate the system, we need to honour the principles of co-design that we have set as a priority and ensure that we are working collaboratively to identify solutions.

As such, OHT members have discussed these questions and set some general directions; though, defer to utilizing the OHT leadership structure and principles outlined in Section 4 to guide the work of defining the needs of the population and the initiatives that will truly meet those needs and transform the system. This means utilizing the respective Working Groups to lead the work, and Councils to inform the work. ***This requires time and proper process – as such the fulsome answers to these questions will be developed in Year 1 of the OHT implementation plan.*** *The current timelines and process have not allowed for fulsome discussion on these topics.*

Overall, the OHT has agreed to the following priorities to improve care coordination, navigation and transitions in care, as a starting point:

How will we coordinate care and improve transitions in care?	How will we help individuals navigate the system?
• **Identify and address service gaps** (update system capacity analysis, across all OHT Members) • **Promote services** and **ensure awareness** (develop a comprehensive inventory and communication plan/infrastructure for how individuals can access services – i.e. leverage OHT website and HCNS work underway) • **Develop simpler access points** – central access and referral; including self-directed access (leverage, integrate and expand existing central referral systems) • **Improve access to primary care –** focused efforts to improve primary care attachment, including recruitment and retention of resources • Process **improvement efforts focused on transitions in care** (simplify the system) • Ensure welcoming environment – **address systemic racism** • **Coordinate efforts across existing structures** – common Vision and objectives – align efforts	• **Engage patients/clients/residents** regarding their needs and desires • Consider investment in **System Navigator positions** (expand existing and create new; evaluate and evolve) • Create **directory of services** (tied to existing efforts/funding re: HCNS and website development)
• Implement regional digital health strategy (see Section 5.3) to enable coordinated care, patient navigation and transitions in care (i.e. shared Health Record & data platform, security and privacy, patient/client/resident self-management, addressing vulnerable populations)	

In addition to the above, the following priorities have been identified that will enable and support overall population health:

<u>Coordinated Care – Year 1 Population</u>

The OHT Members are committed to building on existing efforts to put in place 24/7 Coordination of Care for our Year 1 population. This will include:

- Identify existing MH&A services and "gaps" for each local community
- Identify solutions for HHR recruitment and retention challenges
- Implement coordinated wait list management
- Implement a single point of access/central referral to ensure streamlined access to community MH&A services
- Improve access to primary care – focused efforts to improve primary care attachment, including recruitment and retention of resources. NOTE:

Approximately 25,000 people in Thunder Bay do not have access to Primary Care. This puts undue pressure on all of the other agencies.

- Leverage existing networks and form new pathways and resources - work with existing structures where possible until new ones can be developed or enhanced, if needed. Look for opportunities to work across existing structures i.e. TBDMHAN and the Child and Youth Mental Health Network which would also support transitions of care.
- Revisit organizational mandates and policies and look at how these might create barriers, be open to revisiting how service delivery can be done
- Support better transitions to home from hospital and throughout care continuum (e.g. expand Patient Oriented Discharge Summary (PODS), coordinated care plans, etc.)

The following are examples of where providers are currently coordinating care across multiple providers and care settings, that will be leveraged:

- **Redeployment of services provided by hospital ED for IV infusion therapy patients to implement a clinic-based program –** program implemented within 48 hours during the pandemic onset - March 2020. The Marathon Family Health Team Nurse Practitioner worked in collaboration with the physician to create an operational process and manual. The NP had oversight of the program with built in staff redundancy from the Family Health Team RN and RPN staff.
- **Local Hospital - Wilson Memorial General - 7-day post discharge planning / follow-up program in collaboration with Marathon Family Health Team and Physician Clinic -** Marathon Family Health Team and clinic providers have a 'within 7-days'' post discharge plan for clinical follow-up with persons being discharged from the local hospital who are considered vulnerable with the potential for re-admission within 30-days or less.
- **Mental Health Addiction Discharge Planning in collaboration with Thunder Bay Regional Health Sciences Centre and the Centre for Addictions and Mental Health - p**ersons admitted to the Mental Health program at TBRHSC are assigned a Social Worker, who works with a District Care Coordinator (DCC) embedded in District of Thunder Bay community primary care organizations. They work together to facilitate the person's discharge plan, so that timely follow-up care can occur for the person once the local clinic is aware the person is back in the community. As part of the plan, a brief discharge summary is also provided to the DCC, so they can provide the clinical provider with some information regarding the person prior to the formal discharge summary from psychiatry being received, which often takes a few weeks.
- **Marathon Rapid Access to Addiction Medicine Clinic and Marathon Palliative/EOL Committee Wellness Check Program - d**uring the pandemic, the Marathon Family Health Team Addiction Prevention Care Coordinator (APCC) and Registered Dietitian (RD) implemented a wellness check-in program for persons who frequently accessed the RAAM Clinic (risk of lack of mental health supports) and the frail elderly (risk of social isolation). Initial contact was via phone, where both providers then followed a program developed template to assess the need for in-person visit or other supports / assistance, that the MFHT and RAAM clinic could provide for them.
- **Marathon Family Health Team Care Coordination System Navigation Algorithm for tracking semi-urgent/urgent referrals - t**his program was implemented in 2020 during the pandemic in order to manage the tracking status

of semi-urgent/urgent referrals the Clinic processed, in an effort to ensure patient's did not "fall through the cracks". We are currently updating the algorithm as we have changed our "non-urgent" referral tracking process, and the method in which we track procedures that have resulted in a patient admission. The intent of this program is to ensure a patient referral results in a scheduled appointment for the patient and subsequent follow-up also occurs (non-admission as well as post-admission).

- **Regional Mental Health Assessment Team (RMHAT)** – a collaborative program between Thunder Bay Regional Health Sciences Centre, St. Joseph's Care Group and partner hospitals. The RMHAT service consists of 24/7 on-site RNs who provide urgent mental health assessments in the emergency department of TBRHSC. The model uses a virtual platform, Ontario Telemedicine Network (OTN), to provide timely access to urgent psychiatric nursing assessment for patients presenting in rural hospital EDs to determine if admission to the Schedule 1 Facility is the best care pathway. It is designed to guide and improve access to care in the most appropriate setting based on the patients' needs at the time of assessment. Expansion to support community MH&A agencies is planned.
- **Access Point North West** – provides coordinated access to outpatient mental health programs including specialized psychiatric assessments, case management as well as supportive housing programs.
- **Integrated Addiction System Complex Case Review**
- **Situation Tables**

Evaluation

The following 'big dot' performance metrics are intended to measure progress towards our goals – additional 'little dot' indicators will be developed in support of progress towards these goals:

- Composite patient/client/resident/ caregiver experience score(s)
- Avoidable ED visits for MH & SA
- Primary Care attachment (including NPs)
- Composite provider/staff experience score (across OHT organizations)

5.2.2. How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services they need. Considering the needs of your initial target population(s), please propose how your team will provide system navigation services in the short and longer-term of operation. Describe what activities are in and out of scope for your system navigation service in this timeframe. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

Describe how the system navigation service will be deployed and resourced, and

whether your team has sufficient existing capacity to meet the anticipated navigation needs of your initial target population.

Describe how you will determine whether your system navigation service is successful. Where applicable, references may be made to Health Care Navigation Service Resource Funding.

As noted in the preamble within Section 5.2.1, the response to this question articulates the general direction that the OHT will take in identifying specific Patient Navigation initiatives that need to be undertaken in Year 1, and beyond.

Patient Navigation

The ultimate goal of the OHT Members is to create a system that does not require extra resources to support navigation. As such, a key priority for the OHT in Year 1 is to improve processes within the system and "simplify the system". Recognizing that this will take time, there is ongoing commitment to invest in Patient/System Navigation resources – both to support individuals in the current system, and to help identify process improvements for the future state. Currently in our system, there are roles dedicated to System Navigation that may be under-utilized and will be a priority of our OHT to enhance. Connecting patients to system navigators will allow them to find the resources they need.

The OHT is currently undertaking work through the Health Care Navigation Services (HCNS) funding received in 2021/22. The development of the service inventory and asset mapping will be the foundation for the work the OHT undertakes in Year 1 related to Patient Navigation services.

The OHT Members are committed to building on existing efforts to implement a coordinated Patient Navigation service. This will include:

- Engage patients/clients/residents regarding their needs and desires; with a specific focus on individuals at higher risk due to social determinants of health
- Consider investment in System Navigator positions (expand/rethink existing models)
- Create a sustainable and real-time directory of services (tied to existing efforts/funding re: HCNS and website development)
    - Finalize HCNS service inventory/mapping
    - Review recommendation from HCNS project
    - Refine and implement model
- Connect patients with local system navigation resources via system navigators
- Improve access to primary care – focused efforts to improve primary care attachment, including recruitment and retention of resources
- Implement case management that is consistent and coordinated
- Ensure low barrier access to services
- Implement central point of access; also, self-directed access
- Educate patients/clients/residents
- Integrated Electronic Health Record

The following are examples of where providers are providing Patient Navigation services, that will be leveraged:

- **Patient/Client and System Navigators** – these roles exist across many organizations in the City and District of Thunder Bay; in hospitals, primary care and community agencies. The opportunity is to understand where these resources align and can work better together.
- **Indigenous Patient Navigators and Liaisons** – these important roles exist across many organizations within the City and District of Thunder Bay.
    - Indigenous Cultural Health Associates at St. Joseph's Care Group provide cultural/spiritual support, advocacy and navigation to Indigenous clients and families through: connections to cultural supports; translation services; supporting and facilitating Sharing Circles; and assisting with answers to questions about care.
    - Indigenous Patient Navigator Services at Thunder Bay Regional Health Sciences Centre provides a number of services for Indigenous patients, including: interpretive services in Cree, Ojibway, and Oji-Cree anywhere in the Health Sciences Centre; support before, during, and after clinical appointments; linking patients and families to community resources; tele-visitation services with remote family members; information and education in a culturally-sensitive manner; liaison and advocate between the care team, patients, and families; and, assistance with discharge planning.

Evaluation

The following 'big dot' performance metrics are intended to measure progress towards our goals – additional 'little dot' indicators will be developed in support of progress towards these goals:

- Composite patient/client/resident/ caregiver experience score(s)
- Avoidable ED visits for MH & SA
- Primary Care attachment (including NPs)
- Composite provider/staff experience score (across OHT organizations)

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

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

As noted in the preamble within Section 5.2.1, the response to this question articulates the general direction that the OHT will take in identifying specific transition in care initiatives that need to be undertaken in Year 1, and beyond.

Transitions in Care

The OHT Members are committed to building on existing efforts related to transitions in care. This will include:

- Improve the process for timely discharge MHA reports back to community provider from MHA specialists/providers

- Identify the top 10 MHA hospital diagnoses and develop intervention strategies/plans
- Improve timely transitions into treatment services
- Improve patient/client/resident follow ups
- Ensure individuals at risk are attached to care
- Implement transition in care/post-discharge follow processes/tools and well-defined roles/responsibilities – including, engage the local community's resources in advance of the client returning to their community
- Support existing services that are trying to ensure transitions of care are in place, remove barriers that might create tensions and barriers when trying to provide this support
- Explore development of formal MOUs that outline pathways, particularly between child and adult system
- Minimize waste and non-value added steps
- Integrated Electronic Health Record

To guide this work the OHT will look to evidence-based practices, such as those articulated in the Health Quality Ontario Standards of Care for Transitions in Care.
https://www.mcmasterforum.org/docs/default-source/rise-docs/partner-resources/hqo_quality-standards-playbook-transitions-between-hospital-and-home.pdf?sfvrsn=641f57d5_5

Evaluation

The following 'big dot' performance metrics are intended to measure progress towards our goals – additional 'little dot' indicators will be developed in support of progress towards these goals:

- Composite patient/client/resident/ caregiver experience score(s)
- Avoidable ED visits for MH & SA
- Primary Care attachment (including NPs)
- Composite provider/staff experience score (across OHT organizations)

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

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

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

response to COVID-19 and your plans to continue providing virtual care. Please also describe what digital health solutions and services are either currently in place or planned for imminent implementation to support equitable access to health care services for your patient population and what your plans are to ensure that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery. Please demonstrate how the proposed plans are aligned and consistent with the directions outlined in the *Digital Health Playbook*. Responses should reference digital health solutions that both predate COVID-19 (where applicable) and any that have arisen as a result of the pandemic response[11] and/or through provincially available digital funding initiatives.

Digital Health Today

Currently in place digital health services that support equitable access include:

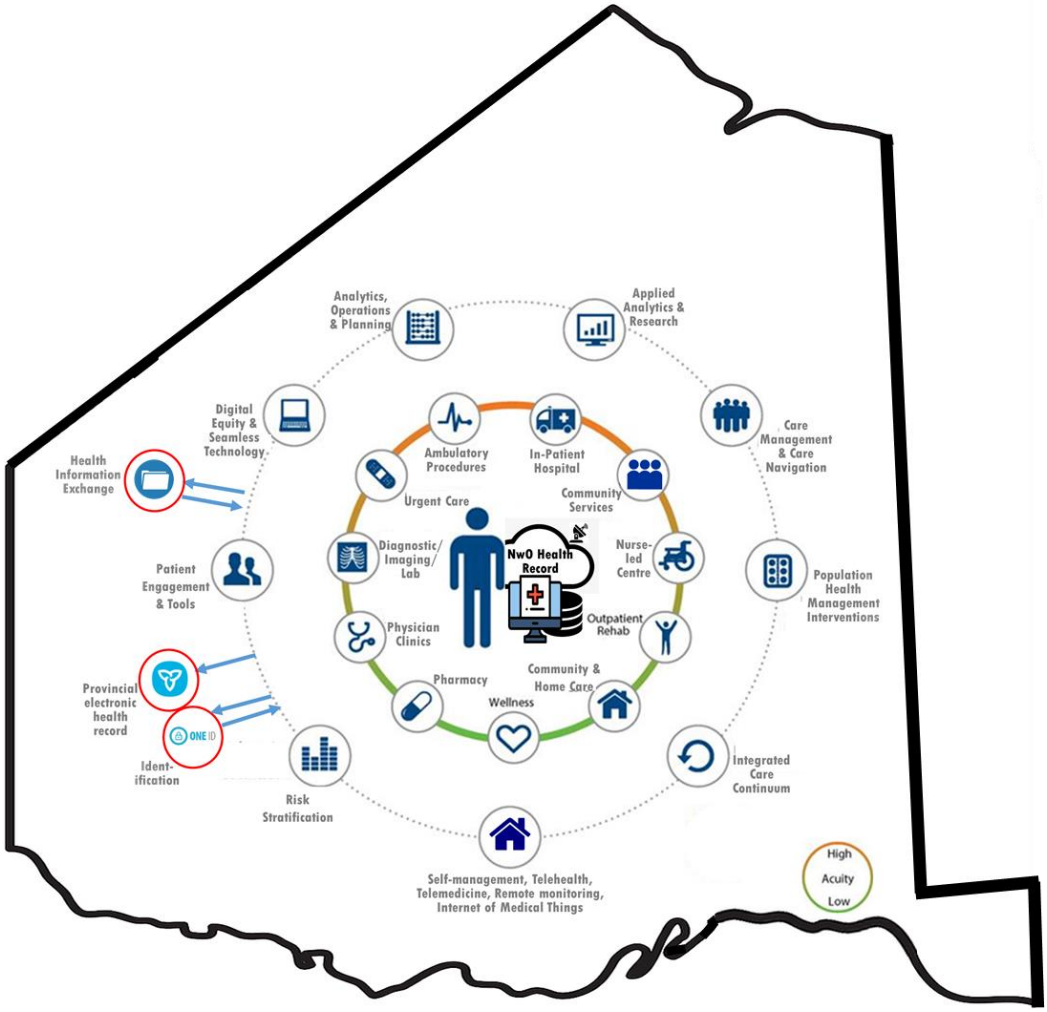
- Strong utilization of the Ontario Telemedicine Network support remote patients/clients/residents across most clinical domains
- Sharing of information to support circle of care by various means, including electronically, using provincial assets, e.g., mental health for remote communities
- Remote monitoring pilots for congestive heat failure, diabetes and wound care. These are all priority services in the Northwest whereby remote (and inherently Indigenous and Francophone) individuals are more severely impacted by access inequity
- Wait list management for surgical, wound and imaging services to prioritize individuals equitably
- Some shared medical records (notably between all hospitals), laboratory and radiology information systems, PACS (including some Far North health centres), and other hospital-based clinical tools among the hospitals.
- Utilization of tools such as Extension for Community Healthcare Outcomes (ECHO)– a virtual tool used for building capacity in chronic pain management and, most recently, Indigenous Health practices. ECHO will serve as a key enabler in building capacity across the OHT. Provides interdisciplinary training at no cost.

Digital Health Tomorrow

Our health system is working towards a **Northwestern Ontario Health Record (NOHR***)* across the continuum of care. This record envisions that hospitals, primary care, mental health and other community services join onto a single record where possible to be able to share care and ensure safe transitions.

In our area there are many single specialized services necessitating patients/clients/residents to 'move' between many organizations at times. Clinical priorities – diabetes and mental health – are common examples of multiple services for a single patients/clients/residents. This model will enable clinical population health management and planning, and also resolve biases in our current data sources. All others may utilize a health information exchange for specific use cases and utilize the Provincial Patient Record (ONE ID, CRV, etc.). Below is conceptual diagram of our Vision aligned to the *Digital Health Playbook*.

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



Our NOHR record will enable care in Indigenous, Francophone and remote communities. In this model data is inherently secure, utilizing he eHealth network when it is necessary for data transmission between records.

This record will enable clinical pathways across providers and community services, as well as, providing the right data to the right person at the right time. This record will support a **single patient/client/resident portal** across the area. A needs assessment exercise for the portal is currently underway to ensure patients across our geography and in particular patients/clients/residents who may be underserviced, clinically or digitally, have their needs met. This will include for example, secure messaging, self-scheduling important, etc. The expected Provincial portal will be strongly considered for the area. The portal will be complemented by patient/client/resident-driven tools, such as, self-management tools and patients/clients/residents' own contribution to their health record and care. Digital health equity will also be a focus to ensure individuals experiencing MH&A and are at risk have the services they require.

Other key work underway includes:

- **Patient navigation services**, along with the mapping of pathways, is currently being undertaken. The City and District of Thunder Bay OHT applied in 2021/22 for the HCNS Patient Navigation funding, as an emerging OHT. With the receipt of this funding, work is almost complete to develop an inventory of services and asset mapping that will provide a foundation for the work of the OHT in Year 1.
- Northwestern Ontario is working towards a **security operations centre** initially between the hospitals and extended to all other partners.
- Work is already underway to **harmonize privacy and security policies**, supported by renewed data share agreements.

Virtual Services and Vulnerable Populations
The Northwestern Ontario health system providers and patients/clients/residents are mature users of telemedicine services, as a key venue for healthcare delivery given the vast geography. Telemedicine has been used in this area for decades. Francophone, indigenous and vulnerable communities, due to geography, use the current telemedicine services. These services will continue. In some communities access to virtual care is limited by the availability of the internet.

Virtual Services, the Pandemic and Post-Pandemic
Although the area has always used telemedicine, during the pandemic the use of virtual services increased dramatically, including phone and video, across most clinical services in community, primary and secondary care. For example, primary care converted ~80-90% of appointments online. Specialised services added to the virtual offering included mental health and addictions and many others. This transition not only protected people physically during the pandemic, but in many cases relieved patient travel from distances as far as 700 km.

Our Commitments
As part of the broader regional digital plan, the OHT will support the following commitments/deliverables:

Shared Health Record & Data Platform	• Implement a shared Northwestern Ontario Health Record (NOHR) with integrations to other records and to the Provincial Patient Record - beginning late 2022/23/ early 2023/24 • Plan for a robust data platform to support day-to-day needs along with population health management and planning needs – to be initiated late 2022/23/ early 2023/24
Security and Privacy	• Implement a system-wide cyber security operations centre with the hospitals initially – to be implemented in 2022/23 • Harmonize privacy and security policies across Northwestern Ontario – complete in 2022/23
Patient/Client/ Resident Self-management	• Design and implement a "people-centred" portal (patient/client/resident, specific to the needs of our population and ensuring equity – to be delivered in 2023/24 (goal: 10-15% of Year 1 population will access their health information digitally) • Assess patient/client/resident self-management and other patient/client/resident-driven tools – beginning in Year 1 and implement in Year 2
Vulnerable Populations	• Ensure access to satellite internet is provided – in Year 1 • For otherwise vulnerable populations strategies are currently being explored with the Patient/Client/Resident and Family Forum to address digital access issues. There are a number of options developed including community-based computers and digital health navigators. These initiatives will be implemented in Year 2. • Augment our Technology Stock Take (completed in 2021) to ensure all technology from partner organizations is captured. This Stock Take will inform detailed virtual care and future architecture plans. – in Year 1
Other	• Refine use-cases for each virtual platform to ensure high patient satisfaction and choice, sustainability and optimal value for investment – complete in Year 1; resulting protocols and education will then be deployed • Virtual services will be expanded by 2-5% in Year 1

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Cindy Fedell
	Title: Regional Chief Information Officer
	Organization: Thunder Bay Regional Health Sciences Centre & St. Joseph's Care Group (working on behalf of all 12 hospitals in the North West region)
	Email: fedellc@tbh.net
	Phone: (807) 620-6507

5.4. How will you address diverse population health needs?

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

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

5.4.1. How will you work with Indigenous populations?

Describe how the members of your team currently engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your initial target population(s) and full attributed population, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in the short and longer-term.

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

If there is one or more First Nations communities in your attributed population or within the areas your team serves, what evidence have you provided that the community has endorsed this proposal? If your team's attributed population/network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the

nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

Our team includes an Indigenous governed Aboriginal Health Access Centre (Anishnawbe Mushkiki) as well as an Indigenous Family Health Team (Dilico Family Health Team) who plan, design and deliver culturally-safe care to the Indigenous community. Anishnawbe Mushkiki will work in partnership with OHT members to design and deliver fully integrated, client-centred services including options for available traditional wellness services across the continuum of care.

It is important to note that our Full Application does not reflect the full scope of what we would consider a meaningful and necessary partnership with local Indigenous organizations and communities. Although preliminary conversations have occurred, we all agree that we have not addressed the important issues discussions that will need to take place to ensure meaningful and reciprocal partnership between Indigenous and non-Indigenous organizations. These conversations will form a foundation as we work collectively to meet the needs of the people we serve; and, concurrently take appropriate steps towards addressing systemic racism and Truth and Reconciliation.
In engagement with Indigenous organizations to date, including members of the Indigenous Primary Health Care Council (IPHCC), we acknowledge that the current OHT planning process has not allowed for meaningful collaboration between Indigenous and non-Indigenous organizations. More specifically, we see it as reflective of colonial practices that need to be examined and addressed at the organizational level going forward. While our proposal outlines proposed leadership structures and priorities, it must be noted that these are draft and will be evolved based on ongoing discussions with Indigenous organizations to ensure fair and equitable representation, and that they are appropriate and reflective of reciprocal and equitable partnerships.
As we advance our OHT, we commit to addressing the following:

- **Authority and voice** - it is important to understand who has authority and a voice in decision-making. This process needs to be spelled out clearly and in a transparent way before decisions are made regarding resources and money (not after). It is also important to respect and validate Indigenous Health in Indigenous Hands.

- **Governance** - Indigenous organizations cannot participate meaningfully and equally when governance has not yet been decided. Indigenous organizations must at minimum have proportional representation at the leadership level on the governance council – this provides inclusion in decision-making and makes room for the Indigenous voice to be embedded on a continuous basis. For example, if Indigenous people represent 25% of the population then Indigenous organizations should have at minimum 25% of the voice/seats that represent decision making; however, we know that this number is low and requires further validation. OHT leadership/governance structures must reflect the diversity of the population and communities they serve.

- **Jurisdictions and complexity** - there is currently a lack of understanding of the complexity of the systems and context Indigenous organizations work within as they are often caught between provincial and federal governments having to advocate and

navigate unfair, complicated and racist systems. There needs to be a commitment by the province, the region, and local non-Indigenous organizations/partners to understand and advocate with Indigenous partners where and when Indigenous partners decide it will be helpful.

- **Priorities** - Often priorities identified by OHTs and non-Indigenous organizations are not reflective of Indigenous priorities and needs – for example, much of OHT focus at this present time relates to seniors but in reality for the Indigenous people, half of the population is below the age of 30 years and many individuals experience health complexities at much younger ages than 65 years. This again shows that realities are different, and priorities need to be adjusted from a population health management lens so that it is inclusive of equity needs. We commit to ensuring the voice and priorities of Indigenous people are reflected in the OHT decisions regarding priority programming.

    - Anti-Racism and Cultural Safety: It is well documented that racism continues to be rampant within the City of Thunder Bay, the North region and health systems that serve Indigenous people. We commit to and prioritize working with Indigenous partners to address racism and build trust at the organizational level and create safer spaces for Indigenous people in the health care system.

    - Data: It is acknowledged that there is significant work required to collect and analyze current, accurate information on the Indigenous segment of the population and health inequities. We are committed to working with Indigenous organizations to invest in data collection and the development of performance indicators that reflect Indigenous needs and health outcomes.

We acknowledge that discussions amongst our organizations are ongoing, and the necessary engagement is comprehensive and will take time and resources to continue to advance beyond current stages. We commit to ensuring that our OHT processes and governance structures respect First Nation jurisdiction and sovereignty as well as urban Indigenous people who live on territory and off territory (reserve), who are status, non-status, Inuit, and Métis. We commit to being flexible to and supporting any parallel Indigenous-led health transformation processes.

We acknowledge that through an agreement with the Ministry, IPHCC members are developing regional models for inclusion within the OHT framework that do not interfere with or dismantle Indigenous-governed health systems, partnerships, funding models, or service delivery models.

Prior to the formal advancement of our OHT, we commit to coming together in ceremony as Indigenous and non-Indigenous organizations to commit to meaningful, inclusive and reciprocal relationships based on trust and transparency, governance, and commitments to addressing systemic racism and Truth and Reconciliation.

Further details on how our OHT plans to work together as Indigenous and non-Indigenous partners are described in Section 4.

5.4.2. How will you work with Francophone populations?

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

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

Within the OHT, the District of Thunder Bay communities of Geraldton, Longlac, Marathon, Manitouwadge, Beardmore, Terrace Bay and Nakina are French Designated Areas. Within the City of Thunder Bay there are 15 French Identified Agencies and within the District of Thunder Bay there are 6 French Identified Agencies.

The OHT is committed to comply with the *French Language Services Act (FLSA)* by ensuring provisions in French to our catchment area. The needs of the Francophone populations will be met by ensuring the following:

- Prioritize FLS services where gaps are identified
- Implement and/or improve the active offer of FLS, meaning services that are clearly communicated, visible, available at all times, easily accessible and equivalent to the quality of services offered in English
- Develop and work toward an OHT FLS HR recruitment strategy
- Address issues specific to Francophone patients in service planning, design, delivery and evaluation by working in collaboration with the FLS Planning Entity
- Collaborate with the FLS Planning Entity, develop policies, bylaws and requirements related to FLS, as outlined in the FLS annual reports
- Ensure information intended for patients and the general public is actively offered in French
- Ensure Francophone patients receive information on services available in French
- Ensure access to virtual care, interpretation services or provision of French services by another HSP when services are not available in French by OHT members
- Adoption of the linguistic variable to identify Francophone patients

Members of the OHT will engage the Francophone population by the following means:

- Evaluation of the quality and access of FLS through client and patient surveys
- Inclusion of Francophones in the Leadership Structure (including Working Groups and Councils)
- Collaboration with the Francophone community to seek input on how to offer services and programs that meet the needs and reflect their values, cultures and experience
- Collaboration with the FLS Planning Entity on engagement and planning activities

It is envisioned that the increased collaboration between providers who are part of our OHT will increase the compliance and the commitment toward the improvement of FLS. As per past practice, providers will continue to improve access and quality FLS offered to the Francophone population. Identified providers will continue to provide health services in French in accordance with the provisions of the FLSA. Providers identified to provide FLS will continue to improve and provide health services in French in accordance with their existing FLS capacity. Providers not designated under the FLSA, nor identified to provide FLS, will develop mechanisms to address the needs of the Francophone community including improving their provision of FLS and providing information on local health services available in French.

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

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

Our OHT is committed to meeting the needs of marginalized and vulnerable populations. The OHT will leverage existing mechanisms in place across various organizations the system broadly to ensure the needs of these populations are met.

There are many examples of how partners are currently working together to meet the needs of vulnerable and marginalized communities – some examples include:

- **Vulnerable Populations COVID-19 Planning Table** – established at the outset of the pandemic to plan and respond to gaps to meet the needs of vulnerable individuals in Thunder Bay and District to reduce the risk of the spread of COVID-19 among those individuals and the community at large. The table comprises 30+ organizations who have partnered on multiple community responses, including the development of isolation shelters, severe weather response plan, warming centre services and care bus.
- **Community Safety & Well-Being Plans** – municipalities across Ontario have been mandated to prepare and adopt a Community Safety and Well-Being (CSWB) Plan by July 2021. The legislation required a CSWB plan that proactively addresses locally identified priority risks to community safety and well-being and that they be developed in partnership with a multi-sectoral Advisory Committee comprised of a number of partners, including police services and local service providers in health/mental health care, education, community/social services, and children/youth services. In Thunder Bay, the CSWB Plan identifies mental health & substance abuse as one of six local priority areas, provides an important opportunity to come together as a community to work collectively to address the greatest risks to safety and well-being in Thunder Bay, so that all residents can live a safe and healthy life.
- **Hospice Northwest leads a Vulnerably Housed Working Group** where palliative care partners meet bi-weekly for rounds on vulnerably housed palliative patients and then the committee meets bi-monthly to further plan care for vulnerably housed,

palliative clients. They also provide education on Palliative Care for front line workers of shelters and marginal housing settings. Further work that is needed is working with Primary Care to ensure clients/patients are identified earlier.

- **Community Paramedicine mobile testing**
- **Collaboration with jails to improve IPAC and discharge processes**
- **Fire and flood responses**
- **Collaborations with DSSAB for supportive housing**

The following engagement mechanisms will be utilized:

- For the disadvantaged, vulnerable population, we will seek the input of the Client Advisory Board of the Thunder Bay Drug Strategy organization.
- For youth, we will likely be able to seek the input of the parents and guardian/caregiver council of Children's Centre, one of our Signatories. It is more difficult to engage youth clients themselves, but we will continually look for innovative ways to do so.

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

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

As articulated previously in our proposal, one of our key principles is: *Person and population focus – we will co-design a system that puts patients, clients, residents, caregivers and their families at the centre of services and addresses the holistic needs of the population we serve.*

The OHT Members take this seriously, and have embedded a People-centred Leadership Council at the core of the leadership structure, to ensure that all decision-making is informed and led with the patient/client/resident/caregiver/family at the centre.

To date there have been two regional engagement sessions with patients/clients/residents/caregivers/families from across the North West region, which has shaped the development of the OHT model. They have also reviewed the provincial Declaration of Values and provide feedback on how to contextualize and implement this locally – this will be a key guidance document for the OHT going forward.

The following structures and engagement mechanisms will be put in place to ensure our commitment to people-centred care:

- Patient/Client/ Resident/Caregiver/Family Co-Leadership of Collaboration Council
- People-centred Leadership Council (guides all levels of decision making, from the patient/client/resident/caregiver/family perspective)
- Patient/Client/ Resident/Caregiver/Family member on all Councils, Networks and Committees (representative of populations being served)
- Patient/client/resident/ caregiver/family stories/experiences embedded at meetings/discussions
- OHT-led survey (to inform patient/client/resident experience measure)

- Adoption of the provincial 'Patient Declaration of Values' – feedback from the regional engagement sessions

It will be important to engage and seek the input of clients/families/patients/residents and other caregivers to ensure that development efforts at the beginning and throughout the life cycle of the OHT are kept on track from a people-centred care perspective.

Past early engagement with patient and family advisors (PFAs) and client and family partners (CFPs) has been moderately successful. Under the OHTs, we anticipate expanded engagement participation as public awareness increases, through PFA volunteerism at every level of the OHT organization, as well as through the establishment of more and larger patient family advisory councils (PFAC), likely grouping institutions' PFACs together for engagement sessions where sensible.

One effective way to encourage engagement participation could be the development of a "buddy-system" whereby every current PFA/CFP volunteer is asked to bring along another person to the live or virtual sessions.

These efforts will be continually evaluated through the following mechanisms:

- Development and implementation of an OHT-led patient/client/resident experience measure – this will be a key metric in the performance measurement framework, to ensure that all efforts are focused on the improvement of patient/client/resident experience and outcomes
- Community engagement with patient/client/resident/caregiver/family regarding needs assessment, strategic planning, service planning, program design, and decisions regarding services
- Surveys of patient/client/resident/caregiver/family members on all Working Groups and Councils to evaluate their perspectives on how their voice is being heard
- Collaboration with patient/client/resident/caregiver/family members across the North West region (across OHTs) to share knowledge and evaluate efforts

Other notable initiatives that will support our people-centre care and co-design approach:

- One of our signatory partners has recently partnered with Dr. Elaine Hogard of the Northern School of Medicine (NOSM), their client relations and engagement Coordinator, and a client/family partner with oversight provided by the Client and Family Council, to develop a comprehensive evaluation framework for patient and family council/PFAC, which will serve as a proposed structure to support the City and District of Thunder Bay OHT Council. The framework serves to evaluate the patient's perspective of the program.
- Our region has partnered with Dr. Laura Rosella and Dr. Kerry Kuluski, Research Chairs at Trillium Health Partners' embedded research unit, the Institute for Better Health (IBH), to study the delivery of person-centred segmentation to populations through the application for a CIHR grant. The proposal entitled "Person-centred segmentation: characterizing population segments to inform care" is in line with our collective aim to apply a population health approach with a strong collaborative component from the community we serve. Our team has already started to look at our population's healthcare utilization data and greatly value an opportunity to expand the information we gather and apply segmentation to our population in a patient-centred manner.

6.0. Implementation Planning & Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 5 (e.g. virtual care, population health equity etc.)? Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 5.1.

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

The OHT members have discussed and agreed to the following high-level implementation plan for Year 1:

Timelines	Priority Deliverables
0 months	• Come together in ceremony as Indigenous and non-Indigenous organizations to commit to meaningful relationships, governance and commitments to addressing systemic racism and Truth and Reconciliation
3 months	• Set up **Collaboration Council** and appropriate processes • Initiate **education/training** – i.e. consensus, conflict resolution • Finalize **decision-making framework** • Develop and implement **communications strategy/plan** • Initiate **leadership structure** (Working Groups, Councils and Networks) • Agree to **OHT branding**; implement website

6 months	• Finalize **priorities and actions plans** (Working Groups to lead; approval by Collaboration Council)
	• Finalize **performance measures**
	• **Begin implementation**
	  • Begin implementation of Patient Navigation tools/recommendations (based on current HCNS resource funding/work)
	  • Begin implementation of digital priorities – per digital plan

12 months	• Ongoing **implementation of priorities and actions** • Implement **collaborative QIP** • **Annual review – set Year 2 priorities, plans**

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

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

In addition to adequate, equitable and sustainable funding for the OHT to operationalize and provide services to meet population health needs, the following non-financial resources and supports have been identified as core needs:

- Legislation changes/modifications to eliminate barriers
- Simplified government contracts that support creative "out-of-the-box" thinking
- Flexibility in funding/contracts that support innovative thinking – i.e. integrated Service Accountability Agreements
- Supports for Health Human Resources recruitment & retention
- Alignment – of priorities and mandates
- Data - require good, consistent and integrated data solutions
- Support for informatics/digital integration
- Access to translation services to support meaningful and appropriate engagement

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

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

See above.

6.4. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting early implementation expectations as set out through guidance[12]. Please describe any mitigation strategies you plan to put in place to address identified risks.

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

Patient Care Risks • Scope of practice/professional regulation • Quality/patient safety • Other	**Resource Risks** • Human resources • Financial • Information & technology • Other
Compliance Risks	**Partnership Risks**

[12] Approved OHTs are expected to work towards the expectations set out in the 2019 Guidance document.

• Legislative (including privacy) • Regulatory • Other	• Governance • Community support • Patient engagement • Other

Risk Category	Risk Sub-Category	Description of Risk	Risk Mitigation Plan
Patient Care Risk	Other - geography	Geography – the North West faces significant barriers to accessibility (including transportation)	Continue to develop and implement innovative solutions – transportation, virtual – as ways to meet population health needs
Resource Risk	Financial	Adequate, equitable and sustainable funding is required for services and for OHT implementation resources (i.e. IT, FTE, service funding)	Ensure implementation and operating funding
Resource Risk	Financial	A critical and foundational enabler of our integrated model is the development and implementation of an integrated digital platform and Northwestern Ontario Health Record. This has significant cost that requires investment (in the order of ~$20- 40 M) across the entire system.	Funds to support digital integration and movement to one health record in the North West.
Resource Risk	Human Resources	Workload – amount of work that needs to be done; may overwhelm providers if not resourced properly; risk that we won't meet objectives in implementation plan and achievement of Vision	Obtain adequate and sustainable funding for resources and ensure realistic implementation plan (start with quick wins)
Compliance Risk	Privacy	Privacy/confidentiality - legislation limits the ability to share patient information between organizations in a timely fashion	To be addressed as part of digital strategy
Compliance	Other - Reporting	Bureaucracy – including significant reporting requirements (reporting the same information to many agencies on	Bring attention to issues/solutions LEAN approaches

		different report formats or databases); fear that OHT will create more "paperwork" and take away from care	
Compliance Risks	Legislation	Lack of consistency of legislation/policy – not all following same regulations – may create barriers to working together and integrating care Funding discrepancy between ELDCAP and LTC beds; ELDCAP is funded through hospital branch and is falling behind in the LTC world as they do not get program funding as does other long term care	TBD
Partnership Risk	Community Support	Meaningful engagement with Indigenous partners – there is significant work and time that needs to be dedicated to this	Follow through on commitments made in preamble and Section 5.4.1
Partnership Risks	Other – time/resources	Due to timing, attention to important OHT details may have been missed (that could later create issues)	Embed CQI principles
Partnership Risk	Community Support	Risk that public gets confused by "OHT" messaging/branding and efforts and the system appears disorganized	Coordinated communication strategy
Partnership Risk	Governance	Commitment – risk that commitment of partners is not sustained	Organization commitment to Vision and principles
Partnership Risk	Other – political	Impact of upcoming election and potential policy delays that may occur	Develop model and principles that sustain any potential delays/changes; partner commitment

7.0. How will your Team collaborate across the region?

7.1. How will your Team engage with the regional plan?

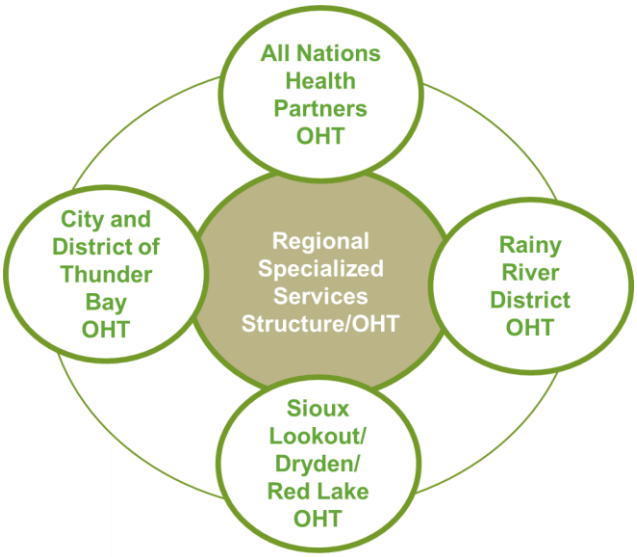
OHTs in Northern Ontario can benefit from connection and collaboration with each other and through regional plans and structures.

Please describe how your team intends to collaborate with other OHTs across the region and participate in regional-level planning and service delivery. In your description, please identify any anticipated benefits or risks to your team from regional collaboration.

Integral to our success as an OHT, is the connection to broader regional services – including other OHTs and regional specialized services providers.

As an OHT, we support the need for a Regional Specialized Service Structure/OHT. This is integral to ensure that we can work in a coordinated way with regional specialized service providers to ensure the needs of our population, across the full continuum of care, are met and that the patient/client/resident experience and outcomes are optimal.

We support the proposed high-level governance/leadership structure below that will support communication among regional specialized service providers, as well as with all four OHTs in the North West region, to ensure the needs of our population are being met across the full continuum of care:



Through this structure and approach, we will have 1-2 of our OHT Collaboration Council Members (likely 2 of the Co-Leads) sit on the Regional Specialized Services Structure/OHT, to ensure the voice of our OHT (and respective communities) are heard and considered in regional services planning. This will ensure that our OHT needs are considered in all levels of planning, including:

- Coordination of regional specialized service delivery and planning
- Coordination of regional enablers – i.e. digital health, population health/data capacity, knowledge sharing, standards development (as appropriate) across OHTs
- Advancement of the following regional deliverables:

- Coordinated regional service planning and delivery framework(s)
- Common definitions for regional specialized services (with consideration of how 'district-level' service need to be considered)
- Common needs assessment tools/approaches
- Common performance metrics
- Common improvement initiatives/approaches – i.e. transitions in care, referral systems
- Common voice/advocacy
- Coordinated approach for enablers – digital and population health/data

This will also allow us to stay connected with other OHTs as we will be at the table with peers from our neighbouring OHTs.

Given our border with OHTs in the North East, we will also develop linkages with appropriate OHTs in the North East to ensure seamless care for people that may access care across both regions.

We will also remain connected and aligned in our efforts through the following mechanisms/tools:

- Common performance metrics – consideration of common Quality Improvement Plan metrics to cascade from regional to local levels

The benefits and risks associated with this approach are outlined below:

Benefits	Risks
• **Connectedness** – ensures collaboration and knowledge sharing across new OHT structures. Shared initiative are already being explored and implement – i.e. Patient Portal, OHT Impact Fellows to support all four OHTs re: population health approaches and data. • **Coordination** – as new OHT structures develop, the regional structure ensures a coordinated way for regional specialized services providers to work with these OHTs, and for OHTs to work with each other. It mitigates the risk of creating 4 silos of care. This is particularly important as it relates to MH&A – given this is a priority of all four OHTs, this will provide strength in a common regional approach. • **Common voice** – supports a collective voice on key issues/challenges that affect the North West; support collective action on solution. • **Efficiency/scale** – provides opportunity to most efficiently and effectively develop system enablers at a regional level that would be more costly, or complex, or less efficient to do at a local level (i.e. digital, data, etc.) • **Improved access** – by using coordinated, data-driven approaches to population health planning we will make better decisions together and better advocacy together on ways to improve access to care and improve population health. Enhance access to existing regional services. • **Capacity building and education** • **Standardization and best practice implementation** • **Quality improvement and common performance measurement**	• **Local autonomy** – need to ensure that local (community, district and OHT) autonomy is not lost in a broader regional structure. 'Care as close to home' needs to remain the priority – the regional structure and approach will only enhance that, not take away from it. Local OHT must also have a strong voice for their population; the regional structure cannot take away from that (i.e. Ministry only engaging through the regional structure); must ensure that the regional structure only enhances the voice, does not replace. • **District approaches** – need to put same consideration to district approaches to services, so that these needs do not get lost in the broader regional approach. • **Funding/resources –** appropriate, equitable and sustainable funding is needed to support the regional structure/OHT in the same way other OHTs are funded, as it is a critical component of the model.

7.2. Additional comments

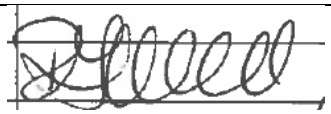
Is there any other information pertinent to this application that you would like to add?

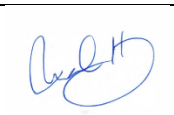
NA

Membership Approval

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

Team Member	
Name	Nicole Latour
Position	Executive Director
Organization (where applicable)	Alpha Court Non-Profit Housing Corporation
Signature	
Date	March 22, 2022

Team Member	
Name	Pamela Gerrie
Position	Executive Director
Organization (where applicable)	Alzheimer Society Thunder Bay
Signature	
Date	March 22, 2022

Team Member	
Name	Micheal Hardy
Position	Chief Executive Officer
Organization (where applicable)	Anishnawbe Mushkiki Aboriginal Health Access Centre
Signature	
Date	March 22, 2022
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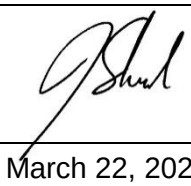
Team Member	
Name	Jason Shack
Position	Physician
Organization (where applicable)	Aurora/ Mountdale Clinic
Signature	
Date	March 22, 2022
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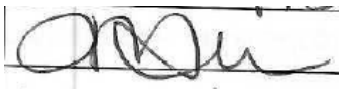
Team Member	
Name	Jennifer Hyslop
Position	Chief Executive Officer
Organization (where applicable)	Canadian Mental Health Association Thunder Bay
Signature	
Date	March 22, 2022
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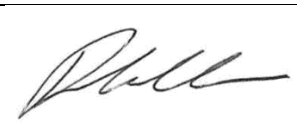
Team Member	
Name	Diane Walker
Position	Chief Executive Officer
Organization (where applicable)	Children's Centre Thunder Bay
Signature	
Date	March 22, 2022
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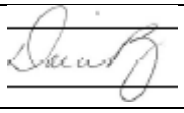
Team Member	
Name	Norm Gale
Position	City Manager
Organization (where applicable)	City of Thunder Bay (Inclusive of Pioneer Ridge Long-term Care and Superior North EMS)
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Jan Adams
Position	Executive Director
Organization (where applicable)	Crossroads Centre Inc.
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Darcia Borg
Position	Executive Director
Organization (where applicable)	Dilico Anishinabek Family Care
Signature	
Date	March 22, 2022
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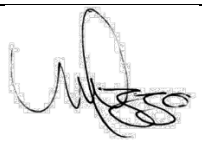
Team Member	
Name	William Bradica
Position	Executive Director
Organization (where applicable)	District of Thunder Bay Social Services Administration Board
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Nathanial Izzo
Position	Executive Director
Organization (where applicable)	Fort William Family Health Team
Signature	
Date	March 22, 2022
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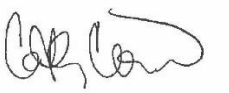
Team Member	
Name	Darryl Galusha
Position	Chief Executive Officer
Organization (where applicable)	Geraldton District Hospital
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Cherrie Kok
Position	Executive Director
Organization (where applicable)	Hospice North West
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Joanne Berube
Position	Executive Director
Organization (where applicable)	Marathon Family Health Team
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Shannon Jean
Position	Executive Director
Organization (where applicable)	Nipigon District Family Health Team
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Cathy Eady
Position	Chief Executive Officer
Organization (where applicable)	Nipigon District Memorial Hospital
Signature	
Date	March 22, 2022
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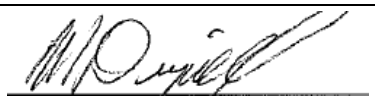
Team Member	
Name	Bobby Jo Smith
Position	Executive Director
Organization (where applicable)	North of Superior Counselling Program
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Adam Brown
Position	Chief Executive Officer
Organization (where applicable)	North of Superior Healthcare Group
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Mary Lynn Dingwell
Position	Administrator
Organization (where applicable)	North Shore Family Health Team
Signature	
Date	March 22, 2022
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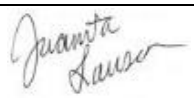
Team Member	
Name	Beverley Kelly
Position	Interim Vice President
Organization (where applicable)	North West Local Health Integration Network – Home and Community Care
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Juanita Lawson
Position	Chief Executive Officer
Organization (where applicable)	NorWest Community Health Centres
Signature	
Date	March 22, 2022
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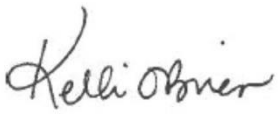
Team Member	
Name	Georgina McKinnon
Position	Executive Director
Organization (where applicable)	People Advocating for Change Through Empowerment (PACE)
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Debbie Hardy
Position	Chief Executive Officer
Organization (where applicable)	Santé Manitouwadge Health
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Kelli O'Brien
Position	President and Chief Executive Officer
Organization (where applicable)	St. Joseph's Care Group
Signature	
Date	March 22, 2022
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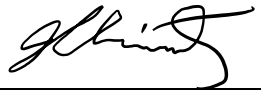
Team Member	
Name	Jack Christy
Position	Client & Family Partner
Organization (where applicable)	St. Joseph's Care Group and Co-Chair, Northwestern Ontario Integrated Care Working Group
Signature	
Date	March 22, 2022
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Team Member	
Name	Nancy Chamberlain
Position	Executive Director
Organization (where applicable)	Thunder Bay Counselling Centre
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

Team Member	
Name	Rhonda Crocker Ellacott
Position	President and Chief Executive Officer
Organization (where applicable)	Thunder Bay Regional Health Sciences Centre
Signature	
Date	March 22, 2022
Please repeat signature lines as necessary.	

The following organizations have confirmed their participation in the OHT as **partners**:

- Canadian Red Cross Thunder Bay
- Thunder Bay District Health Unit
- George Jeffrey Children's Centre
- Port Arthur Health Centre
- Marathon Physician Associate Group

The following organizations have confirmed their participation in the OHT as **observers**:

- Upsala Volunteer Home Support Association

C. Sioux Lookout/ Red Lake/ Dryden

Ontario Health Team: Full Application – Adapted for In Development Teams in Northern Ontario (February 2022)

Introduction

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

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

The following Full Application form has been adapted to reflect the Ministry of Health's (ministry) ongoing work with local providers and Ontario Health to support the advancement of Ontario Health Teams in Northern Ontario.

The Full Application form consists of two parts.

Part A, to be completed by each of the proposed Teams individually, is intended to provide assessors with a comprehensive understanding of each Team and its capabilities, including proposed implementation plans. This information is used to assess each Team's ability to meet the readiness criteria, as set out in *'Ontario Health Teams: Guidance for Health Care Providers and Organizations'* (Guidance Document).

Part B of the application, to be completed regionally (e.g., by the regional planning/working group or its equivalent in collaboration with the proposed Teams in the region), is intended to provide assessors with key information about the regional plan for all Ontario Health Teams in the region, including how the regional structures and functions will connect individual Teams across the region.

OHT Implementation & COVID-19

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

Additional Notes

- Details on how to submit your application will be provided by the ministry.
- Word limits are noted for each section or question.
- The costs of preparing and submitting a Full Application are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).

- The ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The ministry is bound by the *Freedom of Information and Protection of Privacy Act (*FIPPA) and information in applications submitted to the ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

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

PART A: TO BE COMPLETED BY EACH TEAM

(Sioux Lookout/ Red Lake/ Dryden OHT)

With this application, your Team demonstrates interest and commitment to serve the population attributed your Team and to work collaboratively within the proposed regional plan set out in Part B.

Part A of the Full Application form is adapted from both the original 2019 Full Application Form to become an Ontario Health Team and the revised 2020 version. It consists of eight sections:

1. About your population
2. About your Team
3. Leveraging lessons learned from COVID-19
4. How will your Team work together?
5. How will you transform care?
6. Implementation planning & risk analysis
7. How will your Team collaborate across the region?
8. Membership approval

Information about Patient Attribution

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

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

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

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

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

For more information about attribution, please refer to the *'Ontario Health Teams: Data Supports Guidance Document'*.

To complete this application, please use information available to you about your patient population. If your Team is approved, the ministry will provide your team with additional information about your attributed population to support your Team in serving the needs of your attributed population.

Participation in Central Program Evaluation

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Sue LeBeau
	Title: President and CEO
	Organization: Red Lake Margaret Cochenour Memorial Hospital
	Email: slebeau@redlakehospital.ca
	Phone: 807-728-0807
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Sue LeBeau
	Title: President and CEO
	Organization: Red Lake Margaret Cochenour Memorial Hospital
	Email: slebeau@redlakehospital.ca
	Phone: 807-728-0807

1. About Your Population

In this section, you are asked to demonstrate your commitment and understanding of the populations that your Team intends to focus on initially (also referred to as "Year 1" or initial target population) and at maturity.

1.1. Who will you be accountable for at maturity?

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

The ministry will assign your Team an attributed population using data about who the members of your Team serve. Based on the population health data available to you, please describe how you intend to work toward caring for this population at maturity.

Maximum word count: 500

OHT area: At maturity, the entire attributed population of Dryden, Red Lake Sioux Lookout is 38,000. The land area in square kilometres is 51,061.74 which is over 12% of the District of Kenora's land area. The population density per square kilometer in this area is very low at 1.3 in comparison to all of Ontario which is 15.9.

OHT catchment area: The OHT's catchment area is considerably larger and encompasses the 407,213.01 square km of the District of Kenora which is 38% of the province's total area, of which 2% is covered by the neighbouring All Nations Health Partners OHT (See Appendix 1)

When comparing the Public Health Unit ON-MARG index for this area to other Public Health Unit areas it is noted that this population experiences greater residential instability, material deprivation and dependency which demonstrates that there are factors that undermine individual and area health within this OHT.

Statistics Canada census data from 2016 reports 55% of the population as identifying as Indigenous. This statistic is likely underreported due to some communities not participating in census data collection. This reported rate is five times higher than the provincial rate of 2.8%.

This proposed OHT has an aging population with 14.8% of the population over the age of 65 and 1.4% of the population over the age of 85. This OHT has a younger population with

20.5% of the population between 0 to 14 in comparison to Ontario with 16.4% of the population between 0 to 14. The average age in comparison to Ontario is also slightly younger with this proposed OHT's average age being approximately 37.6 in comparison to Ontario at 41.

Using census language data from 2016:

- 74.4% of the population identify English as their mother tongue which is much higher than Ontario
- 1.7% identify French as their mother tongue, which is slightly lower than the province.
- The 22.1% of the population that have identified non-official languages as their mother tongue include:
    - 19.3% identifying Indigenous languages as their mother tongue.
- This area has a very high rate of 88.1% of the population identifying that they speak one of the two official languages most often at home with 9.4% of the population identifying that they speak an Indigenous language most often at home.

List of OHT member and catchment area communities (alphabetical):

- Balmertown
- Bearskin Lake
- Cat Lake
- Cochenour
- Collins
- Deer Lake
- Dinorwic
- Dryden
- Eagle River
- Ear Falls
- Fort Severn
- Hudson
- Ignace
- Kasabonika
- Keewaywin
- Kingfisher Lake
- Kitchenuhmaykoosib Inninuwug
- Lac Seul
- Madsen
- McKenzie Island
- Minnitaki
- Mishkeegogamaang
- Muskrat Dam
- North Spirit Lake
- Oxdrift
- Perrault Falls
- Pickle Lake
- Pikangikum
- Poplar Hill

- Red Lake
- Sachigo Lake
- Sandy Lake
- Savant Lake
- Sioux Lookout
- Slate Falls
- Vermilion Bay
- Wabigoon
- Waldhof
- Wapekeka
- Weagamow Lake
- Wunnumin Lake

1.2. Please identify your initial target population(s).

Over time, Ontario Health Teams will work to provide care to their entire attributed population. However, to help focus initial implementation, it is recommended that Teams identify initial population groups on which to focus care redesign and improvement efforts. This initial target population(s) should be a subset of your attributed population.

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

We first need to understand our region ourselves as a system, and are focusing on this as our first year target. Our large and complex remote region requires innovative and strategic planning to achieve seamless integration of services and maximize our effectiveness as an OHT. With an even larger catchment area of remote and isolated northern communities, who intersects with both Provincial and Federal Governments, our people require coordinated services and planning. With such a large and diverse geographical area, statistics alone, though helpful, do not paint a true picture.

Access to care across a continuum of services is low and challenging. Our OHT stretches 411 km between Sioux Lookout and Red Lake on mostly secondary highways. This stretch has multiple small towns, villages and First Nations Communities along the way and beyond it, which often require great distances to travel for care. We are also experiencing significant challenges in health human resources and most notable primary care and emergency department coverage. Integrating care and leveraging technology where possible, will be a key enabler for effective, efficient and patient centred care that will allow for services closer to home.

We anticipate that mental health and addictions, chronic disease with poor social determinants of health may be amongst the areas we focus once we become more established. Data to support the prioritization of these is includes:

- ED visits for conditions entirely attributed to alcohol across the Northwestern Health Unit area at 5,483.6/100,000, compared to the provincial average of 514.6/100,000.
- Mental Health ED visits are 3,868.25/100,000 which is significantly higher at 2,006.42/100,000.
- All chronic conditions show higher rates of ED visits with diabetes at 299.2/100,000 and provincially 109.4/100,000.

Identifying gaps in a system that has too many siloes to effectively reach hard-to-reach vulnerable populations requires system understanding and improvements. We aim to do this while not losing sight of mental health and addictions, chronic diseases, and social determinants of health.

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

Our OHT has noted equity concerns related to:

- service access in rural remote communities,
- culturally specific services for Indigenous and Francophone populations,
- disproportionate and growing socio-economic pressures specific to this region.

Recognizing the need for culturally appropriate patient centred care, will require a shift in delivery to allow for both Western and Traditional medicine.

Combined, the Dryden, Red Lake, and Sioux Lookout local health hub areas serve an estimated population of 42,093, sparsely dispersed over a large geographical area within the Kenora District. The area includes a sizeable remote population residing in First Nation communities of 16,890 people, within a District that is estimated to be 49.2% Indigenous identity. It is estimated that Indigenous populations are significantly underreported by the Census, therefore the Indigenous population within the area and by extension the population of the area in general is likely much larger.

The Kenora District has an unemployment rate of 11.6%, which is 57% higher than the Ontario rate of 7.4%. 35.2% of the population of the District has no certificate, diploma, or degree, which is twice as high as the provincial rate of 17.5%.

The area lies mostly within a health region (Northwestern Health Unit) characterized as follows:

Condition	NW Health Unit % Prevalence	Ontario Overall %
Diabetes	9.4	7.7
Smoking	19	15.3
Heavy alcohol use	24.6 (40% higher than Ontario)	17.6
Hypertension	21.8	17.9
Obesity	33.6	25.9
Emergency room visits for substance use-related issues	67.3 visits per 1,000 people per year (7X higher than Ontario)	9.8 per 1000
Emergency room visits for mental health and behavioural issues	89.3 per 1000 (4x higher than Ontario)	22.4 per 1000
Hepatitis C	140.2 cases per 100,000 people per year	19.8 per 100,000
Chlamydia	591.5 per 100,000	224.2 per 100,000
Gonorrhea	163.9 per 100,000	61.4 per 100,000
Syphilis	137.8 per 100,000	27.2 per 100,000

Supporting references:

- Alcohol Harms Snapshot | Public Health Ontario
- Alcohol-Attributable Hospitalizations Health Equity Snapshot | Public Health Ontario
- Mental Health Emergency Department Visits Health Equity Snapshot | Public Health Ontario
- Stimulant Harms Snapshot | Public Health Ontario
- Self-Reported Overall Health Snapshot | Public Health Ontario

The northern communities, most of who received support from the Sioux Lookout First Nations Health Authority (SLFNHA). However, they receive many of their medical services in the community of Sioux Lookout greatly impacting the planning. At this time, the Sioux Lookout First Nations Health Authority cannot commit to partner status and have opted for observer status based on their Treaty rights and relationship with the Government of Canada. However, as the OHT develops and grows, the opportunity to leverage and integrate our collective mandates to deliver the full continuum of care and monitor the health status of the population we serve, will enable our team to measure performance and make improvements together.

The challenges are many for our First Nations Communities accessing care including past traumas from Residential Schools and colonialism creating barriers. Accessing care requires many to travel from home for extended periods of time, away from family friends and work. With many levels of government both federally and provincially, this creates many barriers often not seen for many others. Examples of barriers include unapproved formulary drugs and often long approval processes, which prevent many receiving best practice care at home, particularly as new and more effective treatments are discovered. Trained or well supported staff presence in communities is improving, but many lack the confidence or the tools to support patients who have been offloaded for a diabetic foot ulcer, as one example.

2. About Your Team

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

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

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

In the face of the ongoing COVID-19 pandemic, teams should look at efforts to engage with public health and congregate care settings including long-term care, and other providers that support regional responses.

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

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

2.2. Confirming Partnership Requirements

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

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

Please describe how the members of your team have previously worked together to advance integrated care, shared accountability, value-based health care, or population

health, including through a collaborative COVID-19 pandemic response if applicable (e.g., development of new and shared clinical pathways, resource and information sharing, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities, or participation in Health Links, Bundled Care, Rural Health Hubs).

Describe how existing partnerships and experiences working together can be leveraged for ongoing COVID-19 response and recovery, and to deliver better-integrated care to your patient population more broadly within the initial phase of implementation. In your response, please identify which members of your team have long-standing working relationships, and which relationships are more recent.

Max word count: 1000

Within our region, there are many existing partnerships across the health care systems that have been utilized to best serve our population. Forming this OHT will allow us to strengthen and form new partnerships in order to enhance our pathways to deliver the best possible integrated care.

It is through understanding each other's needs and leveraging existing pathways, we can improve patient flow through for mental health and addictions, improve social determinants of health and chronic disease outcomes. We however, must improve our primary care and other health human resources levels by understanding where there is duplication and opportunities for integration first and breaking down siloes.

Things we do well across the district:

- Telemedicine provides a sustainable, holistic, community driven and culturally appropriate care to many communities throughout the district and is of great use for the isolated and remote First Nations. Services being provided by Keewaytinook Okimakanak is a good example where clinical, educational and administrative services are being provided.
- Situation table
- Pharmacy: central mixing of chemo
- Mental Health and Addictions:
    - Suboxone,
    - Mobile Crisis,
    - OPP-Hospital transfer of custody
- Indigenous Patient Experience work group
- Community Health Care Committee: physician recruitment and retention
- Community Wellbeing work plan
- Regional hospital transfer nurse program
- Diabetes program collaboration between EFFHT and RLFHT. Potential to outreach further
- Footcare between RLIFC and RLFHT
- Expanding virtual care access: online booking, remote check-in, Patient portal, virtual visits
- RLIFC Kare Program for RL and EF
- Food banks
- Regional Palliative Care Committee

- Regional Laboratory: The Kenora Rainy-River Regional Laboratory Program exists to provide six hospital laboratories (in the following communities: Atikokan, Dryden, Fort Frances/Emo/Rainy River, Kenora, Red Lake and Sioux Lookout) with administrative and technical advice, consultative, education and quality support services. This program has been in place since 1992 and has allowed for state of the art laboratory equipment, regional standardization for manuals, reagents, methods and policies. This collaboration also provides education, training, quality management programs that enhances the laboratory services provided in the Northwest. Rationalization of services occurs for strategic planning, new initiatives and addressing complex issues to meet the clinical needs and goals of each facility.
- Regional IT working group: cybersecurity, planning, interconnectivity
- Common work on care pathways and transitions in care
- Relevant clinical services planning, integration and delivery (i.e. housing, MHA, diagnostics, chemotherapy mixing, shared patient navigation planning resources)
- Relevant back-office opportunities
- Shared data and decision-support resources to support population health planning (e.g. better insights on who is in LTC)
- Funding – collaboration on proposals and associated funding allocations
- French language capacity building
- 4D community pathways program in schools with NWHU student support navigators
- Ready to quit program (shared clinical pathways)
- Regional Mental Health Committee – bringing SLMHC, SLFNHA, SLRPSI, TBRHSC, OPP and Canadian Mental Health Association partnership and LWDH together to discuss pathway to improve mental health services in region and specifically Schedule 1 services. to provide mobile outreach and mobile crisis response, Kathy to check)
- Partnership between Northwestern Health Unit and Kenora District Services Board related to dental programming for Dryden.
- Partnership between Red Lake Margaret Cochenour Memorial Hospital and Northwood Lodge, for maintenance, food and other services
- Northwood Lodge hosts community support programs in Red Lake such as meals on wheels, adult day care
- Princess Court shares their building with Patricia Gardens (Supportive Housing) and Patricia Gardens provides all meals for Patricia Gardens supportive housing services
- Committees and working group related to early childhood development; a Northwestern Health Unit facilitated committee to increase training for home visiting programs included Friendship centres, SLFNHA, Best Start committee led by KDSB.
- Partnership between NWHU and SLFNHA related to audiology services/
- Partnership between NWHU and SLFNHA related to food insecurity
- Partnership between NWHU and Mary Berglund Community Health Centre on a dental hygienist.
- Ongoing partnerships with municipalities and townships as it relates to health eating and physical activity policy.
- Sioux Lookout First Nations Health Authority – partner on many initiatives to help serve the population
- Sioux Lookout Regional Physicians Services Inc (SLRPSI) provide physicians to the hospital, local clinics, northern communities, and regional phone coverage
- Kenora District Services Board - have collaborated on several proposals and initiatives within the Sioux Lookout region.
- Regional shared Meditech system

- Participation at regional CEO, COS, and CNE committees, planning regional strategies to care
- We work collaboratively with SLFNHA for diabetes education
- Partnerships with multiple Tribal Councils on different initiatives (i.e.) diabetes remote patient monitoring
- Regional surgical network
- The Community Paramedic (CP) program champions collaboration and integration. By forming key relationships with health partners such as local hospital discharge planners, community care coordinators, Family Health Team leaders, clinic managers, and/or community program representatives. This level of collaboration aims to provide wrap-around-services, while avoiding duplication. Community Paramedics become integrated into the circle of care and can begin to act as an extension of the patient's care team. Furthermore, by collaborating with their team, effective and efficient interventions can be made to improve the patient's quality of life. Examples of where the CP team leverages collaboration and integration include Home Safety Assessments, Medication Compliance Assessments, Vital sign Monitoring/Check-Ups, etc. During the COVID-19 pandemic CP's have provided mobile testing/vaccinations, supported mass vaccination clinics, supported COVID assessment centres, as well as providing support for many on home isolation.
- Partnership with FIREFLY as the Lead CYMH agency and provider across the region.

3.0. Leveraging Lessons Learned from COVID-19

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

Max Word Count: 500 561 words

Throughout the COVID-19 response, broader collaboration through various systems has occurred, such as, COVID-19 Surge and Outbreak Table, consisting of Hospitals, Long Term Care, Home and Community Care and other partners, in order to stay on top of operational needs, health system concerns and areas where support is needed. Another pandemic response that has been successful is our COVID-19 Vaccination, which led to high vaccination rates throughout our region, including Northwestern District Health Unit which has a rate of 88.6% fully immunized for those 5+. COVID-19 Isolation Shelters for those who tested positive for COVID-19 within our marginalized population, was an initiative that formed due to strong collaboration in order to meet the needs of those in our community. Working in collaboration throughout the pandemic has allowed our region to adapt, work successfully and enabled us to address major issues effectively.

There has been a significant improvement in cross sector collaboration and between communities that include the sharing of HR resources. In response to the pandemic, there have been a number of changes to care provision, in addition to new services offered in the communities. New services in the community include:

- It was discovered that staying in one's lane/silo is not a productive place to go back to post COVID
- We learned that we can quickly and effectively come together to implement significant programs e.g. Isolation Centre
- COVID-19 Assessment Centres were rapidly established in our region. This strategy has been helpful in diverting away from ED visits and supports the large scale testing.
- Clinics developed to engage and support Indigenous populations; involved partnerships with Friendship centres, SLFNHA, and tribal councils.
- Clinics regularly reviewed local vaccination coverage statistics to ensure efforts were targeting the population with low coverage rates.
- Primary care partners leveraged their relationship with patients to increase vaccination rates
- Mobile clinics provided by Kenora District Service Board for clients who could not attend vaccination clinics
- Changes to how services are provided in the community have been significant with a rapid and largescale shift to virtual care, discontinuation of in-person group-based care and interventions, implementation of physical distancing measures within care settings, and the implementation of COVID-19 screening and testing protocols. In many instances, Improvement in accessibility and convenience with virtual care offerings with a variety of platforms and greater efficiencies recognised by users.
- Within a client-centred framework, services continued to operate utilizing a multi-pronged service-delivery approach. Innovative adaptations include home visits, food security, and activities to reduce social isolation.
- Sharing staff and reduce related barriers e.g. vaccination, Isolation Centre…
- Virtual physician visits, including when physicians are not physically in the community
- More emphasis on care provider wellbeing and mental health
- Being more flexible and adaptable, taking a bit more risk
- Telephone appointments better: longer, easier to access e.g. for seniors, looking at whole health instead of one issue. Physicians have more time, fewer interruptions when working from home/virtually
- Showed that we can do things like physiotherapy virtually
- Followers for virtual information e.g. Facebook communications
- Therapeutic relationships can be developed through virtual means!

- The implementation of a Community Paramedic Program by the Kenora District Services Board paramedic service to provide care to high intensity needs patients to wait for LTC beds at home and community clinics to help divert patients away from the ED.
- Partnered with ORNGE to provide COVID-19 vaccines to health care workers and LTC residents within Sioux Lookout

4.0. How will your team work together?

4.1. What are the proposed governance (or collaborative decision-making) and leadership structures for your team?

Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. For additional guidance on the development of Collaborative Decision-Making Arrangements (CDMAs), please refer to the '*Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System'.* Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

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

- ***How will your team be governed or make shared decisions?*** Please describe the planned governance (or collaborative decision-making) structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?

- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.

- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***

- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?*** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

Max Word Count: 1000

Our Vision, Mission and Values

Our Vision: An integrated holistic health system meeting the culturally appropriate needs of the people of Northwestern Ontario

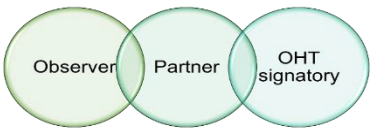
Our Mission: Our Ontario Health Team works collaboratively to provide responsive, locally led, equitable, cultural safe services that address the social determinants of health.

Our values: reflect the Seven Sacred Teachings

- **Honesty** – speak openly and truthfully always.
- **Truth** – Focus on facts; be prepared to accept information you may not want to hear.
- **Respect** - Everyone has value and should be treated with respect. Being on time, listening, and speaking humbly, and respecting personal boundaries are all ways in which respect is demonstrated.
- **Bravery** – Take risks; move toward your vision despite fears and unknowns. Have the courage in sensitive or difficult conversations.
- **Love** – Love describes the good life – Minobimaadiziwin. It is given and received through life, earth, people, choices, and opinions.
- **Humility** - No one person or community is more important than another; we are all equal. Everyone has a voice, and all contributions have value. We all have gifts as well as limitations.
- **Wisdom** - We constantly learn by listening, hearing, and applying what we learn – especially from our elders – in a never-ending process.

Our Scope

- Clear Terms of Reference, including
    - Frequency of meetings
    - Finalized description of organizational roles, including:
        - Signatory
        - Partner
        - Observer



- Work Plans for established priorities
- Success criteria and timelines
- Identification of constraints, challenges and potential mitigators

Our Communications Strategy

- **Communication and engagement methods**: Websites, Radio, etc. and Cost
- **Status reporting requirements to Signatories/Partners/Observers**: who, when, how, how often, and cost of meetings
- **Strategy for communication to Outside Organizations/Communities**: First Nations and Observers; how will they have a voice
- **Representation of off-reserve Indigenous population**: – Metis, Friendship Centres, ONWA & Sunset Women's Group

- **Involvement and reporting structure to focused groups:** Francophones, First Nations, PTO's, TC's, Municipalities, and People (Patients/clients/families/caregivers/relations)
- **Reporting to Funders/Province**
- Guidelines for Committee/Unit Council/Steering Group Communication
- Clear Communication Policy

Our Proposed Support and Resources

Subject matter expertise and support in:

- Systemic and operational leadership
- Project management
- Finance management
- Legal
- Information Services and Digital Technologies
- Other subject matter experts from other sectors such as transportation experts.

Funding:

- Remuneration and contract for management and admin support
- Administrative Costs and Administrative Organization
- Honoraria for developmental Support/Resources (Elders, Traditional healers)/Professional Staff (Medical/Professional committee members)

Our Structures

Operational leadership (proposed; to be further defined and finalized in our first year)

- Governance Board and chairpersons
- Signatory governance board tables
- Patient committees
- Advisory councils
- Physician groups
- Unit/staff councils
- Working groups

Other structures

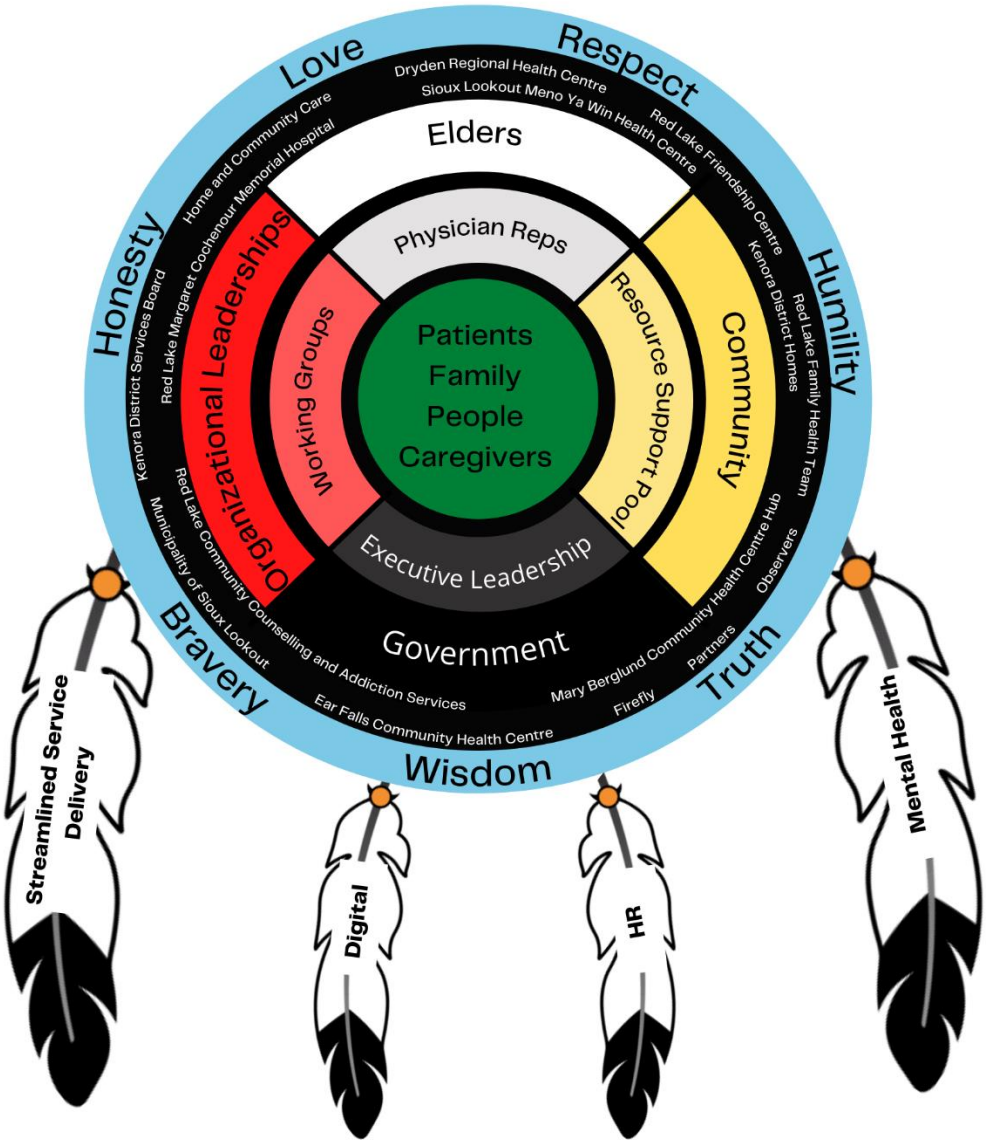
- Dispute Resolution Process
- Decision Making Process - Accountability and Decision Making Criteria
- Performance Management
- Information Sharing
- Resource Allocation
- Quality Management Structure Indicators which address the Quadruple Aim

Agreements:

- Operational and funding for project lead, website development and maintenance
- Development of corporate by-laws and other legally binding agreements
- How will future amendments be made
- Memberships and how does our OHT bring new partners
- Voting process or consensus decision making process
- Required Working Groups and bringing new working groups

Conceptual Medicine Wheel Model

Our conceptual Medicine Wheel Model illustrates the centrality of People (patients/clients/families/caregivers/relations) in our OHT. It also depicts the interrelationships between the people involved, our shared values, and our priorities.



- **Centre circle:** shows Patients, Clients, Family, and Caregivers. They are the nucleus of why we do the work we do. This is colored in green to showcase the importance of a healthy Earth/environment

- **Circle closest to patients:** depicts the working groups or OHT leadership
    - Resource Support Pool: Legal, Digital, HR
    - Executive Leadership: Signatory Organizations

    - Working Groups: Unit Councils, Committees,
    - Physician Groups: Chiefs of Staff & Other medical Professionals

- **Third circle**: illustrates Community, Government and Organizations and Elders. The directional leadership
    - Community: Machin, Sioux Lookout, Ignace, Dryden, Wabigoon, Ear Falls, Red Lake, Hudson, Pickle Lake, First Nations,
    - Governments: Federal, Provincial, Municipal, First Nation PTO's/TC's
    - Organizations: Friendship Centres, Observers & Partners, Women's Group Locals
    - Elders: Metis, Francophone, First Nation, Friendship Centre

- **Second outer circle:** in black shows the signatory organizations who have agreed to come together

- **Encompassing circle:** illustrates the seven grandfather teachings upon which our OHT's Mission, Vision and Values are founded. This is shown in a blue circle depicting the importance of water in our lives. This circle of values surrounds and guides all the work we do, and the decisions we make.

- **Four Feathers:** show the priorities this OHT has initially identified. Feathers can be added or taken out depending on new priorities and completed work.

- All layers are interdependent and are at the same, equitable level within the circle. This is not a hierarchy structure but a structure recognizing the interdependence of each level of authority.

- The circle depicts the medicine wheel and the four colors used in the medicine wheel teachings such as spiritual/mental/physical and emotional health and wellbeing of people.

- The entire wheel depicts the healing continuum.

- The directionality of the circle has meaning – everything starts in the east and flows clockwise. This will be the reporting direction as well in our OHT.

- This model could ground our communication plan, our ethical decision making, our engagement/involvement, our leadership and governance structure, and our priorities.

Please note that this model is conceptual. We are committed to continue collaborating together to ensure it is representative of and meaningful to our communities.

5.0. How will you transform care?

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

improvements in health outcomes for your patient population.

At maturity, OHTs will be held to a standardized *Performance Measurement Framework* based on the internationally recognized Quadruple Aim. The Quadruple Aim is a framework for measuring the delivery of high-quality care and is focused on: Better Patient and Caregiver Experiences, Better Patient and Populations Health Outcomes, Better Value and Efficiency, and Better Provider Experiences.

5.1. Recognizing that measuring and achieving success on the Quadruple Aim will take time, the ministry is interested in understanding how your team will measure and monitor success improving population health outcomes, patient care, and integration in the short-term.

Using data available to you, please identify between 3 and 5 performance measures your team proposes to use to monitor and track success in the short term. In your response, you may consider the *Collaborative Quality Improvement* (cQIPs) indicators.

Please complete section 5.1 in the full application supplementary template.

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

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

5.2.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your initial target population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings. Identify whether your Team has plans to organize care coordination resources differently from how they are currently deployed in order to better serve your population.

Max word count: 1000

Ways to coordinate care for our population begins with ensuring all potential providers are a part of the team and engaged in the process our OHT will be forming. Working with strong existing structures is crucial to identifying patient and family needs, as well as gaps and barriers in our current system. This will allow our OHT to build off current networks and pathways that are working well for patients and families, while looking to adapt new ways of connecting patients to the proper channels. Identifying gaps and barriers in current pathways by engaging with organizations who service this population will allow us to best understand the needs patients and families in our region are facing and come together to form detailed plans that will address current gaps. Planning principles will include:

- Improving access to care
- Every door is the right door, through leveraging existing technology and capability
- Determining system needs as a region, together with patients

We are exploring how we might further enhance and implement a Medicine Wheel Model of Care, where we would incorporate care of the spiritual, mental, emotional and physical into each visit, where feasible. Partnerships with service provider organizations will be required so that care is coordinated and navigation of the system is supported across jurisdictions for patients and their families.

Our approaches could include:

- Identifying and addressing service gaps
- Promoting services and ensuring awareness of how to access
- Developing simpler access points e.g. central access and referral, self-directed access as appropriate
- Process improvements to simplify the system and system transitions
- Working towards cultural safety
- Aligning efforts across existing structures
- Establishing OHT website and directory, to be used by providers and patients
- Using e-referrals which make visible the path the patient is following. Accessible to patients, and agencies, ensuring there is never a wrong door when entering
- Building French language and Indigenous care capacity with a focus on adequate translation services and practices for both
- Coordinating and planning with regional specialized services
- Developing patient experience measurement tool and patient reported outcomes tool.
- Beginning to prototype of new care models
- Developing detailed performance scorecards and key performance indicator dashboard.
- Rapid cycle learning and continuous improvement to ensure course correction.
- Ongoing Stakeholder feedback/engagement sessions.
- Establishing service-level agreements, as needed
- Establishing data sharing agreements as needed
- Establishing our risk matrix

5.2.2. How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services they need. Considering the needs of your initial target population(s), please propose how your team will provide system navigation services in the short and longer-term of operation. Describe what activities are in and out of scope for your system navigation service in this timeframe. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

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

Describe how you will determine whether your system navigation service is successful. Where applicable, references may be made to Health Care Navigation Service Resource Funding.

Max word count: 1000

Navigating our health care system has been an ongoing struggle for patients and families. Currently in our complicated health care system, navigators have become necessary, we aim to reduce the reliance on navigators through streamlining, integrating and removing doors. Partners within our OHT will be able to engage with other services and form strong relationships for connecting care. Education and acknowledgment of the resources in our region will come from the many partners and networks within our OHT.

Our approach may include:

- Creating and implementing a no wrong door approach
- Recognizing the importance Primary Care plays as the patient's medical home
- Establishing a defined care team responsible for care coordination for every Patient
- Fostering case management that is consistent and coordinated
- Implementing Patient navigators, including Indigenous, although our aim is to reduce the need for these
- Establishing a central point of access and self-directed access with a universal digital record/integrated EMR, to enable improved Patient journey following, education and navigation
- Lowering barriers to access to services
- Providing discharge planning support
- Improving access to interpreter services
- Continuing access to secondary and tertiary care as required

Patients should experience seamless transitions as they move from one care setting or

provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your initial target population(s). Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in the initial phase of implementation.

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

Max word count: 500

Improving transitions of care will be measured based on various performance measures. Performance measures our OHT will utilize will include better patient and caregiver experiences, better patient and population health outcomes, better value and efficiency and better provider experiences. The way we will determine better patient and caregiver experiences includes composite patient/client/resident experience score. Lastly, better provider experiences will be measured by composite provider/staff experience score (across OHT organizations).

Reporting mechanisms could include:

- Issues being identified and reported by Patients, navigators, care teams and brought to OHT tables
- Interagency situation tables
- Sharing organizational patient surveys
- Sharing organizational patient and family advisory committee reporting

How will we know we have improved?

- % of referrals made but not followed through (exploring if this possible to track; one of our partners tracks through OTN system with quarterly report)
- Patient stories
- Physician stories: fewer incidents of not making a referral because patient cannot access care
- Bringing services to patients (e.g. CT, MRI, breast screening, psychiatry)

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

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

In the context of COVID-19, increasing the availability of digital health solutions, including virtual care, has been critical for maintaining the provision of essential health care services for patients, while respecting public health and safety guidelines to reduce transmission of the virus. Please describe how virtual care was implemented and used to support a response to COVID-19 and your plans to continue providing virtual care. Please also describe what digital health solutions and services are either currently in place or planned for imminent implementation to support equitable access to health care services for your patient population and what your plans are to ensure that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery. Please demonstrate how the proposed plans are aligned and consistent with the directions outlined in the *Digital Health Playbook*. Responses should reference digital health solutions that both predate COVID-19 (where applicable) and any that have arisen as a result of the pandemic response[2] and/or through provincially available digital funding initiatives.

Max word count: 500 changed to 1000

The pandemic has accelerated the adoption of virtual care across multiple sectors within our proposed OHT. Patients and Providers have readily accepted the adoption of this change as a necessity of staying safe. The current virtual care strategy is varied with several platforms utilized across multiple sectors. The population in our proposed OHT is varied, and digital equity will be a critical consideration, requiring a strategy that operates on a continuum, from low to high-tech while ensuring privacy and security of health information. Evaluation of the penetration and sustainability of virtual care will be a key deliverable. This team will work to develop a standardized and consistent virtual care strategy and develop a future state integrated care strategy. Patients accessing their own health records will be enabled through patient portals.

Digital Health Today

Currently in place digital health services that support equitable access include:

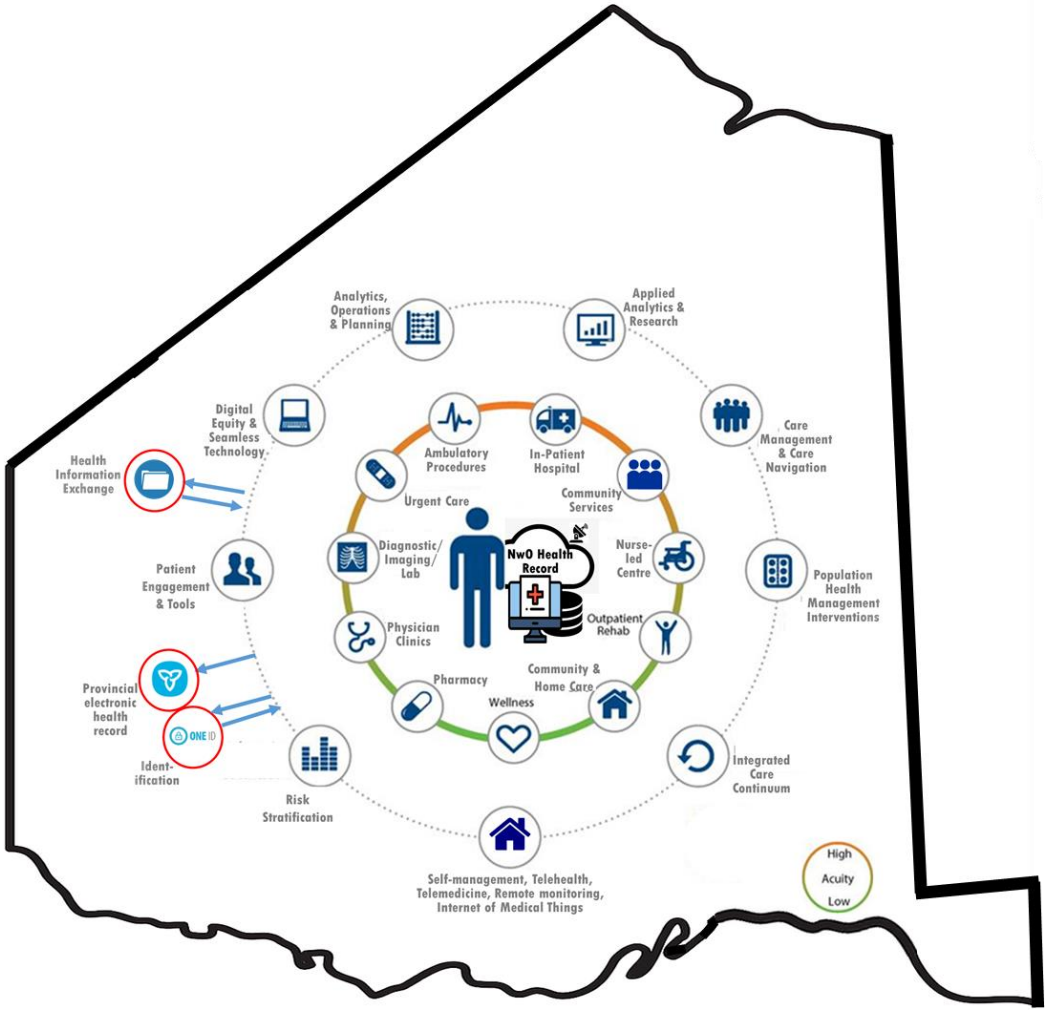
- Strong utilization of the Ontario Telemedicine Network support remote patients/clients/residents across most clinical domains for the hospital and also for community services such as the Red Lake Indian Friendship Centre and Keewaytinook Okimakanak
- Tele-visitation for families, appreciating the vast geography.
- Sharing of information to support circle of care by various means, including electronically, using provincial assets, e.g., mental health for remote communities
- Remote monitoring pilots for diabetes. This are all priority service whereby remote (and inherently Indigenous and Francophone) individuals are more severely impacted by access inequity

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

- A number of virtual services to keep people at home as much as possible: Virtual Mental Health counselling, Virtual physiotherapy, Virtual primary care, Virtual pre/post operative clinic, Virtual diabetes appointments, a number of virtual clinical services (see 3.1)
- Many virtual meetings to support staff
- Wait list management for surgical, wound and imaging services to prioritize individuals equitably
- Some shared medical records (notably between all hospitals), laboratory and radiology information systems, PACS (including some Far North health centres), and other hospital-based clinical tools among the hospitals.
- eReferral services have also been deployed and will continue to expand.
- Secure messaging is also in use and set to be extended to Primary Care and community Counselling, and cross-sector

Digital Health Tomorrow
Our health system is working towards a **Northwestern Ontario Health Record (NOHR***)* across the continuum of care. This record envisions that hospitals, primary care, mental health and other community services join onto a single record where possible to be able to share care and ensure safe transitions.

In our area there are many single specialized services necessitating patients to 'move' between many organizations at times. Clinical priorities – diabetes and mental health – are common examples of multiple services for a single patient. This model will enable clinical population health management and planning, and also resolve biases in our current data sources. All others may utilize a health information exchange for specific use cases and utilize the Provincial Patient Record (ONE ID, CRV, etc.). Below is conceptual diagram of our Vision aligned to the *Digital Health Playbook*.



Our NOHR record will enable care in Indigenous, Francophone and remote communities. In this model data is inherently secure, utilizing he eHealth network when it is necessary for data transmission between records.

This record will enable clinical pathways across providers and community services, as well as, providing the right data to the right person at the right time. This record will support a **single patient/client/resident portal** across the area. Currently a Patient portal is being developed by Red Lake, Ear Falls, and Vermilion Bay FHTs. A broader needs assessment exercise is currently underway to ensure patients across our geography and in particular people who may be underserviced, clinically or digitally, have their needs met. This will include for example, patient secure messaging, self-scheduling important, etc. The expected Provincial portal will be strongly considered for the area. The portal will be complemented by patient-driven tools, such as, self-management tools and patients' own contribution to their health record and care.

Other key work underway includes:

- **Patient navigation services**, along with the mapping of pathways, is currently being undertaken. The OHT applied in 2021/22 for the HCNS Patient Navigation funding, as an emerging OHT. Work is almost complete to develop an inventory of services and asset mapping that will provide a foundation for the work of the OHT in Year 1.
- Northwestern Ontario is working towards a **security operations centre** initially between the hospitals and extended to all other partners.
- Work is already underway to **harmonize privacy and security policies**, supported by renewed data share agreements.

Virtual Services, the Pandemic and Post-Pandemic

Although the area has always used telemedicine, during the pandemic the use of virtual services increased dramatically, including phone and video, across most clinical services in community, primary and secondary care. For example, primary care converted ~80-90% of appointments online. Specialised services added to the virtual offering included mental health and addictions and many others. This transition not only protected people physically during the pandemic, but in many cases relieved patient travel from distances as far as 700 km.

Our Commitments

As part of the broader regional digital plan, the OHT will support the following commitments/deliverables:

Shared Health Record & Data Platform	• Implement a shared Northwestern Ontario Health Record (NOHR) with integrations to other records and to the Provincial Patient Record - beginning late 2022/23 /early 2023/24 • Plan for a robust data platform to support day-to-day needs along with population health management and planning needs – to be initiated late 2022/23 /early 2023/24
Security and Privacy	• Implement a system-wide cyber security operations centre with the hospitals initially – to be implemented in 2022/23 • Harmonize privacy and security policies across Northwestern Ontario – complete in 2022/23
Patient Self-management	• Design and implement a patient portal, specific to the needs of our population and ensuring equity – to be delivered in 2023/24 (goal: 10-15% of Year 1 patients will access their health information digitally) • Assess patient self-management and other patient-driven tools – beginning in Year 1 and implement in Year 2
Vulnerable Populations	• Ensure access to satellite internet is provided – in Year 1 • For otherwise vulnerable populations strategies are currently being explored with the Patient and Family Forum to address digital access issues. There are a number of options developed including community-based computers and digital health, including Indigenous and Francophone, navigators and translators. These initiatives will be implemented in Year 2. • Augment our Technology Stock Take (completed in 2021) to ensure all technology from partner organizations is captured. This Stock Take will inform detailed virtual care and future architecture plans. – in Year 1
Other	• Refine use-cases for each virtual platform to ensure high patient satisfaction and choice, sustainability and optimal value for investment. Extend virtual care to other sites, e.g., Friendship Centre, Women's Shelter, Homeless Shelter – complete in Year 1; resulting protocols and education will then be deployed • Virtual services will be expanded by 2-5% in Year 1

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of*	Name: Cindy Fedell
	Title: Regional Chief Information Officer
	Organization: Northwestern Ontario Hospitals
	Email: fedellc@tbh.net

digital health activities for your team	Phone: (807) 684-6008

5.4. How will you address diverse population health needs?

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

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

5.4.1. How will you work with Indigenous populations?

Describe how the members of your team currently engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your initial target population(s) and full attributed population, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in the short and longer-term.

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

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

Max word count: 1000

Our catchment area includes a significant proportion of Indigenous people (e.g. 90% for SLMHC, and 24% for Red Lake). We work closely with SLFNHA who provide preventative and primary health care to Indigenous people on and off-reserve. It is not clear as to the direction that NAN will take in relation to NAN Health Transformation and Ontario Health Teams; however, we understand the importance of our continued work to embrace both methodologies for the benefit of the people we serve.

We have a shining success story in our region, who has led the way in establishing harmonious relationships with Indigenous communities. In the creation of the Sioux Lookout Meno Ya Win Health Centre (SLMHC), representatives from the Municipality of Sioux Lookout, the Government of Canada, the Government of Ontario and Nishnawbe Aski Nation (NAN) on behalf of the area Chiefs signed a Four Party Agreement. To this day, SLMHC honours that agreement and continues with the vision that was set in 1997. SLMHC's Traditional Programs department that manages six Anishinaabe programs:

- **Odabidamagewin** (Governance & Leadership),
- **Wii'chi'iwewin** (Patient/Client Support – interpreter service 24/7 in Ojibwe, Cree and Oji-Cree),
- **Andaaw'iwewin** (Traditional and Ceremonial Practices – sweat lodge, healing room, drum, Elders, Traditional Healers…),
- **Mashkiki** (Traditional Medicines, kitchenette),
- **Miichim** (Traditional Foods; MNRF is a major partner, many other partners)
- **Biimaadiziwin** Program (Anishinaabe Cultural Training & Culturally Safe Care Training; mandatory for all staff).

SLMHC are leaders in providing culturally safe and appropriate care to the populations we serve. SLMHC will work to expand some of these services across our OHT, and we will encourage our OHT partners to implement portions of these programs across our structure.

In addition:

- Our OHT signatories and partners include Indigenous organizations and leadership
- One of our shared priorities is Indigenous Person care and experience
- Many of our individual organizations are working on cultural safety (education, policies, resources, consultation)
- We are creating consultation pathways for non-Indigenous and Indigenous organizations (who can I call if I have a concern or question)
- We have had formal consultation with Indigenous groups in Fall and winter
- We will continue:
    - Taking the time to listen and to learn
    - Fostering trust, respect and reconciliation
    - Recognizing and honouring Indigenous communities' needs
    - Being mindful of jurisdictional challenges, and striving to transcend such barriers

We are interested in exploring the possibility of establishing an Indigenous Services Plan, similar to the French-language services Annual Plan.

5.4.2. How will you work with Francophone populations?

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

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

Max word count: 500

Many of our organizations adhere to the French Language Services Act and report annually on French Language Services (FLS), as set out in accountability agreements. We recognize that there are barriers that the Francophone population may face when accessing services.

Many OHT partners have French language capacity and will leverage this as we involve the Francophone community including patient/client, caregiver, advisor, and other stakeholders' voices. To ensure that the needs of the Francophone population are better captured throughout the continuum of care, work needs to be done around identifying needs and gaps, as well as capacities, and developing strategies and solutions to efficiently meet the needs identified. Currently in our region, within the District of Kenora, the Township of Ignace is a designated area (see Appendix 2). It is because of this area that many surrounding providers are identified to offer French Language Services. In total we have 4 Identified HSPS for FLS.

We will continue to strengthen the local involvement with Francophone stakeholders and members in our communities. including the North West French Language Health Planning Entity and the local French Language Services Coordinator in the planning, design, delivery and evaluation of services to meet the care needs of the Francophone population. Translation services are also available across all sectors, and several organizations employ French-speaking clinicians.

Sharing French Language resources and/or staff as required across the system is encouraged by all members of the OHT. We will also leverage the Ministry of Health guidance to requirements and obligations relating to French language health services Ontario Health service toolkits.

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

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

Max word count: 500

Already stated above, in 1.2., which includes:

- Vulnerable people, those with adversely impactful determinants of health and those with chronic diseases including mental health and addictions

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

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

Max word count: 1000

Note: when we use the term patient or say we are people-centred, we are referring to patients, clients, residents, caregivers, families and relations.

We are exploring the possibility of a locally-created conceptual *Medicine Wheel Model of Care,* which by design, involves many partnerships including Patients. Patients will provide a crucial perspective of how care redesign is working and whether it is meeting their needs.

Patients/Families/Caregivers will be engaged through means which could include:

- Patient Advisory Committee/Counsel
- Patient Advisory presence at all working groups, and part of OHT leadership table
- Targeted issue-specific consultations
- Invitation to patients to OHT planning meetings
- Navigator solicitation of patient stories
- Patient journey mapping with patient family advisors
- Sharing how the OHT model of care works through Newsletters, our Website, and Social Media. The purpose will be to inform and build trust about the overall purpose and structure of the OHT model.
- Consulting with the General Public through Virtual Town Halls across our communities. The purpose of this will be to inform and build trust about the overall purpose and structure of the OHT model and seek broad priorities for visioning and broad direction of the work.
- Involving patients in determining the overall purpose and structure of the OHT model and, more specifically, about the care redesign for their subpopulation.
- Developing health literacy materials to help this group be active members in their care.
- We will consult with Patients through check-ins at regular intervals to assess both Patient experience and patient outcomes.
- Creating a patient relations process that enables patients/Families/Caregivers to voice concerns, including safety incidents, and seek resolution.

We will know these activities are successful when patients tell us they feel the system was easy to navigate, when they need minimal navigation support, and that their care needs were met with their full involvement.

6.0. Implementation Planning & Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 5 (e.g. virtual care, population health equity etc.)? Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 5.1.

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

Max word count: 1000

The members of our OHT are fully and completely committed to achieving the vision of enhanced, more connected care for the people and communities we serve and we have continued to work collaboratively toward that goal. The COVID-19 pandemic presented challenges to all of us beyond anything we have imagined, but the strength of our relationships, trust and commitment to patient care allowed us to respond seamlessly to the challenges faced. COVID-19 has shone a spotlight on the multiple determinants of health, many of which lie beyond the traditional scope of health systems. Accordingly, we recognize the importance of inter-sectoral partnerships at the community level, across and amongst different levels of government, and between Health Care Providers and other Professionals who have a role in influencing health.

The OHT members have discussed and agreed to the following high-level implementation plan:

Our timelines	Priority deliverables
0-6 months	**1. Formalize OHT structure** o Defining leadership roles, role description … o Develop Terms of Reference, team charter o Clearly define role of signatories, partners, observers o Identify interim champion/lead/project manager until staff hired o Identify finance and digital supports 2. Establish **OHT branding** and **website** 3. **Ensure key partners are involved** as they need to be e.g. Physicians, Indigenous, Federal agencies, others we may have missed 4. Establishing **communication plan** o **Between partners** o **With communities and general public** 5. Clearly **defining what our values, vision and mission** mean 6. Establish our first **working groups**: o **Physicians:** e.g. Chiefs of Staff, Dr. Douglas, private practice o **Performance measures:** establish 90-day measures on our overall collaborative work (sets clear and shared expectations) e.g. **Build trust and relationships** 7. **Talk about digital unity plan** across our OHT, with all partners **8. Involve our respective boards**
7-12 months	1. **Finalize priorities and action plans** (led by working groups, approved by leadership team/collaboration council) 2. Finalize **performance measures** 3. Participate in specific **regional digital priorities** 4. Ongoing 5. Annual review – set **Year 2 priorities**

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

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

Max word count: 500

Category	Resource
Leadership from MOHLTC	• Support to be flexible in our focus • Facilitation and guidance
Human resources	• Project management experts • Support to be flexible with labour approaches (e.g. like in COVID)
Data and Information Services	• Data gathering and reporting on selected metrics, including patient and systemic costs of travel for care • IT support and leadership – regional, to ensure interconnectivity
Learning	• Subject-specific communities of practice with other OHTs working on similar issues (digital, navigators…) • Provincial vault of other OHTs successes and tools e.g. memoranda, policies/procedures (e.g. Rise website) • Education
Patient/Family/Relations resources	• Housing: Many people from north want to move to our region for work but lack of affordable housing

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

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

Max word count: 500

Enablers	Resources Required
• Collective want to do things better • Indigenous leadership and voice • Having a shared platform and forum to advocate to address identified gaps • Virtual OHT – flexible • Room for innovation • Partnerships with the OHT that enhance services delivery and equitability for all • More IT/digital services • Legislation changes /modifications to eliminate barriers • Simplified government contracts that support creative "out-of-the-box" thinking • Successful HR recruitment & retention • Shared policies • Transparency • Learning from our Northern partners • Currently we work with other OHT partners at a local and regional level • Some of our signatories are also a partner in the All Nations Health Partners OHT and a participant in the Rainy River District OHT. There are opportunities for shared learning, resources and regional initiatives to maximize and leverage our collective resources	• Adequate funding • Project Management •

Please note: barriers identified in the risk analysis section, 6.4

6.4. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting early implementation expectations as set out through guidance[3]. Please describe any mitigation strategies you plan to put in place to address identified risks.

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

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

Risk Category	**Risk Sub-Category**	**Description of Risk**	**Risk Mitigation Plan**

[3] Approved OHTs are expected to work towards the expectations set out in the 2019 Guidance document.

Category	Risks/Barriers	Mitigations
Access (Patient Care)	• Relative absence of resources e.g. residential addiction treatment, stabilization, MRI, CT, remote ultrasound within reasonable distance from patients • Vast geography (See Appendix 1) • Lack of transportation (patient, lab, medication, materials…) •	•
Information technology (Patient Care)	• Technology gaps and lack of connectivity between organizations • Lack of connectivity for Patients	• Investment to enable virtual services, for both Clients/Patients and Providers
Determinants of health (Patient Care)	• Significant lack of affordable housing: Housing is a key social determinant of health and will affect our success in healthcare transformation for distinct target populations.	•
Human Resources (Resource)	• Access to Family Physicians: This has been a significant historical barrier to our Patients receiving true continuity of care • Challenges to recruit/retain expert HR • PSW and Nursing and other shortages • Labour restrictions/constraints, making it difficult to move people around • Wage disparity across sectors. • Volunteers for delivering services; many have declined or unable to support • Bill 124 • Lack of nurses, physicians and other allied health • Physician contract constraints • Wage disparities • Lack of affordable housing for staff • Union contracts	• Working with other OHT's in northern Ontario on resource sharing/planning may assist with current HHR shortages. Also needed are: • Appropriate funding formulas, long term/permanent funding (rather than temporary or one-time funding) and appropriate staff compensation models. • Hire full time ER physicians • Cap nurse agency wages • Repeal bill 124 and appropriately fund organizations to cover costs • Revisit physician contracts to improve complement and flexibility • Affordable housing for staff • Northern living allowance for health care workers • MOH capping salaries of agency staff • Increase healthcare salaries • Legislation to enable us to move workforce when it makes sense to do so • Coordinate staff wages
Funding (Resource)	• PPE shortages and costs • Lack of funding in general to support organizations • Funding through intermittent requests for grant applications is an inefficient way to fund a new system. • Funding for LTC homes	• Continued financial support for PPE • Stable permanent funding to support an OHT to develop that does not require ongoing grant applications.

	• Multiple funder requirements may limit flexibility in leveraging resources. Organizations such as FIREFLY are funded by the Ministry of Health and the Ministry of Children, Community and Social Services which complicate collaborative planning for health related services in the area of children's rehabilitation services – a service often intertwined with health. •	
Legislation (Compliance)	• Privacy Legislation: PHIPA legislation constraints make data and information sharing across sectors next to impossible • Non-insured health benefits • Barriers between ministries	• Amendments of this legislation to support integrated teams and OHT models.
Data (Compliance)	• MRP Data capture issues with Nurse Practitioner and CHC Physicians as these practitioners do not bill to OHIP • Data sharing agreements and privacy •	•
OHT structure and partnerships (Partnership)	• Having an OHT which differs from regular referral pathways • Virtual OHT e.g. no office building • Mechanisms to involve physicians. • Capacity to participate in OHT's for each organization is going to be limited as there is no additional people or capacity provided to each organization. • NAN does not endorse	• Continue regional collaboration across NWO OHTs • Keep advocating for NAN to sign on for OHT with us • Coordinated planning for regional specialized services •
Federal-provincial-Indigenous jurisdiction	• Federal and provincial agreements and jurisdictional boundaries • Two systems of travel (provincial and federal jurisdictions)	•

7.0. How will your Team collaborate across the region?

7.1. How will your Team engage with the regional plan?

OHTs in Northern Ontario can benefit from connection and collaboration with each other and through regional plans and structures.

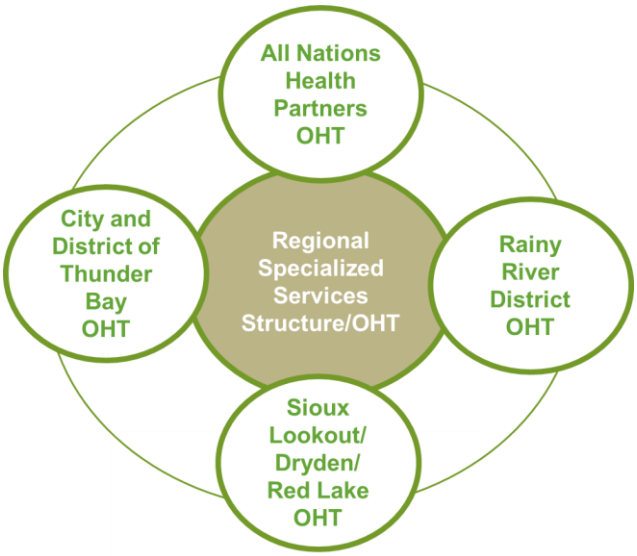
Please describe how your team intends to collaborate with other OHTs across the region and participate in regional-level planning and service delivery. In your description, please identify any anticipated benefits or risks to your team from regional collaboration.

Max word count: 1000

Integral to our success as an OHT, is the connection to broader regional services – including other OHTs and regional specialized services providers.

As an OHT, we support the need for a Regional Specialized Service Structure/OHT. This is integral to ensure that we can work in a coordinated way with regional specialized service providers to ensure the needs of our population, across the full continuum of care, are met and that the patient/client/resident experience and outcomes are optimal.

We support the proposed high-level governance/leadership structure below that will support communication among regional specialized service providers, as well as with all four OHTs in the North West region, to ensure the needs of our population are being met across the full continuum of care:



Through this structure and approach, we will have 1-2 of our OHT Collaboration Council Members (likely 2 of the Co-Leads) sit on the Regional Specialized Services Structure/OHT, to ensure the voice of our OHT (and respective communities) are heard and considered in regional services planning. This will ensure that our OHT needs are considered in all levels of planning, including:

- Coordination of regional specialized service delivery and planning
- Coordination of regional enablers – i.e. digital health, population health/data capacity, knowledge sharing, standards development (as appropriate) across OHTs
- Advancement of the following regional deliverables:
    - Coordinated regional service planning and delivery framework(s)
    - Common definitions for regional specialized services (with consideration of how ‘district-level’ service need to be considered)

- Common needs assessment tools/approaches
- Common performance metrics
- Common improvement initiatives/approaches – i.e. transitions in care, referral systems
- Common voice/advocacy
- Coordinated approach for enablers – digital and population health/data

This will also allow us to stay connected with other OHTs as we will be at the table with peers from our neighbouring OHTs.

Given our border with OHTs in the North East, we will also develop linkages with appropriate OHTs in the North East to ensure seamless care for people that may access care across both regions.

We will also remain connected and aligned in our efforts through the following mechanisms/tools:

- Common performance metrics – consideration of common Quality Improvement Plan metrics to cascade from regional to local levels

The benefits and risks associated with this approach are outlined below:

Benefits	Risks
• **Connectedness** – ensures collaboration and knowledge sharing across new OHT structures. Shared initiative are already being explored and implement – i.e. Patient Portal, OHT Impact Fellows to support all four OHTs re: population health approaches and data. • **Coordination** – as new OHT structures develop, the regional structure ensures a coordinated way for regional specialized services providers to work with these OHTs, and for OHTs to work with each other. It mitigates the risk of creating 4 silos of care. This is particularly important as it relates to MH&A – given this is a priority of all four OHTs, this will provide strength in a common regional approach. • **Common voice** – supports a collective voice on key issues/challenges that affect the North West; support collective action on solution. • **Efficiency/scale** – provides opportunity to most efficiently and effectively develop system enablers at a regional level that would be more costly, or complex, or less efficient to do at a local level (i.e. digital, data, etc.) • **Improved access** – by using coordinated, data-driven approaches to population health planning we will make better decisions together and better advocacy together on ways to improve access to care and improve population health. Enhance access to existing regional services. • **Capacity building and education** • **Standardization and best practice implementation** • **Quality improvement and common performance measurement**	• **Local autonomy** – need to ensure that local (community, district and OHT) autonomy is not lost in a broader regional structure. 'Care as close to home' needs to remain the priority – the regional structure and approach will only enhance that, not take away from it. Local OHT must also have a strong voice for their population; the regional structure cannot take away from that (i.e. Ministry only engaging through the regional structure); must ensure that the regional structure only enhances the voice, does not replace. • **District approaches** – need to put same consideration to district approaches to services, so that these needs do not get lost in the broader regional approach. • **Funding/resources –** appropriate, equitable and sustainable funding is needed to support the regional structure/OHT in the same way other OHTs are funded, as it is a critical component of the model.

7.2. Additional comments

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

Max word count: 500

Membership Approval

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

Partners

Canadian Mental Health

North West Health Unit

Observers

Grand Coucill Treaty #3

Sioux Lookout First Nations Health Authority

Dryden District Senior Services Inc.

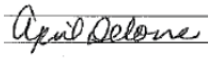
Keewaytinook Okimakanak

Points North Family Health Team

Doug Lawrence
Municipality of Sioux Lookout

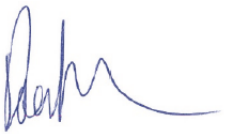
Karen Ingebrigtson
Firefly

Marcia Scarrow
Red Lake Community Counselling and Addictions



April Delorme
Ear Falls Community Health Centre

Pat Delf
Red Lake Family Health Team



Doreen Armstrong
Dryden Regional Health Centre

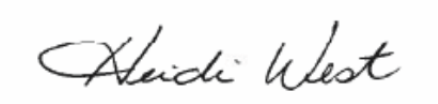
Sue LeBeau
Red Lake Margaret Cochenour Memorial Hospital

Heather Lee
Sioux Lookout Meno Ya Win Health Centre

Beverley Kelly
Home and Community Care Support Services North West

Stephen Viherjoki
Dingwall Medical Group

Monique Tougas
Red Lake Indian Friendship Centre



Heidi West
Mary Berglund Community Health Centre Hub

Henry Wall
Kenora District Services Board

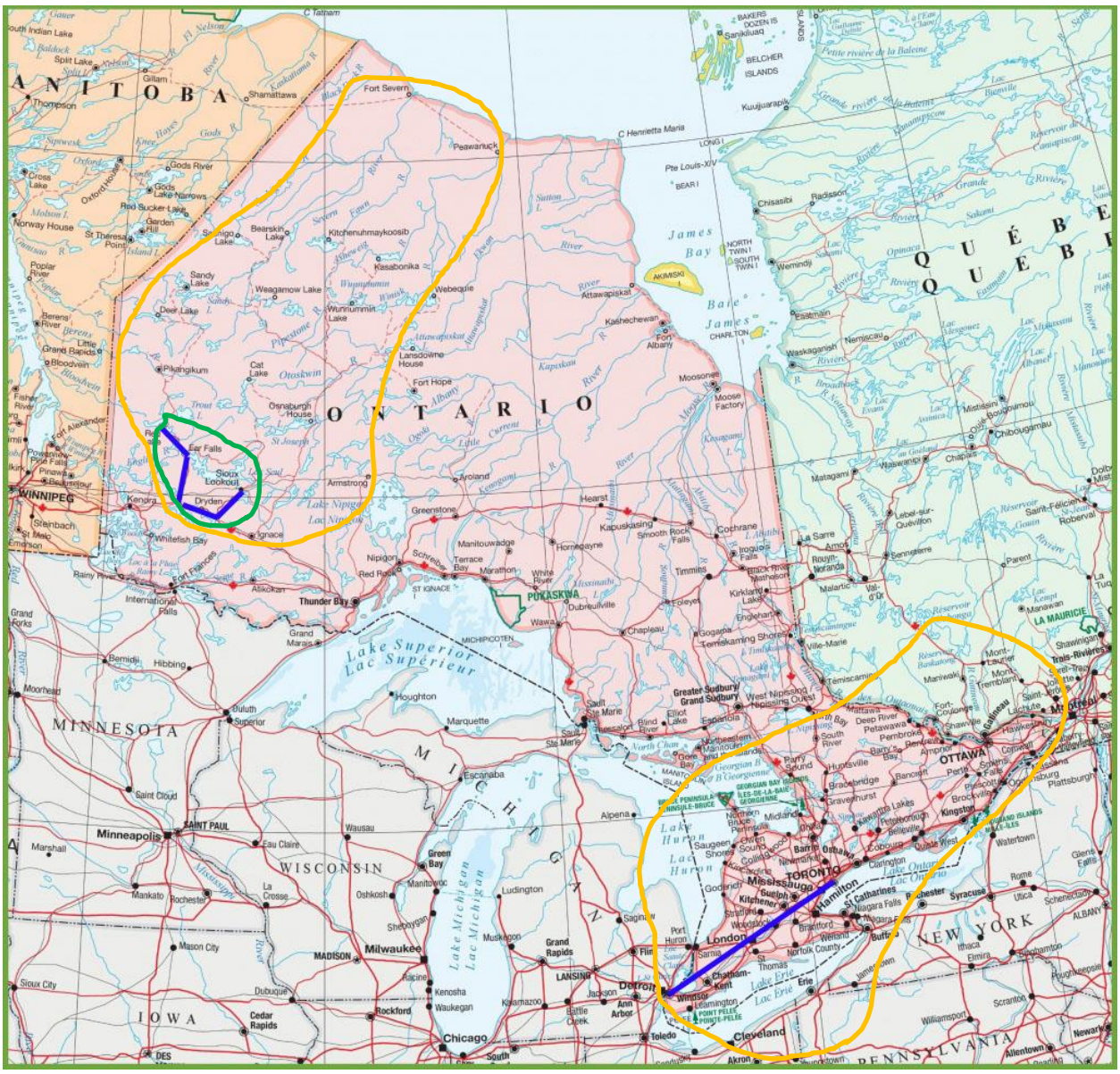
Kevin Queen
Kenora District Homes

Appendix 1 – Our Geography

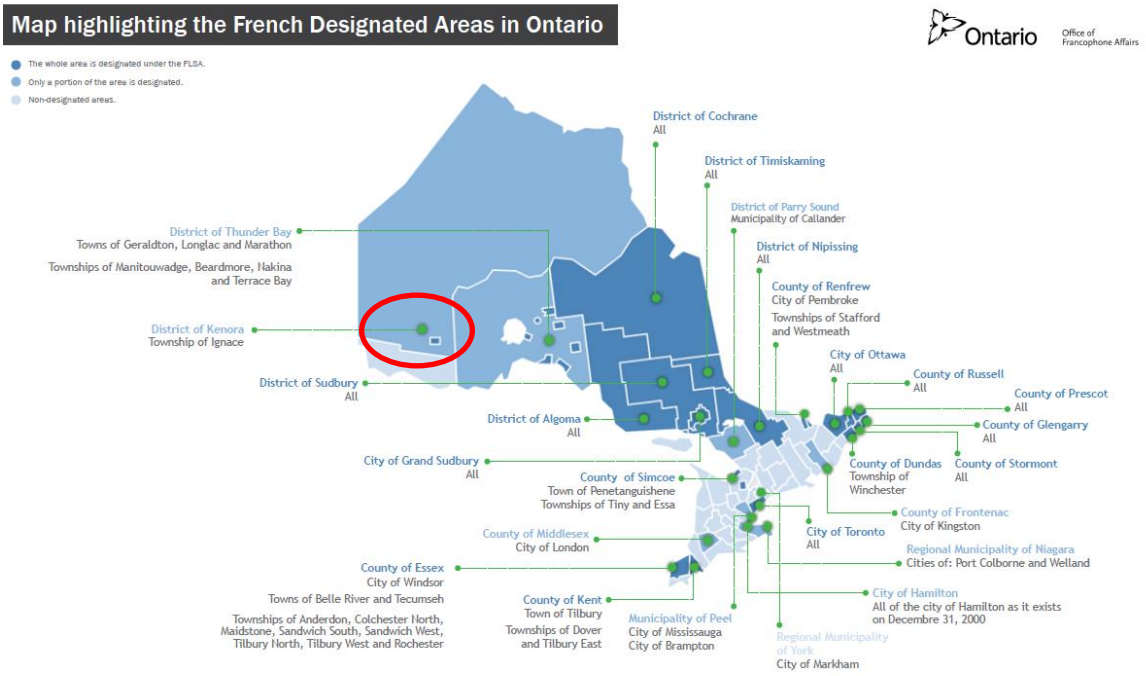
Blue lines: Our proposed OHT covers the equivalent driving distance of Toronto to Windsor, where there are roads

Green circle: OHT area

Orange circles: Our proposed OHT catchment serves a geography approximately the size of all of southwestern to southeastern Ontario



Appendix 2
French Designated Areas



D. Regional Specialized Service Structure OHT

PART B: TO BE COMPLETED REGIONALLY

The presence of regionally coordinated plans and/or structures within Northern Ontario brings the opportunity for greater coordination and integration for Northern Ontarians. This section seeks to provide assessors with more information about any proposed regional plans and/or structures and how they will serve to support the implementation of the model

B.1. Please describe how the regional plans and/or structures will be operationalized. This includes the proposed operational and governing relationships between the regional structure and local OHTs.

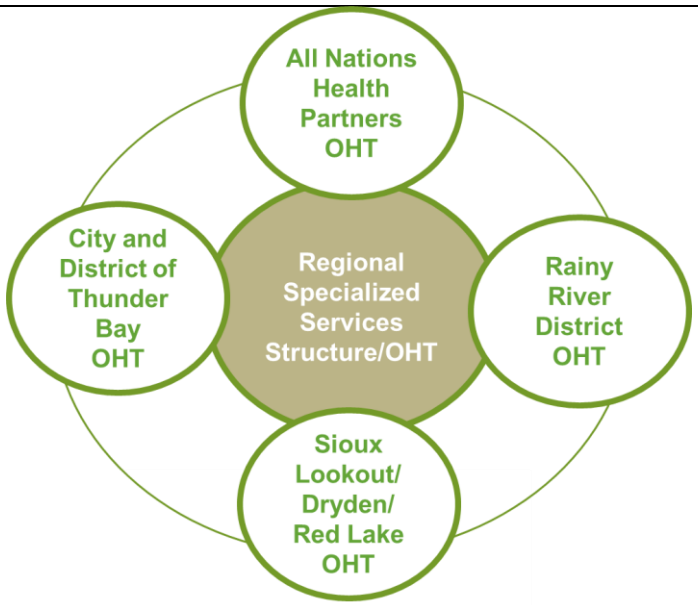
An overarching regional OHT structure (coordinating across and supporting the four locally integrated OHTs) is foundational to the North West model. It ensures a coordinated approach for planning and delivering 'regional specialized services' that is required to ensure the full continuum of care is available to the OHT population. The regional structure will also support regional enablers (i.e. digital health, population health data/management, etc.) and will provide support and scale to the region for functions that are not reasonable and feasible to do at a local level. This will ensure coordination and consistency that better supports patient/client/resident care and ultimately improved population health and experiences.

Through the extensive engagement that has been completed to date regarding the development of the North West region OHT model, some of the key themes that have been raised relate to the following:

- Focus is needed on better coordination of care between local, district and regional levels of care – this needs to be supported by work on transitions in care and common digital platforms.
- Care as close to home needs to be the goal – this needs to supported and enabled by regional services (in person in communities to every extent possible) through service provision, planning and advocacy/common voice; though, centralization is not the goal.

Our proposed Regional Specialized Services structure/OHT is in direct response to this feedback.

Regional Specialized Service providers have been working together through a series of discussions and engagements to build a model that makes sense for the North West, in collaboration with OHT partners. The following high-level leadership structure has been agreed that will support communication among regional specialized service providers, as well as with OHTs, to ensure the needs of the population are being met across the full continuum of care:



The structure is intentionally high-level, as further development of communication channels, decision-making processes and priorities will be developed in collaboration with partners, as outlined below.

The following describes the scope, deliverables and membership of the Regional Specialized Services structure/OHT:

Scope

- Coordination of regional specialized service delivery and planning
- Coordination of regional enablers – i.e. digital health, population health/data capacity, quality and standards development (as appropriate; including linkage/liaison/coordination with provincial specialized programs)
- Knowledge sharing across OHTs

Deliverables

- Coordinated regional service planning and delivery framework(s)
  - Common definitions
  - Common needs assessment tools/approaches
  - Common performance metrics
  - Common improvement initiatives/approaches – i.e. transitions in care, referral systems
  - Common voice/advocacy
- Coordinated approach for enablers
  - Digital
  - Population health/data

Membership

- Regional service providers (will begin with those listed as “Signatories” in Part B of this application, though work in Year 1 will determine a common definition of Regional Specialized Service providers which will inform how memberships needs to evolve)
- Patient/client/resident/caregiver/family members (1-2)
- Local OHT members (1-2 per each of the four OHTs)
- Indigenous providers/members

- Francophone providers/members
- Ontario Health North representative(s)
- Other roles as determined appropriate – i.e. Regional Chief Information Officer

Leadership

Overall, through this structure and approach, members of each respective OHT will sit together with Regional Specialized Services providers and other key stakeholders, to ensure the voice of each OHT (and respective communities) are heard and considered in regional services planning. This will ensure that each OHT's population needs are considered in all levels of planning. This will also allow OHTs to stay connected with other OHTs to prevent any unintentional fragmentation of silos of care.

The structure/OHT is proposed to be co-chaired by the following:

- Administrative lead
- Patient/client/resident lead
- Primary care lead
- Indigenous lead

The Regional Specialized Service Structure/OHT is not an authoritative or decision-making body over local OHTs. Each OHT is guided by their respective decision-making processes and principles, and will have their own unique voice. The Regional Specialized Service Structure/OHT will work collaboratively to identify and guide a coordinated implementation of regional priorities – starting in the areas of specialized service delivery, digital health, data/population health and knowledge sharing among OHTs.

Overall, our model aims to reflect best practices and ensures the following:

- Robust patient/client/resident, family and caregiver engagement related to the both the specialized services and their intersections with Ontario Health Teams
- Seamless coordination between Ontario Health Teams and those organizations providing specialized services
- Supports the advancement of key enablers, such as common digital health tools that allow for the safe and efficient sharing of patient/client/resident information
- Careful attention to equity implications, including differential effects of each model for specific populations

The following operational priorities have been identified for Year 1:

Timelines	Priority Deliverables

3 months	• Set up **Regional Specialized Services Structure/OHT** and appropriate processes (this will be the evolution of the existing Northwestern Ontario Integrated Care Working Group, with evolved leadership, membership and scope)
	  • Terms of Reference
	  • Education
	  • Alignment of existing regional networks/councils, where appropriate to support efficiency and alignment towards common goals (i.e. Digital efforts)
	• Develop **guiding principles** and **decision-making framework**

	• Develop and implement **communications strategy/plan** • Agree to **OHT branding**; implement/evolve website

6 months	• Initiate **priority-setting and work plan development** – inclusive of:
	  • Common definitions
	  • Common needs assessment tools/approaches
	  • Common improvement initiatives/approaches – i.e. transitions in care, referral systems
	• Develop **performance measures** (supportive and aligned to local OHT measures as well as provincial measures)
	• **Begin implementation of work plan activities**

12 months	• Ongoing **implementation of priorities and work plan** • **Annual review – set Year 2 priorities, plans**

B.2. Please identify the specific clinical service delivery functions that the regional plans/structures will address. Where possible, please identify (i) the criteria that will guide the selection of which services/clinical conditions/patient populations will be regionally-coordinated, (ii) how the relevant care pathways or models will be designed; (iii) how the regional structure will support different OHTs or OHT members to work together to collaboratively deliver those pathways or models across the region.

Regional specialized service programs will enable the provision of specialized care within the North West region. Regional specialized services are inclusive of services that may be disease-based (e.g. cancer), population-based (e.g. seniors), or enable delivery of key services across the region (e.g. HIS, data/decision support).

Examples of existing specialized regional programs and services are: Acquired Brain Injury, palliative care, seniors, wound care, rehabilitative services, Specialized Independent Living, Respite services, Specialized acute/inpatient, Specialized MHA, Rapid Access to Addictions Medicine, etc.

As a starting point, the following providers are coming together to form the regional services structure:

- Brain Injury Services of Northern Ontario (acquired brain injury services)
- Canadian Mental Health Association - Thunder Bay (regional MH&A crisis services, early psychosis intervention)
- Community Services for Independence North West (specialized independent living)
- Home and Community Care Support Services (home and community care support services)
- St. Joseph's Care Group (specialized rehabilitative care, seniors, wound, MH&A – psychiatry and community, palliative care, etc.)
- Thunder Bay Regional Health Science Centre (MH&A – psychiatry, cancer, cardiac, stroke, surgical, renal, pharmacy, etc.)
- Wesway Inc. (respite)

As part of the Year 1 work plan, work will be done to finalize a common definition of regional specialized services that will be inclusive of consideration of district-based services (providers that services multiple OHTs, but are not comprehensive across the region) as well as provincial programs that are providing services within the North West region. This will inform further evolution of the membership and scope of the regional structure.

Regional services also include components of education, research, knowledge exchange, adoption of evidence-based practice and system navigation.

Definition and criteria for regional specialized services

Partners in the North West have worked together to develop the following definition for regional specialized services. This definition has been developed by a sub-group of the Northwestern Ontario Integrated Care Working Group, and utilizes the definition developed by the Ontario Hospital Association as a starting point, while making it locally applicable, and inclusive of broader community services.

Proposed definition:

A specialized service is a service that provides access to care to a population within a defined geographical area, and which requires specific expertise and resources in order to provide high-quality care promoting positive population health outcomes and care experiences. A specialized service is inextricably linked to other services and requires broader planning at the district, regional or provincial level.

Regional specialized services are defined based on:

- Expertise – interprofessional team, specialized teams, clinical coherence and interdependencies
- Resources – extensive requirements for capital and/or operating, planning at a regional and/or provincial level

How pathways or models will be designed

The Regional Specialized Services Structure/OHT will utilize the principles of co-design in the advancement of their work. Pathways and models will be designed in collaboration with the four North West OHTs, through the Regional Specialized Services Structure/OHT – this is also inclusive of broader system partners and perspectives, including (as articulated further in Section B.1):

- Patient/client/resident/caregiver/family members (1-2)
- Local OHT members (1-2 per each of the four OHTs)
- Indigenous providers/members
- Francophone providers/members
- Ontario Health North representative(s)
- Other roles as determined appropriate – i.e. Regional Chief Information Officer

Through the Regional Specialized Services Structure/OHT, partners will work together to identify service gaps, areas for improvement and collectively set priorities for improvements. By working together across OHTs, the regional approach will ensure alignment of Vision and efforts, to result in stronger impact on population health. For example, through regional coordination and collaboration with OHTs to date, we have collectively identified a common priority of MH&A – this will enable providers from across the continuum of care to make significant improvements to the patient/client/resident experience by having common vision, common purpose and common effort.

There are various examples of how regional service providers are already working together in this way. The Regional Specialized Services Structure/OHT will provide the formalized, coordinated and resourced structure and processes to take these relationships and initiatives to the next level – including sustainability. Some (limited) examples to highlight the existing work/relationships that will be leveraged includes:

- **Regional Mental Health Assessment Team (RMHAT)** – a collaborative program between Thunder Bay Regional Health Sciences Centre, St. Joseph's Care Group and partner hospitals. The model uses a virtual platform, Ontario Telemedicine Network (OTN), to provide timely access to urgent psychiatric nursing assessment for patients presenting in rural hospital EDs to determine if admission to the Schedule 1 Facility is the best care pathway. It is designed to guide and improve access to care in the most appropriate setting based on the patients' needs at the time of assessment. Expansion to support community MH&A agencies is planned.
- **Rapid Access to Addictions Medicine (RAAM)** – St. Joseph's Care Group provides leadership across the region as it relates to the development, implementation and evaluation of RAAM clinics (or RAAM-like services) to support access to much needed care in communities, in partnership with multiple system partners.
- **Regional Surgical Services** – Thunder Bay Regional Health Sciences Centre, Riverside Healthcare, Lake of the Woods District Hospital and Dryden Regional Health Centre work collaboratively through the Regional Surgical Services program to deliver innovative models of surgical care; including a regional orthopedics program where TBRHSC surgeons travel to regional sites to perform procedures enabling care as close to home as possible. This program has expanded to broader surgical service to optimize surgical capacity in the region throughout the pandemic recovery. The program is supported by innovative digital solutions such as virtual patient monitoring and post-acute follow up apps to support seamless care across the patient journey. Partners are now advancing a Regional Centre of Excellence for Urology services.
- **Regional Complex Rehabilitative Care Outreach Program** - St. Joseph's Care Group leads this program focus on improving access to rehabilitation services at hospitals across Northwestern Ontario. The team (consisting of physiotherapy and occupational therapy) is deployed to Northwestern Ontario hospitals that have temporary shortages in rehabilitation professionals - similar to a "supply teacher" model for rehabilitation. The OT and PT plan visits to these hospitals each month for in-person assessments and treatment. When they are not on-site, rehabilitation is provided virtually by videoconference and phone calls, using email to provide resources.
- **Digital Health** – significant efforts are underway re: digital transformation across our region. Our health system is working towards a Northwestern Ontario Health Record (NOHR) across the continuum of care. This record envisions that hospitals, primary care, mental health and other community services join onto a single record where possible to be able to

share care and ensure safe transitions. There are other significant efforts underway re: Shared Health Record & Data Platform, Security and Privacy and Patient Self-management.

Many of the examples highlighted above focus on MH&A given the Year 1 focus of the local OHTs and the regional work that will be supported in this area.

Additionally, our approved and emerging OHTs have already started to work collaboratively on regional approaches to the following:

- **OHT Impact Fellows** – All Nations Health Partners OHT, Rainy River District OHT and the Northwestern Ontario Integrated Care Working Group have worked together to submit one application for 2-3 OHT Fellows that can support our region in the areas of data analytics, population health management approaches and process improvements. This collaborative approach acknowledges the need to work in a coordinated way and starts to build regional capacity and working relationships in these key areas.
- **Patient Navigation Funding** – as per the example above, we have applied for (and received) funds in 2021/22 related to patient navigation services (HCNS funding). Both approved OHTs and both emerging OHTs received funding and resources are collaborating across the OHTs to complete the work, in recognition of the regional patient pathways and need for alignment.
- **Patient Portal** - as per the examples above, we have applied for (and received) funds in 2021/22 related to Patient Portal development. Both approved OHTs and both emerging OHTs received funding and resources are collaborating across the OHTs to complete the work.
- Our region has partnered with Dr. Laura Rosella and Dr. Kerry Kuluski, Research Chairs at Trillium Health Partners' embedded research unit, the Institute for Better Health (IBH), to on a CIHR grant application to study the delivery of person-centred segmentation to populations. The proposal entitled "Person-centred segmentation: characterizing population segments to inform care" is in line with our collective aim to apply a population health approach with a strong collaborative component from the community we serve. Our team has already started to look at our population's healthcare utilization data and greatly value an opportunity to expand the information we gather and apply segmentation to our population in a patient-centred manner. This work will be advanced regionally in support of all four OHTs.

How the regional structure will support OHTs

The regional structure will support OHTs in the following ways:

- Common Vision and purpose
- Communication and coordination with regional specialized service providers – service planning, delivery, evaluation
- Knowledge sharing
- Digital health transformation
- Data and population health analytics
- Common voice and advocacy

This is further articulated through the benefits that have been identified through engagement and co-design with the two approved OHTs and two emerging OHTs:

- **Connectedness** – ensures collaboration and knowledge sharing across new OHT structures. Shared initiative are already being explored and implement – i.e. Patient Portal, OHT Impact Fellows to support all four OHTs re: population health approaches and data.
- **Coordination** – as new OHT structures develop, the regional structure ensures a coordinated way for regional specialized services providers to work with these OHTs, and for OHTs to work with each other. It mitigates the risk of creating four silos of care. This is particularly important as it relates to MH&A – given this is a priority of all four OHTs, this will provide strength in a common regional approach.
- **Common voice** – supports a collective voice on key issues/challenges that affect the North West; support collective action on solution.
- **Efficiency/scale** – provides opportunity to most efficiently and effectively develop system enablers at a regional level that would be more costly, or complex, or less efficient to do at a local level (i.e. digital, data, etc.)
- **Improved access** – by using coordinated, data-driven approaches to population health planning we will make better decisions together and better advocacy together on ways to improve access to care and improve population health
- **Capacity building and education**
- **Standardization and best practice implementation**
- **Quality improvement and common performance measurement**

B.3. Beyond clinical services, please identify any other features that the regional plans/structures will address, such as back-office, digital health, data and analytic capacities. Identify how these features will help local OHTs implement and advance the OHT model.

As a starting point the regional services structure will support the following enablers:

- Digital
- Data and population health management analytics
- Knowledge sharing

Details on how these functions will support OHTs in advancing their models are outlined in the sections above.

B.4. Please describe whether or how the regional plan will enable OHTs to work together, including conflict resolution, priority-setting, continuous learning, fair representation shared decision-making, and equitable resource allocation.

Vision – what we want to achieve

The Regional Specialized Services Structure/OHT will be guided by the following regional Vision:

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.

Decision-making and conflict resolution

Similar to the local OHTs, the Regional Specialized Services Structure/OHT leadership structure will utilize consensus-based decision-making. As such, we are committed to finding solutions that everyone actively supports, or at least can live with, in the interest of improving population health. Given the importance of getting this right, the Regional Specialized Services Structure/OHT will build in training and education on the topic into our Year 1 operational plan.

In the case of conflict, the following process, based off of the City and District of Thunder Bay proposal, will be utilized:

- The Team Members will use their best efforts to resolve any disputes in a collaborative manner through informal discussion and resolution, applying the agreed to principles.
- To facilitate and encourage this informal process, the Team Members involved in the dispute will use their best efforts to jointly develop a written statement describing the relevant facts and events and listing options for resolution. The Team Members will request support (may be an elder/knowledge-keeper and/or a mediator and/or a facilitator, as appropriate) on whom all Team Members agree, support them in resolving the dispute. Any OHT Member can request to initiate the conflict resolution process and use of supports.
- If these efforts do not lead to a resolution, any involved Team Member will refer a disputed matter to the OHT Collaboration Council. The Collaboration Council will work to resolve the dispute in an amicable and constructive manner. The Collaboration Council will request support (may be an elder/knowledge-keeper and/or a mediator and/or a facilitator, as appropriate) on whom all Team Members agree, support them in resolving the dispute.

The Regional Specialized Service Structure/OHT is not an authoritative or decision-making body over local OHTs. Each OHT is guided by their respective decision-making processes and principles. The Regional Specialized Service Structure/OHT will work collaboratively to identify and guide a coordinated implementation of regional priorities – starting in the areas of specialized service delivery, digital health, data/population health and knowledge sharing among OHTs.

Further definition of these processes is required. This will be an activity undertaken in the first 6 months through the development of the structure/council, Terms of Reference. This will include definition of the two-way relationship between local OHTs and regional specialized service providers to ensure clear understanding of roles, responsibilities, accountabilities

(including clarity on shared accountabilities for population health processes and outcomes at local and regional levels, as well as with each other as partners), etc. Guiding principles will be defined to ensure clear understanding our how Members will work together.

B.5. Please identify any anticipated risks and mitigations associated with the regional plans/structures.

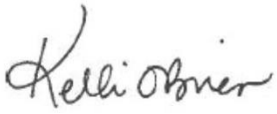
The following risks and mitigations have been identified:

Risks	Mitigation
• **Autonomy** - care as close to home needs to be the goal. Also need to respect pathways with Manitoba; cannot be Thunder Bay-centric. Local OHT must also have a strong voice for their population; the regional structure cannot take away from that (i.e. Ministry only engaging through the regional structure); must ensure that the regional structure only enhances the voice, does not replace.	• Ensure care as close to home continues to be a driving principle. Principles to be developed in Year 1 (first 3 months) • Development of contingency plans for all pathways to ensure care as close to home as possible
• **District-level services and coordination** – Need to consider district approaches, not just regional to ensure seamless care and coordination.	• Inclusion of district-level services when building definitions and approaches
• **Sustainable program/service funding for regional programs** - concern about lack of sustainable funding – need regional advocacy, common voice and engagement (i.e. MHA – structured psychotherapy)	• Common voice and advocacy

• **Funding** – the successful development and implementation of the regional service structure will require appropriate, equitable and sustainable funding to operate. Specifically, the following needs to be considered:
  • Unique consideration to support regional specialized service delivery and enablers in an integrated model (i.e. innovative funding models such as bundled care, with local/regional autonomy on how to plan for and administer funds across the continuum and region)
  • Investment in transformation enablers such as EHR renewal – an integrated information system is the foundation of our integrated system – there will be significant financial investment required (>$30M).
	• Funding to be provided to regional structure/OHT for implementation and ongoing operations.
	• Consideration of the complexity of delivering care in the North West; to drive equitable allocations of funds to meet the needs of the population
	• Truly flexible transformation dollars that can be used to seed innovative models of care

Membership Approval

Please have every member of the regional working/planning group (or its equivalent) sign this application. For organizations, board chair sign-off is required. By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Legal Name of Partner/Member Organization/Provider	**Location (e.g., City/Town/Municipality)**	**Sector**	**Signature (if applicable)**
Alice Bellavance, CEO, **Brain Injury Services of Northern Ontario (BISNO)**	Regional	Community/ Assisted Living/ABI	
Jennifer Hyslop, CEO, **Canadian Mental Health Association - Thunder Bay**	Regional	MHA(crisis)/EPI	
Kristan Miclash, CEO, **Community Services for Independence North West**	Regional	Specialized Independent Living	
Beverley Kelley, Interim Vice President Home and Community Care **Home and Community Care Support Services**	Regional	Home and Community Care	
Kelli O'Brien, President and CEO, **St. Joseph's Care Group**	Regional	Complex Rehab/MHA/ Palliative/etc.	
Rhonda Crocker Ellacott, President and CEO, **Thunder Bay Regional Health Science Centre**	Regional	Acute Care	
Daniel McGoey, Executive Director **Wesway Inc.**	Regional	Community - respite