Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

Version Date: 2019-09-11

- a demonstrated track record or ability, you are asked to **provide evidence** of this ability.

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

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

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

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

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

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population. Identifying the population for which an Ontario Health Team is responsible requires residents to be **attributed** to care providers and the method for doing so is based on

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

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

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

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

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

Participation in Central Program Evaluation

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

[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.

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Additional Notes

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

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

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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: Henry Wall and Anita Cameron
	Title: ANHP Co-Chairs
	Organization: All Nations Health Partners (ANHP)
	Email: hwall@kdsb.on.ca and acameron@wnhac.org
	Phone:
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Laura Loohuizen
	Title: All Nations Health System Planning Community Coordinator
	Organization: ANHP and Kenora Chiefs Advisory (KCA)
	Email: laura.loohuizen@kenorachiefs.ca
	Phone: KCA office 807-468-8144 or cell 204-995-8784

1. About Your Population

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

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

1.1. Who will you be accountable for at maturity?

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

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

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

[2] 'Year 1' is unique to each Ontario Health Team and refers to the first twelve months of a team's operations, starting from when a team is selected to be an Ontario Health Team Candidate.

maturity.

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

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

Maximum word count: 1000

At maturity the All Nations Health Partners (ANHP) aim to deliver coordinated services across urban and rural communities of Kenora and Sioux Narrows-Nestor Falls, local First Nations, Kenora Métis, seasonal residents and visitors. The partners plan to build on the significant degree of integration and coordination of services that already exist at a local level. Partners are working together across the continuum of care to coordinate care for patients through integration/coordination of services among partners.

The partners' catchment area is located within the Kenora Integrated District Network of the Northwest LHIN and covers an area of 15,807 square miles. The combined catchments are outlined on the attached map. See Appendix C - ANHP Map.

Due to the unique geography and weather, both patients and providers are subject to conditions that directly impact access to care demonstrating the need to understand, develop, and sustain services that account for these unique considerations. The ANHP recognizes the history of Indigenous peoples in the area, which further supports greater inclusivity and sense of community, foundational to addressing health inequities in the area. As an existing economic and service hub for First Nations, Métis and unorganized communities around the city, it makes sense for the ANHP to serve this unique area. The year one target population will be limited to the Partners' shared geographic area and percentage of the population with the most significant inequity.

There is a high level of alignment between the proposed population referenced in the self-assessment and the attributed population outlined in this application (as the vision and catchment area remain the same).

The ANHP have acknowledged a number of opportunities and challenges that it will need to address during the course of year one onwards to maturity, which has been detailed as:

Opportunites:
• Having strong local relationships between agencies; past experience working with each other, experience servicing the communities including First Nation communities, agencies that provide culturally sensitive and safe care, relationships with leadership e.g. governance boards, municipal councils, band councils etc
• Past experience with a population health approach as many agencies have worked on sub-LHIN collaborative tables that took a population health approach; also agencies have considered population level statistics when planning and implementing programming.

Challenges:
• Weather, large geographical area (however experience dealing with these challenges as adapted to the weather and use of technology and travel over the geographical area)
• Coordinating leadership from many communities: The partners already have pre-existing relationships with leaders from the communities and have effectively coordinated support from leadership in the past.

1.2. Who will you focus on in Year 1?

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

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

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

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

Maximum word count: 1000

Please note, the Ministry of Health (through IC/ES) was unable to provide relevant and accurate data. Please review the ANHP vision document (Appendix C) which further details the short- and long-term priorities that align with the OHT work as well as details the population, communities, and organizations involved as partners. The ANHP have also incorporated data provided by partners in Appendix D to further support the prioritization of the year one population.

Within the ANHP catchment area, the population requiring and accessing mental health services and specifically crisis intervention has been identified as the priority population for year one, based on the collective understanding of the greatest need/gap within the catchment area. This priority population does not differ from the population identified in the Self-Assessment. Crisis intervention services are the most important performance improvement opportunity given the high needs and risk factors affecting the ANHP population across all age groups. The need for appropriate and coordinated crisis services has been known to affect the number of avoidable emergency visits, frequency of emergency visits, and extended hospital stays (see Appendix D). The challenges in access to community care and well-documented issues related to mental health and addictions have demonstrated strong evidence leading to an increasing burden of illness and poorer health outcomes for the area population compared with the rest of the province. Regional mobile crisis services were divested effective April 1, 2019, which has also led to the ANHP prioritizing the need to develop an alternative crisis response service model.

A lot of the planning work has taken place and is on-going to develop a central support line and build an integrated and responsive network of services that will support children, adolescents, and adults in crisis. Having several partners engaged and committed to developing and implementing an integrated model for crisis services, the scope of work includes the development of several indicators to measure, assess, and enhance the impact of the services. Addressing addictions is also within scope of the services being developed and offered to this priority population. An example of the incorporation of addictions services would be through the planning and implementation of mobile Rapid Access Addiction Medicine (RAAM) Clinic as well as completely redesigning services and programs to support other types/groups/illness/care to scale out to cover other sub-groups within the catchment area towards servicing all peoples at maturity. Primary care will also play an important role overall through early identification of risk factors linked to mental health as well as supporting post-crisis strategies to achieve and maintain healthy communities/patient population. Furthermore, for year one, the partners will be engaging all communities (Indigenous and non-Indigenous alike) to identify and inform priorities including but not limited to the planning of the hospital and health system. The focus of year one will also include reviewing and identifying data gaps and solutions to align with ANHP priorities and reflect the unique geographic area and access to services.

Through the ANHP hospital and system planning, the OHT will be aligning to the development of a new paradigm based on local needs and capacity which will be reviewed service line by service line and community by community.

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

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

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

The ANHP is a partnership with a shared vision of developing a health system designed by local people for local needs. This system would harmonize funding, services, and governance to provide barrier-free healthcare to all people. It includes and celebrates Indigenous healing and governance. Many of the partners have established meaningful and productive partnerships as well as formal service agreements with First Nation and Métis communities. The evolution of this OHT will build the existing foundation of “meaningful” engagement, which respects Treaty Rights and independent governance and supports reconciliation. A resolution was signed in ceremony to formalize this commitment. The signatories of the ANHP resolution consisted of nine First Nations, Kenora Métis Council, City of Kenora, Township of Sioux Narrows/Nestor Falls, and District of Kenora Unorganized Areas.

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

With regards to the Francophone populations, health services will be provided in French utilizing French language volunteers or bilingual staff members as interpreters. This is an extremely small population in this area (approx. 87 voters based on census and school board election data). The current North West LHIN works with the French Language Health Planning Entity (Entity) to address the needs of the Francophone population in the North West region. The North West LHIN meets with the Réseau regularly through the Liaison committee and as well with the LHIN Réseau French Language Services Working Group on a quarterly basis to work on activities in the joint action work plan. In moving forward with planning for French language services the ANHP will work with the Réseau to integrate active offer of services in French as required.

The partners recognize the unique healthcare needs of Indigenous communities. Members of the ANHP have over 20 years of experience providing primary care to these communities and complexity of health needs encountered. Through numerous studies and reports, mental health and addictions along with rising rates of chronic diseases like cancer, diabetes, heart disease and respiratory diseases all demonstrate a need to ensure programming and services are available across all settings (on- or off-reserve) indiscriminately. In these predominately young and rapidly growing populations, the trends point towards a future of dramatically increased chronic disease. From a recent report on KCA communities, 70% of all deaths among community members were noted to occur before the age of retirement (65 years old) compared to rest of Ontario (22%).

The partners recognize the impact of colonialism, racism, social exclusion and lack of meaningful engagement that have an effect on the health of Indigenous people (i.e. historical trauma, catchment area had a high concentration of residential schools, socio-economic disparity, and significantly worse health status/outcomes). These factors are responsible for the socio-economic inequities combined with neglect and fragmented services of the historically uncoordinated federal, provincial, and regional health care systems. While recognizing these challenges, these communities have great strength and resilience having faced these challenges throughout time. Indigenous communities have shown the ability to thrive by restoring and promoting Indigenous identity, keeping cultures and languages alive and promoting self-governance. All these factors have positive effects on community health and well-being. The ANHP was formed based on these strengths and through direct engagement and partnership with and for the Indigenous leadership, organizations, and communities. Throughout the course of maturation of the OHT, the partners will be engaging and delivering services with and for Indigenous communities.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

Note: ***If*** your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as **members**, please also list them and their specialty in this table. The information in this table will be used to assess primary care representation and capacity/coverage.

Name of Physician or Physician Group	Practice Model[4]	Number of Physicians	Number of Physician FTEs	Practice Size	Other

[4] Physician practice models include: Solo Fee for Service (Solo FFS), Comprehensive Care Model (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Blended Salary Model, Rural and Northern Physician Group (RNPG), Alternate Payment Plans. Family Health Teams may also be listed in Table 2.1.1. Community Health Centres, Aboriginal Health Access Centres, Nurse Practitioner Led Clinics, and Nursing Stations should be listed in Table 2.1.2. If you are unsure of where to list an organization, please contact the MOH.

*Provide the name of the participating physician or physician group, **as registered with the Ministry**.* *Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table.* *Physician **groups** should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire*	*Please indicate which practice model the physician(s) work in (see footnote for list of models)*	*For participating physician groups, please indicate the number of physicians who are part of the group*	*For participating physician groups, please indicate the number of physician FTEs*	*For participating physicians, please indicate current practice size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.*	*If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here.* *Note here if a FHT is a member but not its associated physician practice(s) .* *Also note here if a physician practice is a member by not its associated FHT (as applicable).*

group practice is not, then provide the name of the participating physician(s and their associated incorporation name).					
See supplementary Excel spreadsheet					

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

Name of Organization	Type of Organization[5]	LHIN/Ministry Funding Relationship	Primary contact
Provide the legal name of the member organization		*Does the member organization have an existing contract or accountability agreement with a LHIN, MOH, or other ministry? If so, indicate which*	*Provide the primary contact for the organization (Name, Title, Email, Phone)*
See supplementary Excel spreadsheet			

2.2. How did you identify and decide the members of your team?

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

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

Max word count: 500

The membership of the ANHP was established and expanded years before the inception of the OHT, based on grassroot/community initiatives to address the critical systemic healthcare needs in area. In the spring of 2015, the shortage of physicians

[5] Indicate whether the organization is a Health Service Provider as defined under the *Local Health System Integration Act, 2006* (and if so what kind – hospital, long-term care home, etc.), Community Support Service Agency, Service Provider Organization, Public Health Unit, Independent Health Facility, Municipality, Provider of Private Health Care Services, Other: Please specify

serving the Kenora area was identified through a deputation to Kenora City Council. Following this presentation, the City led the creation of the Kenora Area Health Care Working Group in September 2015. At that time, the group included representatives from the City of Kenora, Lake of the Woods Development Commission, Lake of the Woods District Hospital, Waasegiizhig Nanaandawe'iyewigamig (WNHAC), Kenora Chiefs Advisory, Northwestern Health Unit, family physicians, and members of the community. This working group identified three priorities: physician recruitment and retention; cross border access to care between Ontario and Manitoba; and the need for a long-term, collective vision for health care in the Kenora area. Within less than a year, the group had completed a needs assessment, raised funds from committed stakeholders, and hired a Healthcare Professional Recruiter. Within less than two years, progress had begun to be made on the cross-border issues. Replacement of aging hospital infrastructure had also been identified as an additional key priority in support of both successful patient care and physician recruitment, and funding had been secured to begin a formal planning process.

In late winter of 2017, political leadership comprised of Grand Council Treaty#3 Ogichidaa (Grand Chief), the Mayors of Kenora and Sioux Narrows/Nestor Falls, Chief Lorraine Cobiness on behalf of the Kenora area First Nation Chiefs, and the President of the Kenora Métis Council assembled in the roundhouse at Wauzhushk Onigum First Nation to sign a resolution agreeing to work to together in partnership to develop an All Nations Health Care System including construction of an All Nations Hospital and campus with the express purpose of improving health outcomes for all people of the region it serves through a health care service model built on a partnership between First Nations, Métis, and non-Indigenous governments and providing an improved health care system that reflects the specific needs and costs of the north.

The partnership has expanded to include physicians, the Sunset Country Family Health Team, a Long-term Care facility, Children's Community Services (FIREFLY), Mental Health and Addictions organization (CMHA), and municipal services (i.e. housing) – see section 2.6. The ANHP recognizes there are missing team members (e.g. other primary care providers and education system) and are presently engaging these organizations/individuals. Based on the current membership, the ANHP is well positioned to work with the year one population and expand to engage any missing team members through sector specific working groups as the OHT gets to maturity (inclusive approach).

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

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or*	**Form of affiliation** *Indicate whether the member is a signatory member of the other team(s)*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate*

	agreed to work with	*or another form of affiliation*	*itself with multiple teams (e.g., member provides services in multiple regions)*
See supplementary Excel spreadsheet			

2.4. How have the members of your team worked together previously?

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

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

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

Max word count: 2000

The ANHP have extensive experience in working together. This section highlights a sample of collaborative initiatives/projects across and between members of the ANHP. For full list of partnerships, please see Appendix H.

- Sunset Country Family Health Team (SCFHT) and NWLHIN Home and Community Care – the SCFHT runs a multidisciplinary memory clinic. The NWLHIN has provided a care coordinator to sit as part of the team to both assess and plan for the patients, families and care givers attending this bi-monthly clinic.
- Waasegiizhig Nanaandawe'iyewigamig (WNHAC), SCFHT and Canadian Mental Health Association (CMHA) Kenora have been the lead organizations, working collaboratively to plan, implement and lead Kenora in the Health Links approach to care planning.

- Individual Physicians through the partnership's NOSM Local Education Group, WNHAC, Lake of the Woods District Hospital (LWDH), SCFHT, City of Kenora, are lead agencies, funders and committee members of the local Healthcare Recruitment planning position.
- Members of ANHP (Kenora Chiefs Advisory/ [KCA], SCFHT, LWDH, CMHA, Long Term Care, NWHU) are also members of the District of Kenora subregion collaborative planning table supported by the NWLHIN
- SCFHT, WNHAC and LWDH have all pooled funding to increase rehab services offered by LWDH for outpatient services
- SCFHT has had members from the WNHAC, LWDH, patients, family physicians to support their implementation of a new Nurse Practitioner Clinic
- CMHA-Kenora and SCFHT worked together on a Medication and Behavioural Enhancement program funded by the NWLHIN
- WNHAC has contributed funding for succession planning of Certified Respiratory Educators so that patients of both SCFHT and WNHAC have access to spirometry testing, and education with regard to Primary Care Asthma and COPD programs
- SCFHT and Bayshore – OT assessment, ADP and care planning.
- CAPACITI is a 10-step Quality Improvement (QI) project lasting one year. The expectation is that everyone in the QI study team attend the webinars, work together, and try new practices to embed an early palliative care approach into the practice. Partnership members: Family Physician, NWLHIN Care Coordinator, FHT Social Worker, FHT NP, NWLHIN Palliative Care NP, Long Term Care NP.
- NWHU and Primary care – Immunization – daily push of data from primary care EMR to NWHU for immunization.
- NWHU has memorandums of understanding related to the Naloxone program with other agencies e.g. WNHAC
- NWHU and FIREFLY agreement related to Speech and Language Services
- Many agencies belong and meet regularly under committees of the Kenora Area Mental Health and Substance Use Task Force
- NWHU has agreements with WNHAC and SCFHT related to sharing of immunization data to be uploaded into a provincial database.
- NWHU and KCA agreement related to public health services on First Nation communities.
- NWHU and LWDH partnership related to the harm reduction program
- NWHU and LWDH partnership to facilitate collection of perinatal data.

Highlighted partnerships involving the LWDH relevant to the year one population includes:
- Kenora Rainy River Mental Health and Addictions Network
- OPP Situation Table- Rapid Intervention Services Kenora
- Kenora Substance Abuse Task Force
- Interagency Services Committee
- Fetal Alcohol Spectrum Disorder Committee
- Social Service Worker Program Advisory Committee
- Healthcare Leadership Advisory Committee - Con College
- Ontario Network of Residential Withdrawal Management Centres

- Ontario Quality Standards for Schizophrenia Treatment Partnership
- Regional Training Leader for the Global Assessment of Individual Needs - Quick 3 (GAIN-Q3)
- District Training Leader for the Columbia Suicide Risk Assessment and Safe-T Protocol
- Northwest Ontario Eating Disorder Network
- Northern Ontario Wellness (NOW) Gambling Prevention and Treatment Partnership
- Mental Crisis Response contingency plan (LWDH MHAP provides all assessment and disposition planning which is a gateway to hospital admission or a gateway to community services, i.e. CMHAK Safebeds)
- OPP / T3P Transfer of Care Agreement
- Northwest Regional Schedule 1 Committee
- Needle Exchange Program partnership with Northwestern Health Unit / Morningstar Centre
- Youth Addictions service provision partner in Kenora Youth Hub

Highlighted partnerships involving the KCA relevant to the year one population includes:
- KCA partnership with FIREFLY Developmental Services, where KCA provides a full range of early intervention services for children and youth with disabilities to 13 First Nation communities. These services blend traditional knowledge with Western rehabilitation methods and include developmental screenings, infant development, speech/occupational/ physiotherapy, communication and social skills support, assistance with transitions to daycare or school, service coordination, and system navigation.
- KCA's Youth Residential Stabilization Centre, established by the KCA to meet the needs of youth in acute mental health crisis. Currently, young people are stabilized at the Lake of the Woods District Hospital in Kenora or the Child & Adolescent Mental Health Unit in Thunder Bay, 489km away. KCA's proposed model will provide a safe, local, home-like setting where kids aged 10-18 and their families can work on recovery together through wrap-around, bi-cultural programming. In early 2019, KCA received funding from Health Canada for two beds – located at Anishinaabe Abinooji Family services in Kenora -- and is now seeking funds for another eight beds and construction of the building that will house them. The centre involves partnerships with the Treaty 3 Police, Ontario Provincial Police, WNHAC, Thunder Bay Health Sciences Centre, Ontario Telemedicine Network, LWDH, FIREFLY Child and Family Services Grand Council Treaty #3, and Keewatin-Patricia School District.

The CMHA, Kenora Branch sits on some of the following highlighted committees with other members of the ANHP:
• Coalition to End Human Trafficking
• FASD NOW Regional Steering Committee & Network
• Human Trafficking Committee
• Kenora Mental Health Court Stakeholders Group
• Kenora Rainy River District Human Services & Justice Coordinating Committee
• Kenora Rainy River District Mental Health & Addictions Network

• Northwest Center of Responsibility
• Rapid Intervention Services Kenora
• Sub-Region Planning Table (Kenora)

The CMHA Kenora also sponsors a number of committees that involve multi-organizational collaboration and input to addressing the year one population of this OHT. Of note there are two committees that are actively involved to informing a coordinated approach to addressing Mental Health Addictions in the area. These committees are the Human Services & Justice Coordinating Committee and Rapid Intervention Services Kenora (RISK) Table.

The Human Services & Justice Coordinating Committee was established following the Ministries of Health and Long-Term Care, Community Safety and Correctional Services, Community and Social Services, Attorney General, Children and Youth Services, Housing, among others establishing a Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario. Furthermore, this Strategy was established in response to recognize the pressures that have been escalating in sectors such as the police, courts, corrections, and hospital emergency rooms due to a lack of access to community base mental health services and other community social services. The expected outcomes of the Strategy included enhanced public safety, improved resource utilization and greater access to quality services for people.

The purposes of this Committee are to:
• Identity both service and service coordination gaps at the local level;
• Establish a delivery model of care through ongoing partnership agreements and protocols;
• Coordinate resources and services and plan more effectively for people who are in conflict with the law
• Provide a planning table to bring together service providers to find solutions to the problem of the criminalization of people with serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, fetal alcohol spectrum disorder and/or dual diagnosis
• Develop a model of shared responsibility and accountability in dealing with individuals with serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, fetal alcohol spectrum disorder and/or dual diagnosis at points of intersection with the justice system
• Develop creative local solutions to problems or issues through more effective service coordination
• Share best practices
• Provide informed input and advice to relevant bodies concerning research, system design, planning, program implementation, and resource allocation

The objectives of this Committee are to:
• Review existing protocols with HSJCC member agencies and establish new protocols where identified
• Identify and advocate for changes to improve the experience of individuals who come into contact with the criminal justice system
• Identify systemic problems and submit to the Regional Committee (now known as the Northwest Center of Responsibility) & Provincial Committee
• Promote education and training for committee members and community partners
• Monitor progress and promote opportunities for collaboration within the Mental Health Court & Drug Court
• Share information from the provincial and regional committees to local committee members and community partners
• Promote collaboration between the police and mental health and human resources
• Identify challenges within areas of serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, fetal alcohol spectrum disorder dual diagnosis, locally and within the District

The second Committee relevant to the year one population supported by CMHA Kenora is the Rapid Intervention Services Kenora (RISK) Table/Committee. This table is a community-led initiative that brings together representatives from across sectors, including mental health, addiction, justice, social services and education, to help those at acutely-elevated risk of imminent harm or victimization. These are individuals in the community facing complex situations and multiple risk factors. They may be experiencing issues related to mental and physical health, addictions, poverty, negative relationships, housing, education, employment, domestic and physical violence and more. These are also situations where a single agency may have exhausted all its resources trying to help. The goal is to mitigate risk factors and imminent threats of harm of victimization to individuals, families, groups or places. RISK is not case management, but rather a way of utilizing and mobilizing existing symptoms and resources in a coordinated and collaborative way.

The purpose of RISK is to bring multiple human-service sectors together to collectively identify systemic issues and risk factors that are prevalent locally and to provide a network of support for vulnerable populations across the communities in order to prevent crisis situations.

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

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

members of your team are part of.

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

Max word count: 500

The ministry-provided data was not helpful as it was "sub-region" data that includes a far larger geography and population than the ANHP's OHT geographic area that mostly corresponds to the partnerships' previous "Health Hub" area. Thus, this section is based on the qualitative assessment of the question.

The ANHP's analysis of patient flow and care patterns reveal a high degree of alignment between the current membership and the provider networks. The All Nations Health Partners Team Assets include membership from across the Health sector. Indigenous leaders and service providers, the only hospital, primary care, mental health providers across the lifespan, CMHA/CYMH lead agencies, physicians, and public health are all core members. Specific to mental health and addictions the ANHP now bring together a broader community partnership including the police (OPP and Treaty 3), Kenora Association for Community Living, child welfare, and Kenora District Services Board which is responsible for ambulance services as well as housing and homelessness. The ANHP have a distinct geographic area and there are not any major players that are not a part of this project, giving us a very high alignment.

There are several small organizations that are not a part of the ANHP team. Some have been identified since the self-assessment, but the membership has not changed since then. These will be approached over the course of the first year as a small organization may have only one or two employees, but still require office space and a board and there may be many opportunities for sharing and support towards a more efficient system.

The team's alignment is only moderate to low when it comes to specialty services as the OHT is partnered with a remote regional hospital. Service lines for specialties are currently through Thunder Bay or Winnipeg but most service lines are at best unorganized and random. The All Nations Health Partners are part of an application for a new hospital (The All Nations Hospital) that is just starting year one of planning that includes an analysis of all specialty service lines to enhance "Care Close to Home" by bolstering local specialty services where appropriate. It will also establish service lines for each specialty and sub-specialty that the ANHP cannot provide here using the concepts of the "Regional Distributed Department" and the "Step-up Step-down" care model using telephone consult, e-consult, video consult and in-person consults as appropriate.

The ANHP looks forward to the Ministry being able to provide useful data that could be used to address data gaps and further inform enhancements at the OHT reached maturity.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

Name of Physician or Physician Group	Practice Model	Number of Physicians	Collaboration Objectives and Status of Collaboration
			Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)
See supplementary Excel spreadsheet			

2.6.2. Other Collaborating Organizations

Name of Non-Member Organization(s)	Type of Organization	Collaboration Objectives and Status of Collaboration
Provide the legal name of the collaborating organization	*Describe what services they provide*	*Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)*
See supplementary Excel spreadsheet		

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

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

Max word count: 500

The partnership's year one population is based on focusing on centres around crisis intervention. This population reflects the partners' most difficult mental health clientele, addictions, homelessness, and suicide. The suicide rates are 9 times the Ontario average for the 10-24 age group (seen in Appendix D), with hospitalizations for mental/behavioral disorders also 9 times the Ontario average. Thus, the area poses a significant challenge, but one where 24/7 rapid response and linking to wrap-around integrated and coordinated service could make a major impact.

The target for this year one population is to provide a 24/7 rapid response crisis service, linking to integrated coordinated care for ALL patients in this category by end of year one. Actions already taken include a "Crisis-Services 2-day Design Event", with several follow-up meetings.

Please see Appendix F for the draft 24/7 coverage plan across the multiple organizations involved in the planning phase of the year one population. Monthly meetings have been scheduled and work is currently underway to further scope and support implementation.

Following areas/initiatives are currently being planned:
- Homeless shelter redesign including embedding services within from multiple organizations as a "Service Hub".
- RAAM clinic
- Close to home stabilization unit
- Data and outcome measures
- Mobile crisis unit
- Regional crisis line.

Sustainable funding is a problem for programs based on community needs (vs. provincial or LHIN priorities). Organizations are robbing other programs to make this happen.

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

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

Ontario Health Teams
Full Application Form

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)
See supplementary Excel spreadsheet				
Interprofessional team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				
Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				

Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

2.9. How will you expand your membership and services over time?

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

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

Max word count: 500

It is important to note that the ANHP OHT process is occurring parallel to (and overlapping with) planning for the All Nations Health System and Hospital.

The goal is to inform/plan, develop, and implement a full spectrum, all-inclusive health system to provide care to both Indigenous and non-Indigenous communities alike in the catchment area. The year one population – crisis intervention surrounding addictions, mental health and homelessness issues – represents one of the biggest calamities in the province and thus one of biggest priorities. The tight timeframes of the OHT application, combined with the limited resources as a small OHT with limited managerial, planning and administrative resources, have made it difficult to expand beyond the original ANHP membership.

There are multiple smaller organizations that will be approached and invited over time. There is much opportunity in this as the ANPH consists of several organizations that have only a few employees, yet need an entire infrastructure with walls, IT and accounting. Partnerships could generate efficiencies among work spheres (i.e. mental health and addictions) that overlap major providers in the ANHP.

Engaging with Primary Care and Physicians has also been difficult due to time restrictions. The two physicians both involved in ANHP and OHT planning have left the primary care group. Engagement with physicians is ongoing with one-on-one

sessions and group engagement sessions, but full sign on by the full primary care group by the time of the application is unlikely. This also reflects a highly stressed primary care system in its 18 year of a doctor shortage with multiple other administrative duties running the FHN, the FHT, the LEG, in addition to numerous other hospital and community committees. Engagement with primary care and other physicians is an ongoing year one process, that will also involve engagement, education and planning for the new All Nations Hospital and All Nations Health System.

At maturity, the OHT as part of the All Nations Health System is expected to be a full-service, full-spectrum health system that is all-inclusive for all peoples for this distinct geographic area.

There remain a number of system challenges that impact this vision notably:
- The failure of current OMA-MOH negotiated payment systems, plus a failure of the current APP specialist plans to fully recruit a system that has adequate access and continuity, with care close to home.
- Population-based funding which does not fit small, geographically remote populations, that have significantly higher disease burdens than the Southern Ontario population that the funding is based on.
- Significant weather and geography challenges
- Significant cross-border issues as the main referral centre is in Winnipeg, with poor IT and data connectivity and frequent refusal of service.
- Many programs are Thunder Bay centric, a city that is in excess of 6 hours away (depending on the community in area) and not responsive to local needs, or patients refuse to go for service due to distance, poverty and lack of family supports.
- Difficulties between federal and provincial systems with data, IT, funding
- Historical lack of trust in the medical system, given the high rates of residential schools in the area, with an extremely high use of the child welfare system, with poor supports for those graduating from this system

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

Max word count: 500

Efforts to engage local primary care providers include engagement and information sessions, a CME event, and one-on-one sessions with physicians in the Family Health Network. Sunset Country FHT Nurse Practitioners are involved as their organization is a primary member of the ANHP. WNHAC, the Aboriginal Health Access Centre which employs several physicians and Nurse Practitioners, is a major partner in the ANHP and this application, with the Executive Director being a co-chair.

Further engagement will occur over the course of year one for both the OHT and the All Nations Hospital and Health System, with the goal of full participation of all Primary Care Physicians and NPs by the end of year one.

"Expanding primary care partnerships to meet population need at maturity" will be difficult. The last several years of trying to get any attention from the OMA-MOH that the current payment mechanisms are a failure in the North has not registered and is not on the OMA or MOH's list of concerns during the current negotiations. The Northern Human Health Resource steering committee has received minimal to no response from the MOH over the past year on concerns that are not isolated in the North.

The All Nations Health System planning will include primary care planning which includes the principles of care close to home for communities, combined with HQO's recommended same-day/next-day access that defines and drives quality throughout the rest of the system. As a First Nations referral centre, the ANHP have not been afforded the unique status/recognition of that given Sioux Lookout (Men-o-ya-win) and Moose Factory (Weeneebayko) to develop their own systems. This is likely the path forward as any change coming from the current OMA-MOH system remains unlikely. Without this, the Primary Care system will continue to struggle, and the effects of this will minimize most improvement opportunities inherent in the OHT movement.

2.10. How did you develop your Full Application submission?

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

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership, engagement, or consultation activities that took place and whether/how feedback was incorporated.
- If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.
- If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your

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

Max word count: 1000

Formed in ceremony and trust, the All Nations Health Partners (ANHP) was established in 2017 by health providers and advocates, First Nations, Métis and government stakeholders. The partnership was built upon the foundations of pre-existing formal and informal relationships amongst health providers in the Kenora area.

The OHT application seemed to be a natural choice for the ANHP, as they were already forging a path towards many of the goals set out in the OHT application. Sub-committees were struck to formulate a report and propose a response to the rapidly growing addiction, mental health and homelessness crisis in Kenora and local Indigenous communities, strengthening relationships amongst the partners (as seen in Appendix J).

Following this progress, the ANHP leveraged an existing working group that consists of representatives from all sectors of the health care system in the Kenora area, as well as the community at large. By virtue of its partnership based model, the ANHP worked through this working group to bring both organizational and community-based perspectives/input to the group throughout the development of this OHT application. The working group engaged in 5 key functions to develop the application:
1. Gathering input and facilitating discussions on the past and current issues and gaps in health care (including but not limited to social determinates of health);
2. Ensuring a person-focused vision for health care in the Kenora area by framing discussions/input in the context of a person/community member;
3. Engaging partners and identifying those missing in the current development and pending implementation stages of this OHT;
4. Keeping all partners and communities informed of the progress through existing communications strategies (i.e. open houses/forums, rounds, strategic planning meetings);
5. Engaging and advocating for input and support across the partnership at both operational and leadership/political levels.

Furthermore in developing the OHT application, the ANHP held a series of meetings to discuss the application questions and decide on what directions to take in their collective responses. Various partners volunteered to lead the writing of particular sections of the application and provide drafts to the rest of the group for the next group working session. All partners had the ability to contribute their perspectives for

each section following input internally as well as from members of the communities serviced at large. This exchange of knowledge helped to inform and provide necessary directions for the application. Consensus was achieved through open communication and by following the Anishinaabe's Seven Sacred Teachings: Honesty, Truth, Respect, Bravery, Love, Humility and Wisdom.

Input to the application was inclusive of Indigenous and non-Ingenous partners and communities. Although the partnership included Indigenous organizations, these organizations like the Kenora Chiefs Advisory (KCA) further engaged First Nation elders, youth and leadership through their existing program engagements as well as the Strategic Planning Workshop (hosting over 70 participants, including Chiefs, Council representatives, Health Directors, Ontario Works Administrators, Elder Council and Youth Council) to seek input and validate the approach and overall scope of the application.

Community engagement with residents of First Nations and municipalities will be ongoing as the OHT is developed and matures, and will include sharing of information and vision towards the planning of the All Nations Health System and the All Nations Hospital. These complementary initiatives will also incorporate the outlooks of patients, caregivers and family members from Indigenous communities and municipalities, at every stage. Designated staff are in place to ensure that the voices of all area residents are heard, and to allow consistent two-way communication throughout the development and implementation of the partners' projects.

The ANHP expects to continue expanding to include more service providers who wish to collaborate and provide wholistic, culturally appropriate health care to all.

3. How will you transform care?

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

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

a) Number of people in hallway health care beds
b) Percentage of Ontarians who had a virtual health care encounter in the last 12 months
c) Percentage of Ontarians who digitally accessed their health information in the last 12 months
d) 30-day inpatient readmission rate
e) Rate of hospitalization for ambulatory care sensitive conditions
f) Alternate level of care (ALC rate)
g) Avoidable emergency department visits (ED visit rate for conditions best

managed elsewhere)
h) Total health care expenditures
i) *Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures are also under development*
j) Timely access to primary care
k) Wait time for first home care service from community
l) Frequent ED visits (4+ per year) for mental health and addictions
m) Time to inpatient bed
n) ED physician initial assessment
o) Median time to long-term care placement
p) 7-day physician follow up post-discharge
q) Hospital stay extended because the right home care services not ready
r) Caregiver distress

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

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

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

Max word count: 1000

The most important opportunity to improve care is 'Access to Primary Care', which serves to keep people healthier longer, identify issues before they become serious, and reduce the need for acute care services including the crisis intervention services related to mental illness and addictions issues that inform the identified year one population.

The involved measurements are;
- Rate of same-day/next-day access.
- Percentage of continuity with same primary care provider.

These are being measured in Kenora at WNHAC and at SCFHN.
- WNHAC has four interprofessional care teams that provide care to defined populations – arguably providing a greater degree of continuity in First Nation communities than at the central service location.

Baseline reports from recent QIPs indicate same day-next day access rates of 34% with continuity not being measured. Good access (defined as same-day/next-day by HQO) with 80%+ continuity is the primary driver of quality care and cost savings

through a medical system. So much of the rest of the system is designed as Band-Aids and secondary measures to make up for the lack, or the wait. Please see Section 6.4 as there are significant barriers to this in the catchment area. This is the most important issue, yet the least controllable by an OHT. The current system has not been supportive of a full medical staff in over a decade and there has been a Family Medicine shortage for over 18 years. The lack of a system for general specialists (no pediatrics, psychiatry) puts even more burden on the GPs, especially in a FHN roster system. NPs have been helpful for primary care but are not able to help with Hospital work - ER especially.

The main issue is the lack of a primary care system for First Nations communities. Under the federal system, primary care is delivered through nursing stations and also requires road access (whereby some communities are not accessible by road only). WNHAC sends NPs to communities, but not enough to meet the HQO criteria of “same-day/next-day” access. WNHAC sends the full interprofessional team to communities. All providers function to their full scope of practice, thus reducing reliance on any individual member of the team. ANHP OHT planning is occurring alongside the All Nations Hospital Planning and All Nations Health System planning. One of the of the primary goals –is to enhance Primary Care to communities, and to re-establish an adequate physician base for Primary Care, Hospital work, and general specialties.

The year one goal is to build on existing engagement with First Nation communities. An official engagement qualitative study is underway involving First Nations elders, youth and Health Centre staff. All Nations Hospital and All Nations Health System planning are occurring parallel (and overlapping) with year one of the OHT. Culturally appropriate Primary Care planning is paramount in this process. Thus the “at Maturity goal” is culturally appropriate Primary Care Access in all of the communities as well as the hub of Kenora. For the year-one population (crisis management/mental health & addictions) the ANHP will identify and support coordination of care between all providers inclusive of primary care and homecare. This would include linking primary care more directly to MH/A both upstream (prevention/early identification) and downstream (maintenance post-crisis stabilization).

The second opportunity for improvement is in regard to the growing Mental Health and Addictions population. Significant housing and homelessness issues are intricately tied to this. The involved improvement measures would be:
- Frequent ED visits (4+ per year) for mental health and addictions.
- Frequent ED visits for MHA/ED visits best managed elsewhere.
- Homelessness/substandard housing rates
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere) The ANHP’s area also reflects the serious MHA issues where ER becomes the dumping ground instead of problems being managed in the community. Some of these are being measured by various partners.

Baseline data is:
- ED visits for intentional self harm = 9x Ontario for age 10-25, 2.5x Ontario for age 25+
- Suicide rates = 9x Ontario average for age 10-15, over 2x Ontario for 25+
- Hospitalizations for mental/behavioral disorders: 8x Ontario for age 10-25, 1.5x Ontario for age 25+

There is significant work currently happening amongst the ANHP. Establishing a "Service Hub" at the homeless shelter using multiple staff from different organizations, collaboration on the downtown situation table, crisis services and a mobile RAAM clinic are all projects underway. These are both year one and maturity priorities.

The third opportunity is Total Health Care Expenditures.
The ANHP believe providers and ultimately the government overspends on transport costs (especially Air), and underspend on Physician services. Currently LHIN-based costs are tracked. The ANHP require assistance from the MOH to track Physician services and air transport costs.

Sub-measures that will be tracked that reflect overall system costs include:
- Ambulance trips
- Police calls
- In the longer term, total health expenditure is reduced by health promotion and disease prevention programming e.g. immunization, preventive dental services, home visiting programs to screen and support high risk families (Healthy Babies Healthy Children), smoking cessation programs, brief interventions for alcohol misuse etc.,

The fourth opportunity is ALC Days. Hospital ALC days in the north run close to 50% and indicate an opportunity to reduce beds and expand outpatient surgeries and services. The lack of home care, lack of housing, lack of primary care all contribute to both hospital and LTC ALC problems. The ALC rate at LWDH is 31.3%.

Sub-measures include:
- Median time to long-term care placement.
- Hospital stay extended because the right home care services are not ready.
The year one priority is to begin to reduce this rate. The maturity goal is fewer inpatient beds with a stable low ALC rate, combined with an expansion of outpatient surgeries and services as the All Nations Hospital and Health System are planned and built.

The fifth opportunity is Home Care.
The involved improvement measure is: wait time for first home care service from community. This is being measured in the provincial system but there isn't any data from the federal system. The baseline numbers are: 23 days (Ontario 28 days, provincial target 21 days).
- Possibly 30-day readmission rates, hospital stay extended because the right home care services not ready, and ALC days as sub-measures.

There are significant problems with Home Care in the ANHP area. The provincial component is being managed from a centre 5 hours away. The federal component is managed community by community. The lack of integration, standardization, and local control together have contributed significantly to poor care in this region. There are numerous reports of denials of care – mostly to the First Nation population. The proposal is for ANHP to take over provincial home care for the region from the LHIN and combine it into a single entity with the federal component, if not by year one, then by maturity.

3.2. How do you plan to redesign care and change practice?

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

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

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

Max word count: 2000

The ANHP aims to redesign care through the following 5 domains of service/care:

1. Access to Primary Care

Beyond physicians, there are two significant providers of Primary Care for the ANHP and they are the Sunset Country Family Health Team (SCFHT) and Waasegiizhig Nanaandawe'iyewigamig (WNHAC). Both these organizations are committed to empowering a healthy community by providing comprehensive quality primary care while WNHAC proudly offers services combining traditional and contemporary approaches to health and healing to those who self identify as Anishinaabe or Métis persons living in the Kenora area. While working collaboratively to meet the complex needs both WNHAC and SCFHT recognise that there are challenges in identifying the "most responsible provider" in a bi-cultural system. WNHAC and SCFHT propose to work together to align both organizations EMR's to ensure that primary care patients are properly rostered/registered and or otherwise documented to ensure that patient records are complete, and care is provided in a safe, consistent and collaborative manner without duplication of valuable and scarce resources. In 2018, through an IPCT expansion application, the SCFHT was funded for a variety of new positions including the addition of four Nurse Practitioners. Three of the NPs were identified to offer a new system of care for the community. These three NPs would be part of the FHT but operating with autonomy as a Nurse Practitioner Clinic to increase access to primary care for those without a primary care provider.

A Nurse Practitioner Advisory Committee was formed that consisted of

- Physicians
- NPs
- LWDH – clinical and administration
- WNHAC
- Patients
- SCFHT Admin and Clinical Leads
- Health Care Connect - NWLHIN

This group met bi-weekly to strategize and plan for success.
To date the NPs have onboarded approximately 400 unattached from the Health Care Connect registry and the ANHP are tracking to see if connecting to primary care will decrease the number of CTAS 4 and 5 visits to the Emergency Department of the local hospital. Many of these patients had been without primary health care for many years.

In addition to Health Care Connect the SCFHT, CMHA-Kenora and Lake of the Woods District Hospital are working together to ensure access and system navigation is coordinated. LWDH has added “connected to primary care” as part of their discharge checklist. Patients are not to be discharged without contacting the SCHFT or WNHAC to ensure that any patient who is unattached is offered an intake package to be registered with a Nurse Practitioner at SCFHT or with a physician or Nurse Practitioner at WNHAC.

CMHA-Kenora and the SCFHT have established a pathway for CMHA clients who are unattached and needing the services of a primary care provider to access care, referral, or medication that is seamless and coordinated by a trusted support person at CMHA. A similar pathway is intended to be developed with WNHAC for unattached Indigenous clients as needed. WNHAC also expanded its four interprofessional care teams in 2018 through OFNHAP funding enhancements. Each team now has a minimum of 0.5 FTE in each type of position, with the most significant enhancement being to mental health professionals. Each team now has 1.0 FTE in order to meet the need for care and support. One innovation the new FTEs now support is an after-hours walk-in mental health clinic offered in partnership with LWDH community mental health programs. This service is expected to divert significant traffic from the Emergency Department.

Another important aspect of the WNHAC expansion was the creation of 4.0 FTE Clinic Nurse/Care Coordinator roles to address coordination of comprehensive, wholistic primary care for all clients within WNHAC and case management with external providers. 2.0 additional FTE Health Coach roles were created to address the navigation and coordination needs of high needs clients dealing with multiple issues and agencies in addition to WNHAC.

The All Nations Health Partners will work to develop integrated models that include primary care in the delivery of services for those individuals with mental health and addiction issues. There is a great proportion of individuals with mental health and

addictions issues who do not have a primary care provider or do not include their primary care provider within their treatment. Data from the Canadian Mental Health Association, Kenora Branch collected in 2018-2019 fiscal year identified that there were approximately 24% of clients who were receiving services at the organization who did not have access to a primary care provider. LWDH is funding a primary care provider to accompany the Health Unit's mobile van that services the target population in the downtown core (addictions/homelessness) for two 5-hour sessions per week, and WNHAC is also contributing human resources to this service. Work will be done with Health Care Connect to help prioritize our year-one population to connect with a primary care provider. WNHAC is available for First Nations and Métis clients at their central service location in Kenora, or in First Nations communities.

2. ALC Rate
The All Nations Health Partners will work to develop clear and consistent discharge and handover pathways for those individuals identified as ALC who have a mental health and/or addiction issue. Work is ongoing for improvements with the Kenora Homeless Shelter. Kenora Safe Beds is up and running. KDSB is opening transitional housing unit for those leaving the corrections system. Engagement with KACL is occurring to ensure those aging out of the child welfare system have access to the correct diagnoses and services. All of these initiatives are hoped to improve the ALC rate that is highly contributed to by the year one population when there is "nowhere else to go".

3. Total Cost of Care
The All Nations Health Partners will work to identify a total cost of care for the treatment of those individuals with mental health and addiction issues within the entire journey of treatment which includes hospital and community-based care. Some cost factors will be difficult to determine, but instead will be tracked by usage numbers such as number of ambulance calls and number of police calls.

4. Frequent Emergency Department Visits for Mental Health and Addictions
The All Nations Health Partners will identify who are the highest users of the acute system and identify gaps in service within the sector. This is an extension of the existing Health Links plan as a significant portion of the Health Links population is from the Year one target population. Data from the Northwest LHIN identifies that for the first 3 quarters for 2018-2019 there was a 17% return rate of individuals with mental health symptoms returning to the emergency department and 47% return rate of individuals with addiction issues. Health Unit data includes ER visits for intentional self-harm which is 6x the Ontario average for the 10-24 age group and 2.5x Ontario average for the 25+ age group.

This is possibly a key intervention for the OHT in year one, involving a multi-pronged strategy that would consist of the following:
- Intervention prior to crisis via mobile community services including addressing physical health issues that, if unattended lead to ER visits and hospitalization.

- Community providers attending to hospital to provide assessment and discharge planning – linking people with local resources (care plan document and tools).
- To establish common language, forms and assessment tools.
- Improve (faster) follow-up post-crisis with community support services.
- Providing tools/practices for patients/clients to improve self-care and access in community resources (via care plans).
- Building off the success of the Youth Wellness Hub.

An NP clinic at SCFHT has been added to address the increase in CTAS 4 & 5 in ER; another model of partnership. Police (OPP and Treaty Three Police) are active at the Kenora Situation Table - diversion to community programs & mobile services instead of to the ER. The Canadian Mental Health Association, Kenora Branch, Lake of the Woods District Hospital, Ontario Provincial Police, Northwestern Health Unit and the Dryden Regional Health Center have collaborated on coordinating care across multiple providers and care settings regarding the implementation of the Safe Bed Program in Kenora.

Additional acitivies and initiatives include:
- New Stabilization bed for youth through KCA
- Development of an adult crisis team including expansion of the mobile unit. A program exists for 9 First Nations communities through KCA, but it is stretched thin and also needs to be developed further and expanded.
- Diversion of mental health and addiction individuals from the emergency department and screened and connected to community-based services where appropriate. LWDH mental health workers and counsellors now stationed directly in the ER.
- Enhancement of the Mental Wellness Team operated by the KCA - Access to after hour crisis services for those individuals with mental health and addiction issues that is cost effective to the system.
- Development of a lifespan regional crisis line and ensuring there is equitable access (this is an ongoing LHIN sponsored program).

It is noted by multiple organizations that resources are already spread very thin with high risk of burnout and high turnover amongst providers. In addition, travel and travel budgets in many organizations are either non-existent, or inadequate to meet the demands of the remote geographic area. It is again noted that organizations that are based on population-based funding models (established based on Southern Ontario) also do not reflect the realities of the high rates of pathology, mental health and addictions in the Kenora District.

5. Homelessness and Quality of Housing
The All Nations Health Partners will identify successful housing models that will support the needs of those individuals with mental health and addictions to be successful within their recovery. Data from the Canadian Mental Health Association, Kenora Branch collected in 2018-2019 fiscal year identified 55% of the individuals served by the District Assertive Community Treatment Team and 50% of those individuals served by the Forensic Case Management Program required a higher

level of intervention which included a medically monitored facility to meet their needs. The Canadian Mental Health Association, Kenora Branch in May of 2019 in partnership with the Kenora District Services Board and the Northwest Local Health Integration Network and the Ministry of Health & Long-Term Care opened the Safe Bed Program in Kenora which has served 45 individuals to date who have ongoing mental health and addiction issues. The Kenora Homeless Shelter has just reopened with a new “Service Hub” as a component. The city of Kenora has a severe lack of low-income housing and has lost its 3 sub-standard housing units to fire over the past several years. The City is developing a long-term plan to address this but will not be helpful in year one. Cost of building is an issue. Kenora is a bit too small to receive special provincial funding for homelessness. It is also too small but is seeking status as a “Hub City” as many people from other communities migrate to Kenora, especially from outside the ANHP region as the provincial court for the entire North resides here.

The ANHP has not set any targets as partners are in the midst of establishing their baseline data (see other sections). Year one involves developing and gathering baseline data, and targets will then be set accordingly.

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

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

3.3.1. How do you propose to coordinate care?

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

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

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

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

Max word count: 1000

The ANHP aims to embed care coordination throughout the various stages and settings of crisis intervention services:

• Start point: moment when person presents in crisis (through any entry point: police, acute/ED, community, home, etc.)
• End point: moment when person receives intervention and crisis is stabilized
• Care coordination includes the following functions: developing care plans, discharge planning, follow-up care, assessment & planning, crisis support/counselling, medical intervention and environmental interventions and crisis stabilization
• The care coordination services would be delivered through: telephone crisis services, mobile crisis teams, crisis residential services (including withdrawal management) and psychiatric emergency medical crisis services in hospitals

Through the OHT, the ANHP will be reviewing existing capacity to support an integated model which would include sourcing local or more appropriate vendors which were previously managed through regional entities.

- All providers will be trained in cultural safety and humility as well as standardized assessment tools related to mental health and addiction clients (e.g. Columbia Suicide, GAIN-Q3 Assessment, OCAN). There will be a focus on transitional planning to prevent gaps and repeat visits.
- All providers will be trained on which services are to be accessed at which juncture points and the criteria for access

The ANHP have demonstrated coordinating care across multiple providers and care settings. An example where the ANHP have already demonstrated leadership in this area is through servicing high risk children through FIREFLY, which is the Child/Youth lead for service coordination – for complex care children. FIREFLY extends services in Kenora Rainy River area providing coordination support in partnership with family, with education, health, and specialty care services. Another example working with local First Nation communities through the Kenora Chiefs Advisory's (KCA) Family

Well-Being Program, whereby program workers share their time, effort, resources in collaboration with pre-existing programs allowed them to do more and create activities that are of interest to the entire community – building a sense of neighbourhood and community wellbeing. The program has established a partnership with the mental health coordinator to provide 24 hour on-call program to support the family as well as supporting access to safe space if needed outside of women's shelter.

Together the ANHP have identified the following activities that would be considered In- Scope for year one:
- Coordination across health and community services on and off reserve
- Coordination with all Indigenous communities
- Discharge planning
- System evaluation for Home and Community Care (LHIN) regionally for the OHT catchment area (which will further support expansion to address other mental health and support for any life limiting illnesses/palliative care)
- Transportation is a known barrier to accessing care – there is a need to evaluate grants (northern travel grant) – to identify opportunities to look at actual costs and how it could be improved (in and out of community)
- FIREFLY would be planning to contribute some care coordination support
- Afterhours response in the emergency – child and youth (12-18 years old)

Out of Scope or known dependencies:
- CMHA Thunder Bay to support the 24/7 crisis line which would help de-escalate and link to the Kenora model of care;

Success in care coordination will be reflected in several measures that are or will be followed, several of which are in our "most important performance improvement opportunities":
- 30-day inpatient re-admission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere
- Total health care expenditures
- Patient Reported Experience Measures, Provider Reported Experience Measures,
- Timely access to primary care
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions
- Median time to long-term care placement
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready

3.3.2. 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 the need. Considering the needs of your Year 1 population, please propose how your team

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

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

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

Max word count: 1000

Part of a new system development is the creation of a known pathway for each service line. If it is common and known to all, and if the ANHP all have access to the same information, then a system doesn't need navigators. This may be an element where system navigators are utilized in the year one plan as the OHT informs and develops the long-range plan which includes establishing known service lines and a common record which would minimize the need for navigators.

However, for the year one population, the team will provide system navigation services through the design and implementation of patient centred integrated services from point of first contact, linking to services (right service, right time…) and coordination of service planners (using common tools). System navigation will also have to address cultural and geographic needs. The system navigation will be personalized (informed through discharge/handover/care plans) to support cultural needs of patients and caregivers. The same providers have been involved with the Health Links project and have been working with different ways of information following the patient. Without a robust community data system this has been difficult but will continue to be worked on in year one, with a hope that at maturity, the ANHP have a single information/IT system for our All Nations Health System.

There aren't any activities that are out of scope for the first-year population. The work is in progress, and the OHT will adapt and bring in whichever sector is required to help this priority population. Some areas may be difficult (i.e. access to primary care, especially in our remote communities), however just because it is difficult doesn't mean it is out of scope.

The deployment and resourcing of the "System Navigation" for the first-year population is a work in progress (see Section 2.7). There is work with multiple organizations providing providers in different settings such as the homeless shelter, mobile clinic, and crisis intervention.

The ANHP do not yet know if the team has service capacity to continue or maintain or expand this. Organizations are using resources from other programs as there isn't any new funding for this work. However, if effective, it may save work down the line for the same or other organizations where care is more expensive and less effective (i.e. emergency room use, hospitalizations, transfers out of region, especially through air travel, where there are known travel routes to London, Toronto, and Ottawa).

The team will determine whether the system navigation service is successful through decreasing reliance on navigation support, through the development of inventory of crisis services available and the clear pathways of entry into these services. Additionally, there are system transformation improvement opportunities and their measurement list (see Section 3.1) will provide the system process measures. In addition, system outcome measures such as suicide rates, ER use for intentional self-harm, and hospitalizations for mental/behavioral disorders provide feedback.

3.3.3. How will you improve care transitions?

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

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

Max word count: 1000
-The specific actions that the team plans to take to improve care transitions and continuity of care are as follows:

1. Northwestern Ontario Regional Model of Psychiatry

Beginning in April 2019, Lake of the Woods District Hospital (LWDH), Thunder Bay Regional Health Science Centre (TBRHSC), and St. Joseph's Care Group (SJCG), took the joint lead toward streamlining psychiatry services for the entire Northwest Region. Working groups have been established to share locum resources, to assist with surge capacity across Schedule 1 inpatient units, construct safe assessment rooms in rural hospital emergency departments, and an enhanced regional model of inpatient psychiatry triage has been piloted (called a Regional Mental Health Assessment Team).

Supplementing this model of inpatient psychiatry care is the development of an outpatient model of psychiatry. This model of care is evolving, and outpatient clinics started Sept 30, 2019 which include providing service to local and regional partners including primary health care through WNHAC, children's mental health / addiction services, services for the developmentally disabled, and adult mental health /

addiction services. Additionally, with TBRHSC as the lead, an application for a Regional Hub and Spoke Model for outpatient child psychiatry is currently being pursued. At maturity, this model of child psychiatry would have Thunder Bay as the hub and outreach services would be provided to the communities of Kenora, Red Lake, Sioux Lookout, Fort Frances, Atikokan, and Dryden.

2. Youth / Adult Mental Health Crisis Response Services

A cross-sector group of service providers including LWDH Mental Health & Addictions Programs, Kenora Chiefs Advisory, Ontario Provincial Police, Treaty 3 Police Services (T3PS), Kenora Association for Community Living, CMHA Kenora. CMHA Fort Frances and FIREFLY are currently meeting to create an after-hours mobile mental-health crisis response service for the Kenora area.

The initiatives / activities the members of the team currently have in place to improve transitions, and will continue to be built upon in the first year of implementation, are as follows:

a) O.P.P. Situation Table / Rapid Intervention Services Kenora, (R.I.S.K. Table)
The purpose of RISK is to bring together diverse service providers to identify situations of acutely elevated risk, and to prevent negative outcomes from occurring. Service providers rapidly respond and offer wraparound services to individuals with diverse needs who find themselves at risk of criminalization, victimization and / or harm. Acutely elevated risk refers to situations where imminent harm is present. Without immediate intervention these situations will escalate and a negative outcome such as criminalization, victimization and/or harm is likely to occur.

b) LWDH / OPP / T3P Complex Care Table
This complex care table provides a standardized communication format between the OPP, T3PS and the LWDH staff to ensure safe, effective communication about seriously marginalized people known both to police and to the hospital. This table has also underpinned the creation of interagency relationships to positively influence the utilization of the Brief Mental Health Screening Tool which is used by police during mental health apprehensions, as well as the LWDH / Police Transfer of Care Agreement.

The purpose of the Transfer of Care Agreement is to:

1. To ensure a standardized approach to patients arriving to the LWDH,
2. To ensure the safety of patients, hospital staff, police and public,
3. To ensure that patients who are accompanied by the OPP and T3PS to the LWDH are transitioned as quickly as possible from police to the hospital, endeavoring to facilitate the departure of the Police within a 30-60-minute target timeframe,
4. To provide a standardized communication format between the OPP, T3PS and the LWDH staff to ensure safe, effective communication about known risk during the transition from police to hospital,

5. To avoid unnecessary trauma and the stigma of criminalization of patients while experiencing a mental health crisis, and
6. To facilitate discussion on a case-by-case basis in order to review circumstances related to police departure times (review of the Brief Mental Health Screener (BMHS) and patient risk factors).

3.4. How will your team provide virtual care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

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

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

3.5.1. How will you improve patient self-management and health literacy?

Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team's existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Max word count: 500

The ANHP aims to improve patient self-management and health literacy through education a number of initiatives for both patients and providers impacted by mental health and addictions. One specific initiative will be to provide education and relevant resources to those individuals with mental health and addiction issues on understanding the use of psychotropic medications. Primary care will ensure to provide ongoing education to individuals on a regular basis around these medications and their benefit. This will follow the Health Quality Ontario Standards for Depression.

All resources for patients will be developed with direct community input to ensure it resonates with the patient populations.

The ANHP OHT's existing self-management and health literacy tools, processes and programs:
• Diabetes Education
• Healthy Eating and Active Living
• Smoking Cessation
• Reproductive Health
• Early Childhood Development
• Oral Health
• Culturally Based Health Programs
• Chronic Pain Management
• Craving Change
• Prenatal care
• Harm reduction
• Drinking water safety
• Speech and Language
• Parenting
• Road Safety
• Water safety
• Sun safety
• Breast feeding
• Food security
• Housing Support
• Falls Prevention
• Memory Clinic
• PCAP

3.5.2. How will you support caregivers?

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

Max word count: 500

It is important to note that many if not all members of the All Nations Health Partners (ANHP) make public statements within their strategic plans on committing to be held accountable to patients and their caregivers to feel supported and safe when they put their trust in the health care system. This will remain a key pillar to the OHT in providing excellence in care for all people.

Lake of the Woods District Hospital's strategic plan has stated that they will "improve support and relationships with Indigenous partners and patients".
In 2019 the hospital had all staff participate in a customized cultural training program to start to address the historical racism reported in this facility.

Canadian Mental Health Association - Kenora's strategic plan has stated, "every individual has the right to give and receive services in an emotionally, physically and culturally safe environment. We will ensure that the safety of clients, staff and volunteers is an essential component of our service delivery and operations" and that "all people have the opportunity to develop and recognize their self-worth. We will encourage personal development through self-expression, decision making, knowledge and respect," and further; decisions will be based on information from consumers, family and professional best practices which will occur through measurement, evaluation and collaboration.

FIREFLY's strategic plan states it "will champion change that ensures the best outcomes for children, youth and families and promote and support Indigenous partners and communities in developing services that meet the Truth and Reconciliation Commission's Calls to Action."

The Sunset Country Family Health Team's strategic plan states that is it values Empowered patients by enhancing self-management, collaborative primary healthcare and patient-centered care. It has set a priority to support patients in their self-management of care and appropriate use of available health care resources.
In 2018 the Sunset Country Family Health Team ensured that all existing and new staff complete and adopt Cultural Safety Standards.

3.5.3. How will you provide patients with digital access to their own health information?

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

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

3.6. How will you identify and follow your patients throughout their care journey?

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

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

Max word count: 500
The ANHP plans to identify and follow patients throughout their care journey through the following strategies:
- Developing an integrated care plan, for children, youth and their families across health, education and social service systems
- Implementation of Family Intervention Therapy within the area.
- Engagement of PFACs, concept of having safe spaces and service hub(s)
- Community safety planning
- Child/youth mental health services participation on community tables including situation table
- Youth crisis services collaborative planned with LWDH with on site youth mental health counsellors
- Youth mental health workers located on site at youth wellness hub – collective approach

3.7. How will you address diverse population health needs?

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

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

3.7.1. How will you work with Indigenous populations?

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

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

Max word count: 500

More than one-third of the Kenora area population is Indigenous (including status First Nation and Métis peoples, and Indigenous peoples not affiliated with a local First Nation) and nearly 17% of the population speak Ojibway, Oji-Cree or Cree as their mother tongue. The All Nations Health Partners (ANHP) includes Indigenous-led organizations like Waasegiizhig Nanaandawe'iyewigamig (WNHAC), Kenora Chiefs Advisory (KCA), and the Kenora Métis Council who work directly with and for Indigenous peoples in the Kenora area. Through these organizations as well as the non-Indigenous organizations, the ANHP will continue to engage Indigenous communities in service planning, design, delivery of the OHT. This commitment to engagement and partnership is a core function of the ANHP and will complement the other initiatives (i.e. All Nations Hospital and System planning) that will also incorporate the input from patients, caregivers and family members from Indigenous communities and municipalities, at every stage. Designated staff are in place to ensure that the voices of all area residents are heard, and to allow consistent two-way communication throughout the development and implementation of the partners' projects.

In addition to the commitment to sustaining engagement and partnership with and for Indigenous communities, the ANHP recognizes that Indigenous peoples bear a disproportionately high burden of chronic illnesses and face a number of health disparities, barriers, and gaps in health services. One barrier to Indigenous people receiving adequate healthcare is the experience of culturally insensitive healthcare, including racism and discrimination. People who experience culturally safe healthcare are more likely to access care earlier, feel more at ease and empowered throughout the process of receiving care, share details about their health concerns and care preferences, return for follow-up visits and follow treatment plans recommended by healthcare providers.

The ANHP are committed to providing culturally safe care across all settings of care. In partnership with 7 Generations Education Institute (post secondary education) and KCA Elders Council, Cultural Safety and Humility Training was developed and is being delivered to the Lake of the Woods District Hospital (LWDH) staff and board of directors. WNHAC also delivers and promotes cultural safety and humility training and programming. Through these experiences and resources, the ANHP will ensure all partners and providers within the OHT have completed cultural safety and humility training that is renewed regularly as the OHT reaches maturity.

It is important to the ANHP that the Indigenous population are represented through appropriate and meaningful representation (equal decision makers and leadership) and style of leadership (done in ceremony). A key pillar to the ANHP planning process its to ensure Indigenous views and approaches to health and well-being are not just gathered through consultation or engagement; rather its embedding at the core of the programs and services.

3.7.2. How will you work with Francophone populations?

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

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

Max word count: 500

The partners acknowledge the requirements outlined in the French Language Services Act in providing services in French in designated areas where the proportion of Francophones need to make up at least 10% of the area and/or have at least 5,000 Francophones residing within the city. Based on the census as well as service provider data, the catchment area of ANHP does not have sufficient Francophones to officially require services to be available in French.

Despite not meeting the threshold, the ANHP are inclusive of servicing all people and will strive to offer services in French through partnerships with recognized designated areas.

Building on the foundations of reconciliatory action, the ANHP also recognizes the need to address inequities with and for local Indigenous communities in providing services in Indigenous languages (i.e. Anishinaabemowin). Although there are no legislative requirements to provide services in Anishinaabemowin or other Indigenous languages, the ANHP is progressive and acknowledges that language and culture are key components to Indigenous ways of knowing and well-being and is part of a wholistic approach to health and well-being embedded within the partnership.

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

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

Max word count: 500

As noted in previous sections (2.2 and 2.6) and in Appendix C, partners of the ANHP collectively service various segments/sub-groups reflective of the defined communities and catchment area inclusively.

The partnership overall aims to transform the way health care services are delivered and accessed holistically across the entire system applicable to all people regardless of age groups and socio-economic and demographic factors. The partnership has engaged and will continue to engage with patients, families, and care providers to build a shared understanding of the challenges facing the current health system and co-creating new models for connected care.

Regarding the year one population, patients and families, primary and secondary care providers, and advocates have been engaged and are currently working to build from the shared understanding of the challenges and opportunities facing mental health and addictions. Work is underway to strengthen these existing partnerships and build new partnerships among stakeholders to address all aspects of care (i.e. schools and law enforcement).

As seen in Appendix F, the partners have mapped the current capacity within the system to identify opportunities to address shortfalls and gaps for crisis intervention services for everyone in the catchment area. Understanding patient needs and requirements and existing service delivery limitations are important steps to enhancing and aligning existing services to collaborate and deliver improved care.

Any missing team members (e.g. other primary care providers and education system) will be identified and engaged in this process to maintain inclusivity. Based on the current membership, the ANHP is well positioned to work with the year one population and expand to engage any missing team members through sector specific working groups as the OHT gets to maturity (inclusive approach).

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

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

Max word count: 1000

Year one goals for patient /family advisory (adapted from WNHAC) would the informing key topics of ANHP-OHT services and facilities as well as how are models of care and strategic priorities operationalized.

Additional topics for the patient/family advisory to would include informing/advising on:
- Materials on what an OHT is and how it impacts our health care
- All the services and programs of our partners
- Awareness of traditional health practices and activities, and protocols
- Initiatives, projects and services

- Important considerations, i.e. building trust relationships as an integral component of the care process
- Share knowledge and understanding of traditional protocols
- Needs, encourage increased focus on culture as treatment (personal stories of how traditional ways were helpful in healing)
- Supporting expansion of existing traditional services (identify community supports)
- Assisting in identifying health needs and issues in the communities
- Sharing trends for each community
- Bring forward issues that are heard in the community so that they can addressed by ANHP-OHT
- Helping support people taking responsibility for their own health
- Patient education about illness and what is involved in providing care
- Helping build understanding and capacity to clarify/meet client expectations:

a) Staff need to be aware of the communities they work with including Indigenous history and culture
b) Informational needs to be provided in plain language and/or translated
c) Friendly staff,
d) Realistic understanding of services provided

- Acting as a liaison, help promote and build connections for ANHP-OHT in community
- About community protocols & traditional supports
- Promoting what ANHP-OHT does at the community level i.e. at community meetings.
- Promoting ANHP-OHT services and programs
- Bring forward events that they hear about
- Not just surveys but on-going engagements (annual plan that brings in service providers with Chief and Council) – demonstrating greater accountability to supporting system planning – relationship building.

Many Care partners are accredited and meet national standards on patient and family engagement including engagement with patients in service delivery and design. Furthermore, Child and Youth Mental Health Lead Agency for this area follow provincial standards on youth and family engagement.

The Kenora Chiefs Advisory (KCA) has also been accredited through Accreditations Canada. It is also directly accountable to the communities it services which is also reflected through the KCA board of directors, which consists of community leadership (Chiefs) from each of its member communities.

The LWDH and other members of the ANHP conduct regular (i.e. annual) patient/client satisfaction surveys. The LWDH participates in the National Hospital Accreditation with Accreditation Canada and also has standards certification compliance for the Pharmacy, Clinical Laboratory and Pharmacy programs. There is considerable effort to ensure patient, family, and caregiver voices/perspectives are embedded across various tables/commtees/boards across the ANHP members which will continue with the OHT.

Rita Boutette will be a key resource with both LWDH and the OHT. She is a past member of the inaugural Minister of Health Patient and Family Advisory Council. She is also: Board Chair of CMHA Kenora, Member of Health Quality Ontario Primary Care Quality Advisory Committee, Patient Advisor on Canadian Patient Safety Institute, Patient Advisor on a studies for Patient Centered Care for Women, Patient Advisor of LWDH, Board of Director LWDH as a patient advisor representative, and part of the team that developed the Declaration of Patient Values for Ontario which was adopted by the Ministry of Health.

The ANHP will also be including new and existing perspectives representing the youth for example the inclusion Jackie Frank from the KCA Youth Wellness Hub.

4. How will your team work together?

4.1. Does your team share common goals, values, and practices?

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates. Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

Max word count: 500

As described earlier in this document, the All Nations Health Partners (ANHP) were established to, "work together in partnership … with the express purpose of improving health outcomes for all people of the region it serves". In November 2018 the partners hosted an event intended to engage a broad cross-section of community members in developing a common vision. 51 persons representing 29 organizations participated. An additional 13 organizations indicated an interest in being involved, but due to scheduling conflicts were unable to attend the event.

The resulting draft vision statement quite unintentionally echoes the government's quadruple aim in every aspect.

"The Kenora Region All Nations Health Care System is …
… an innovative health system, designed by local people for local needs
… a system that harmonizes funding, services, and governance to provide barrier-free healthcare to all people.
… a system that:
- places people as the priority
- supports community wellbeing
- celebrates Indigenous healing and governance
- nurtures local health care professionals
- strengthens partnerships among organizations"

Having articulated a very clear vision to guide and inform future planning initiatives, discussion briefly addressed actions to which participants could commit that would keep the vision alive as development unfolds over time. Some of these included:
- aligning individual organizational initiatives to the vision,
- working together to break down barriers, and
- continuing to build partnerships based on who needs to know and be involved.

While the OHT process was announced before further planning could occur, it was perceived by the partners as a timely opportunity to move forward on the work already begun. The statement makes it clear that we all share the goal of improving the health status of our respective 'client groups', and that our values are more similar than they are different.

There may be some differences in operating practices, in the sense that different sectors of the health care system (physical and mental health, for example) have historically been siloed and evolved in isolation of each other. The same could be said about Indigenous communities having been isolated from the non-Indigenous population for a significant portion of our shared history. These differences have manifested themselves as systemic problems such as fragmented and inequitable care, with correspondingly poor outcomes. As the ANHP vision suggests, however, at this moment in time the ANHP are united in our commitment to a different, better future.
The partners are aware that in general, people instinctively resist change. However, the partners are equally aware that change is required in all aspects of our local health care system if the ANHP are to achieve meaningful change in the health status of our collective population. Compared to Ontario as a whole, the general population in this area carries a higher burden of chronic disease and poor health outcomes; the health status of Indigenous people in the area is even worse. Our dream is to lead the province in health status by changing our local system to serve our needs.

4.2. What are the proposed governance 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. Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

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

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

- ***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: 1500

Currently, the All Nations Health Partners (ANHP) or work group is based on partnership and collaboration model created following a resolution that was passed to support the establishment of a new and innovative health care system that will better meet the needs of all people living in the Kenora area. Through the ANHP, it has been tasked to develop the All Nations Health System which will be a fully integrated health service delivery model that encompasses wholistic care for everyone.

In order to achieve this goal, the group will focus on three main objectives:
a) Recruitment and retention of physicians and other health care professionals;
b) Cross-border access to services in Manitoba; and
c) Construction of a new All Nations Hospital and health care campus supported by a comprehensive, innovative health care system.

Membership of the ANHP includes representatives from all sectors of the health care system, as well as the community at large. The various sectors will therefore be requested to consider working through representatives to bring their perspectives to the group and be informed of the group's work.

The term for ANHP membership is open-ended, provided that all members/partners remain actively engaged in the efforts of the working group. Co-chairs must reflect the Indigenous/non-Indigenous partnership and will be elected by the group members annually. Committees may be struck to move specific issues forward as they arise. Membership on committees shall be determined by the issue at hand with the approval of the working group and shall continue until the issue has been addressed unless otherwise determined.

The working group and any related committees are established to:
1. Share information and identify issues and gaps;
2. Develop an integrated, person-focused vision for health care in the Kenora area;
3. Engage partners in developing and implementing action plans to address identified health care issues;
4. Keep partners and communities informed through a multi-media communications strategy;
5. Advocate for change through the partnership at both operational and leadership/political levels.

The following points highlight the ANHP meetings and decision-making process:
1. A regular schedule of meeting dates is established and may be amended from time to time.
2. Meeting locations rotate among the various partners.
3. Quorum for meetings comprises of 50% plus 1 of the group membership.
4. The group generally works by consensus.
5. The Kenora Chiefs Advisory (KCA) provides clerical support for the Working Group to schedule and record minutes of meetings.

The ANHP establish and maintain a culture of ethical conduct embodied in the Seven Sacred Teachings:
1) Honesty - Speak openly and truthfully always.
2) Truth - Focus on facts; be prepared to accept information you may not want to hear.
3) Respect - Everyone has value and should be treated with respect. Being on time, listening and speaking humbly, and respecting personal boundaries are all way in which respect is demonstrated.
4) Bravery - Take risks; move toward your vision despite fears and unknowns. Have the courage to engage in sensitive or difficult conversations.
5) Love - Love describes the good life – minobimaadiziwin. It is given and received through life, earth, people, choices and opinions.
6) Humility - No one person or community is more important than the other; we are all equal. Everyone has a voice, and all contributions have value. We all have gifts as well as limitations.
7) Wisdom - We constantly learn by listening, hearing, and applying what we learn – especially from our elders - in a never-ending process.

In the event of a significant dispute or conflict, those involved will be reminded to apply the values we have agreed to be guided by and encouraged to come to consensus. In the event consensus cannot be achieved, an elder on whom all the parties agree will be requested to support the group in resolving the issue.

In the event it becomes necessary to manage funds or engage human resources to further the work of the group, one of the partners who is an incorporated entity with capacity to execute legal agreements may volunteer to hold such funds on behalf of the group, and employ or contract with any persons engaged to carry out such work (i.e. to support or provide Project management). Such arrangements shall be formalized through a Memorandum of Understanding (MOU) between the partner and the larger group. Such arrangements may be guided and monitored by a committee struck for this purpose.

With regards to communications and accountability, the Co-chairs shall be key contacts and spokespersons for the group. The ANHP members will develop and work from a central communication strategy intended to actively engage all interested parties and to keep its partners, Kenora area residents, and other stakeholders informed about its progress. ANHP meetings shall be documented through minutes

that record issues discussed, key discussion points, decisions made, and actions to be taken. Key messages are communicated to the partners through their boards and councils, and the leadership group following each meeting. The ANHP will report in person to the leadership group on a quarterly basis.

This structure is illustrated in Appendix K. The ANHP recognizes that there are some challenges with this model of governance notably:
• The working relationship amongst partners is vital
• Understanding and working within the limits of accountability and structures
• Focus on both on the process and the product of governance in collaborative initiatives
• Need to be deliberate and intentional when adapting traditional organization governance elements to a collaborative effort

As noted in section 2.9, engaging with primary care and physicians has been difficult due to time restrictions. The two physicians both involved in ANHP and OHT planning have left the primary care group. Engagement with physicians is ongoing with one-on-one sessions and group engagement sessions, but full sign on by the full primary care group by the time of the application is unlikely. This also reflects a highly stressed primary care system in its 18 year of a doctor shortage with multiple other administrative duties running the FHN, the FHT, the LEG, in addition to numerous other hospital and community committees. Engagement with primary care and other physicians is an ongoing year one process, that will also involve engagement, education and planning for the new All Nations Hospital and All Nations Health System. At maturity, the OHT as part of the All Nations Health System is expected to be a full-service, full-spectrum health system that is all-inclusive for all peoples for this distinct geographic area.

The ANHP will likely need to move towards one governing body as the OHT matures to ensure the highest level of integration, which will be reviewed over the course of year one of the OHT (further detailed in section 6.1). Over the course of the implementation of the OHT, the ANHP will be engaging providers who are currently not represented to ensure inclusivity of all providers and serviced community members. Through the OHT, multiple partners will formalize relationships and service delivery through MOUs as informed through sector based working groups.

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

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

4.3.1. What is your plan for sharing information across the members of your team?

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions

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

Max word count: 1500

With Mental Health & Addiction Clients / Patients being the priority population for year one, the following are examples of how information is shared across organizations to assist in care planning for people who are experiencing a serious mental health crisis:

1. Safe Beds Program - Canadian Mental Health Association Kenora, (CMHAK),

The CMHAK Safe Bed Program is a short-term residential mental health stabilization intervention (Mental Health & Justice Beds). The Safe Beds provide individuals living with mental illness, and current involvement with the criminal justice system, a 30-day stay with onsite 24 hour supports to assist in resolving current crisis and creating strategies for long-term interventions.

The Safe Bed Program has three pathways by which clients can access services:
- Brought Directly by Police
- Brought by a Mobile Crisis Team (either community mental health or mixed community mental health and police team)
- Brought to hospital by Police on a Mental Health Act Apprehension - not deemed appropriate for admission and then referred by the hospital or brought by police

The information shared across team members includes the Police Inter-RAI, (Brief Mental Health Screener), Police / Hospital Transfer of Care Agreement, LWDH-administered Columbia Suicide Risk Assessment and Safe-T Plan, and the LWDH-administered Social Work Assessment.

2. Global Assessment of Individual Needs - Quick - 3, (GAIN-Q-3)

The GAIN-Q-3 is an evidence-based staged screening and assessment instrument for individuals requiring addictions care. This assessment instrument provides an accurate identification of client need, assists in developing a treatment plan, and matches individuals to the most appropriate level and type of care. The regional lead for the GAIN Q-3 is the Mental Health and Addictions Programs of Lake of the Woods District Hospital. The information from this tool, with client consent, is shared with inpatient treatment centres as a pre-requisite for admission.

3. The Ontario Common Assessment of Need (OCAN) and Integrated Assessment Record (IAR).

The OCAN is the standardized assessment tool used in the Kenora community mental health / addictions sector. The OCAN supports a recovery approach by supporting conversations that capture the client's current situation, needs, strengths and service plan.

The OCAN benefits for consumers of community mental health services, health service providers, and the health care system include:
- Supporting a client-driven approach with the inclusion of a self-assessment
- Supporting conversations with clients about needs, strengths and actions
- Providing aggregate data to support quality improvement planning at the program, organization, LHIN and provincial levels
- Facilitating inter-agency communication through common data standards
- Enhancing the quality of information by having a consistent approach to data collection

The IAR tool provides a central repository for clinical assessment data collected from multiple community care sectors. It allows authorizes Health Service Providers within the circle of care to upload and view a client's assessment information in a secure and timely manner. The IAR enables collaborative care planning as well as enhanced communication between providers, for the ultimate goal of promoting high quality care for clients in the community.

4.3.2. How will you digitally enable information sharing across the members of your team?

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

5. How will your team learn & improve?

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

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

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

Max word count: 500

Two issues are notable for performance amongst ANHP members.

First is the performance of the hospital. LWDH underwent an operational review after a vote of non-confidence in the CEO and hospital Board. The operational review findings were released in February 2018. The longstanding CEO retired in spring of 2018 and a new CEO has been in place and is a key and keen part of the ANHP Team. The hospital Board has undergone restructuring of its governance. The medical staff lifted its vote of non-confidence in summer of 2018. The medical staff of LWDH remains under significant stress with no volunteers to be President or Vice-President of Medical Staff. The relationship with the hospital has improved, but the medical staff is still under significant stress being in year 18 of a doctor shortage, with multiple specialist lines understaffed or non-existent, and HFO providing a significant portion (up to 50%) of ER shifts with fly-in physicians for the past several years. The mood and culture are more positive, with a renewed administration and revamped board. The hospital is undertaking cultural awareness and sensitivity training for all staff. Approval for LWDH and Kenora Chiefs Advisory to enter the next stage of planning for a new hospital has also been a boost, and gives some hope to solve some of our longstanding lack of resources and care close to home.

Second is the recent closure, reassessment and reopening of the Kenora Homeless Shelter. The shelter is run by an organization not currently part of the ANHP but funded by KDSB who is a key member of our team. The closure caused significant stress to part of our year one population. As well, media coverage of the situation was very negative. A series of unfortunate events combined to create the situation, including a recent fire destroying the last remaining, affordable housing unit (others also lost to fire in the past 2-3 years), plus a burgeoning of our community's crystal meth problem. The positive reaction from numerous organizations – most within the ANHP – has been extremely heartening, as the shelter is reopening with a redesign, including a "Service Hub" where providers from multiple ANHP organizations will be attending the shelter to improve access to services and enable care coordination for this difficult to serve and difficult to find population.

At this point there are not any formal accountability structures in place between individual team members and the team as a whole. The initial governance structure will involve Memoranda of Understanding. It is assumed that governance development will occur through year one and beyond, with assistance from MOH guidelines for OHT, and by learning from other, larger teams who have more resources to explore these new complex governance models.

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

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

5.2.1. What previous experience does your team have with quality and performance improvement and continuous learning?

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

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

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

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

Max word count: 1000

Our team members are major believers that a culture of continuous quality improvement, in a system that uses Safe, Effective, Equitable, Timely, Patient-Centred, and Efficient as its core guidelines, is the path towards a high quality, cost-effective medical system.

Our previous experience however is quite variable amongst partners, reflecting different stages of the quality journey, and reflecting the fact that most of our organizations are quite small, and do not have the mid-management layer that is usually behind the drive for Quality Improvement.

Our most experienced organization is FIREFLY. Upon orientation, FIREFLY has all staff trained in the LEAN white belt, and 30 staff have been trained in yellow belt. 4 senior staff have been trained as project champions to help the 7 staff who are currently working on obtaining their green belts. Those 7 staff will have completed projects from start to finish that go through each of the Lean/Six Sigma Define, Measure, Analyze, Improve and Control (DMAIC) phases. Those projects are no shows, workload vs. caseload (phase 1), intake (phase 1), intake (phase 2), purchase requests, report writing and onboarding staff. NWHU also has experience and internal processes for continuous quality improvement which includes some formal training on continuous quality improvement, a cross organizational CQI committee, and team lead CQI projects.

The ANHP also have several organizations who have not begun any quality work (e.g. the mental health sector [as it's not required] and Kenora Chiefs Advisory), and several organizations who do quality work based in their quality improvement plans, but with little formal QI or Lean training (e.g. Sunset Country FHT, WNHAC, LWDH).

Most organizations are using internal data and most improvement work is internal. For example, the Sunset Country Family Health Team using D2D data, combined with Cancer Screening Activity Reports (SAR) and MyPractice reports from individual physicians, combined with Patient experience survey data, to drive improvement ideas.There are numerous cross-sectoral integrated care improvement projects as noted in other areas of this application (Health Links, Crisis Intervention, Homeless Shelter, Situation Table). Data to follow and prove improvement are lacking. As identified in our year one population, our main body of highest needs patients are in the homeless, mental health and addictions, with a significant First Nations component of that population. Data capabilities and Health Cards are lacking, which makes a single patient identifier (Health Card) another year one priority. As well, the LHIN and the Ministry have as yet been unable to provide Health Hub level data, and the sub-region data provided is inadequate as it contains multiple other remote geographic areas.

Our organizations have led cross-sectoral projects. WNHAC and SCFHT have been co-leads on Health Links for several years. CMHA and LWDH have been leads on many of our mental health and addictions projects including crisis intervention, regional psychiatry. Kenora District Services Board is the lead organization around our homelessness issues. Lake of the Woods District Hospital and SCFHT have combined Diabetes Education and Management staff for years, with WNHAC also providing in-hospital Diabetes assessments and education for First Nations patients. SCFHT and WNHAC have provided funding, with LWDH providing the space, for the North's only funded full-service outpatient Physiotherapy department.

One of our ANHP physicians has a Masters Degree in Health Care Quality, Patient Risk and Safety. He has experience coaching and mentoring the Quality Table and Team at the LHIN and at the regional level. Furthermore, approximately 90% of all CMHA Kenora Branch staff have been trained in the Excellence Through Quality Improvement Project which is a provincial initiative amongst community mental health and addiction agencies across Ontario to incorporation quality improvement to make their services more accessible for those who need them most. QI and data coaches associated with Excellence in Quality Improvement Project have been deployed to help participating agencies identify a key service or quality issues to address with QI principles.

As above, our goal is a culture of continuous quality improvement, both within organizations and across organizations within the OHT. There is significant work to do to realize this, both in data analytic capacity and Quality Improvement capabilities.

Data analytic capacity is hampered by consistent patient identifiers across organizations, coupled with the difficult to look after clientele of our year one population. As well (again), our small organization size means there is a very limited mid-manager level in our current organizations, whether it's the hospital (Small Hospital Act: less than 100 patients) or others. The 18-year doctor shortage also minimizes Physician involvement in improvement work. That being said, there is some data analytic capacity in the hospital and the other organizations that submit QIPs. Being far from Southern Ontario and often understaffed, the ANHP generally don't have great relationships with the Ministry of Health, IC/ES, or University-based research that others may have. The North West LHIN has a data person based in Kenora, but there is some anxiety over his ongoing involvement as the LHIN sunsets and Ontario Health is formed.

Our early strategy for year one is to work together, to combine resources, and teach one another. No one organization has robust and/or excess capacity in data capacity and analysis or quality improvement. The ANHP foresee forming a cross-organizational quality improvement team. Combining people, knowledge and resources, the ANHP may be able to slowly develop both data capacity and quality improvement knowledge, to works towards that "culture of continuous quality improvement".

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

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

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches

the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

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

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

Max word count: 500

Our experience using patient input is varied. LWDH has a formal Patient and Family Advisory Committee. They also do regular patient experience surveys. Sunset Country FHT uses patient experience surveys. They are the prime driver of improvement ideas through their Quality Improvement Committee to drive efficiency from small single issue PDSA's, to large problem analyses using Ishikawa diagrams and prioritization matrices. The model of serial PDSA cycles, with the eventual goal of implementation into official policy and procedure once the new pathway is solidified, so that "This is how it's done here" is always the goal.

Involving patients on committees and boards is just starting to spread. LWDH has a patient on a Mental Health and Addictions committee. SCFHT has just switched from a provider-led board to a needs-based board which would now allow the possibility of a patient representative.

LWDH has used direct patient input in some of its design of our Detox Centre and Managed Alcohol program. Client consultation was used in the recent redesign of the homeless shelter, a multi-organizational effort led by the Kenora District Services Board – a key ANHP partner.

WNHAC has also created a client advisory committee and has used client surveys to inform strategic planning and program evaluation for many years.
Finally, a study is underway to analyze primary care needs in our First Nation communities. The study design was developed using the help of First Nations communities' youth, elders and health directors. The study target is also First Nations youth, elders, health directors and other providers and users of the system.

Also enclosed in our extra information is a qualitative study by Kenora Chiefs Advisory on Family Well-being. The federal system has frankly terrible data, plus it is impossible to measure "work not being done". Therefore, qualitative data, especially around patient input, with real stories, gives us more information than numbers.

5.4. How does your team use community input to change practice?

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

Max word count: 500

Our team in a way defines community input. In fact, the ANHP came together four years ago with the goal of changing the whole regional medical system. The first two years were spent in consultation and engagement, resulting in a Leadership Group that resembles our community, with an agreement signed in ceremony to work together. Thus, the local municipalities, combined with First Nations and Métis Leadership groups, are the signatories, and are the group the ANHP working partners report too. Through the Municipalities, the Kenora District Services Board, which is responsible for Ambulance and Housing, is a direct partner. Through the First Nations Leadership of Grand Council Treaty 3 and the Kenora Métis Council, Kenora Chiefs Advisory and WNHAC are direct partners. Thus, the formal relationship is that community leaders set strategy and policy, whilst the working group is in charge of operations, and report at regular intervals back up to the Leadership Group.

Other direct community input is demonstrated with various projects that involve the local police forces, the O.P.P. and Treaty 3 Police. They are direct partners in the Safe Beds program along with CMHA. They are partners with CMHA and the Public Health Unit at the Situation Risk Table. They are also partnering with the hospital in our Morningstar Detox Centre.

Therefore, the overall project represents the broader community, and enables improvement measurement and goals to include the broader system and definition of “Health” including ambulance calls, police calls and rates of homelessness and sub-standard housing.

5.5. What is your team’s capacity to manage cross-provider funding and understand health care spending?

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

Max word count: 500

Our team's ability to understand health care spending is reasonably thorough. Our partners include: Municipalities which understand policing, housing and ambulance, First Nations organizations which understand federal funding, LHIN funded organizations, non-LHIN funded organizations, and Physicians where the budget comes from OHIP via OMA-MOH negotiated mechanisms. The hospital is funded under small hospital funding and has bundled care funding under the Regional Orthopedic Program.

Our team's ability to manage cross-provider funding is reasonably advanced. The following cross-provider projects include shared staff, combined staff for projects including work in each other's organizations, combined funding, and seconded positions:

• SCFHT and NWLHIN Home and Community Care – the SCFHT runs a multidisciplinary memory clinic. The NWLHIN has provided a care coordinator to sit as part of the team to both assess and plan for the patients, families and care givers attending this bi-monthly clinic.
• WNHAC, SCFHT and CMHA Kenora have been the lead organizations, working collaboratively to plan, implement and lead Kenora in the Health Links approach to care planning.
• Individual Physicians through our NOSM Local Education Group, WNHAC, LWDH, SCFHT, City of Kenora, are lead agencies, funders and committee members of the local Healthcare Recruitment planning position.
• SCFHT, WNHAC and LWDH have all pooled funding to increase rehab services offered by LWDH for outpatient services
• CMHA-Kenora and SCFHT worked together on a Medication and Behavioural Enhancement program funded by the NWLHIN
• WNHAC has contributed funding for succession planning of Certified Respiratory Educators so that patients of both SCFHT and WNHAC have access to spirometry testing, and education with regard to Primary Care Asthma and COPD programs
• SCFHT and Bayshore have partnered on OT assessment, ADP and care planning.
• CAPACITI is a 10-step Quality Improvement (QI) project lasting one year. The expectation is that everyone in the QI study team attend the webinars, work together, and try new practices to embed an early palliative care approach into the practice. Partnership members: Family Physician, NWLHIN Care Coordinator, FHT Social Worker, FHT NP, NWLHIN Palliative Care NP, Long Term Care NP.
• LWDH's Diabetes education funding funds seconded staff to the Diabetes program at SCFHT.
• WNHAC's Diabetes Team sees patients in LWDH
• LWDH manages dispatch for E.M.S. (Ambulance) (Financial reporting and accountability)
• The re-organized model of our homeless shelter includes multiple ANHP partners providing staff and services within the shelter.

Our team's experience in tracking patient costs and health care spending across sectors is limited. The ANHP are certainly preparing to and hoping to. However, thus far cost and spending tracking is limited to within individual organizations. Hopefully

the OHT model will allow for this. The LHIN has been unable to provide any cost data beyond LHIN-based funding. It seems impossible to get cost data from the primary care branch or from OHIP. Ministry data systems don't seem to be able to break down data into the health hub level as sub-region data is not helpful. The ANHP feel excessive money is spent in transfers (especially air), and through Health Force Ontario, however the ANHP don't get that data, and certainly don't have access to those funds to actually make system improvements instead of the money being spent on band-aids like referring people to far away and flying physicians in to keep departments open! Local ambulance and policing costs are difficult to calculate, but the ANHP can track numbers of usage.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

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

Max word count: 1500

The All Nations Health Partners (ANHP) conducted an overview of services, gaps, and needs with respect to local mental health and addiction services. Engagement has included the Ontario Provincial Police, the City of Kenora, service provider organizations, primary physicians, and outreach workers. As well, 32 service recipients have provided based on their own needs and lived experiences. Significant gaps were identified in services provided in the five core areas of Prevention, Treatment, Harm Reduction, Enforcement, and Housing. Some of the identified short-term and long-term opportunities and actions have also been outlined to initiate a coordinated response by local organizations. Though this process was expedited, and a more fulsome study is required to understand the full range of longer-term needs, a table of the initially identified short and longer-term actions is included in the Gaps and Needs Analysis (Appendix J).

Over the course of year one, the ANHP will be engaging partners on the following OHT-specific streams of work:
1) Scoping and determining long-term sustainable governance model;
2) Delivering Home and Community Care through local providers; and
3) Establishing a seamless model of care for crisis intervention (priority population).

1) The OHT application is based on partnership and collaboration model, which will likely need to move towards one governing body to ensure the highest level of integration. As such, the ANHP will be engaging patients, caregivers, and organizational leadership as well as Indigenous and non-Indigenous communities at large on the following activities (at the 30-day, 60-day, 6-month time point):
- By the 60-day mark, all consultations/engagements with Primary Care Providers and sector-based engagement (mental health and addictions) will completed.
- Start developing a plan for a long-term governance structure by the 12-month mark which will also account for the other ANHP planning work (i.e. Hospital and System planning)

2) For the planning and changes in Home and Community Care (HCC), the ANHP will be engaging present/former regional planners, leaders from promising practices, patients, caregivers, and organizational leadership as well as communities at large on the following activities (at the 30-day, 60-day, 6-month time point):
- By 30-days the ANHP aim to complete mapping exercise accounting for the current supply of HCC support and unmet demand (inclusive of First Nation communities);
- By 60-days, the ANHP will develop options for review and approval to bring HCC into the care of the ANHP. This will include inferences from experts on collaborative models including but not limited Dr. Harlos and Lisa Streeter from the Winnipeg

Regional Health Authority on discharge planning, Holly Prince and the Ontario Palliative Care Network (OPCN) on developing and supporting community-based Home and Palliative Care.
- By 6-months, the ANHP will be looking for direction and resource allocation from the Ministry to start transition HCC from the LHIN/regional authority to this OHT.

3) Lastly, for establishing a seamless model of care for crisis intervention (priority population) the ANHP will be working through established committees/working groups on the following activities (at the 30-day, 60-day, 6-month time point):
- Developing a local crisis implementation plan – including targets for implementation based on project milestones by 30-day time point. The plan would account for all stages of services, from the moment a person is in crisis (through any entry point: police, acute/emergency department, community home etc.) -> assessment and planning -> Crisis support/counselling -> Medical intervention (if necessary) -> Environmental intervention (if necessary) and crisis stabilization -> Moment when person receives intervention and the crisis is stabilized
- By the 60-day mark, the ANHP will be implementing an interim solution that will reviewed/assessed and adjusted to address any issues/gaps. The current model being proposed for adults is to have a joint mobile response model that has a regulated health professional working side by side with the police to attend to mental health related calls in the community. The regulated health professional would complete comprehensive mental health assessments with individuals in the community to determine if they can be diverted from the emergency department and linked to appropriate services or if acutely at risk would be sent to the hospital for assessment of admission under the Mental Health Act. As the funds currently available do not allow for a 24-hour mobile response model the request is to continue with as well the current mitigation plan that is in place with the Lake of the Woods District Hospital to provide ongoing support to the emergency department. The Kenora Chiefs Advisory evening hours crisis services response for youth will continue at the Lake of the Woods District hospital.
Also, by the 60-day mark, the ANHP aims to develop a safe space in emergency department as well as a crisis bed in the LWDH through reallocate funding from Dryden Regional Health Centre to the LWDH.
- By 90 days the ANHP will be able to start to measure implementation as well as complete the development of resource guide for Regional Crisis Line.
- By 6-months – an interim evaluation plan would be developed and involve informing a long-term sustainability of the model. This work would include sustaining a hospital-based community mobilizer (discharge/crisis) as well as formalizing partnerships/service arrangements through Memorandums of Understanding (MOUs).

Across all three streams of work related to the OHT, the ANHP will be tracking progress through the listed milestones and activities through an OHT status tracker (use of Harvey Balls and/or Red, Yellow, Green). The tracking will initially be based on qualitative measures of progress (i.e. on or off-track); however, the ANHP aims to establish quantitative indicators linked to both progress and outcomes to quantify the changes or improvements to care.

The ANHP believes sustainability of programming and services will be seen in the changes within partnership organizations' ability to respond, in culturally safe and appropriate ways, to the sub-regional context of the Kenora area. The work and engagement process with existing partners will result in adaptations to systems of care. The provision of newly-developed tools, protocols, materials, trusting relationships and communication strategies will impact existing care providers' frameworks, policies and changes toward providing culturally safe and appropriate care. The process cannot outline pre-determined expectations or outcomes but needs to allow for the partnerships to form in true collaboration and solution-finding unique to the geographical and cultural context of the area.

The proposed OHT outputs, outcomes and partnerships will result in:
- Early communication and awareness of mental health and addiction (approach will be scaled out other illnesses as the OHT reaches maturity) in terms of explaining crisis, introducing people and expectations from the health care team, connecting to services and appointments so patients feel safe and help get ready for appointments.
- Identifying gaps and fractures and setting standard/benchmarks to overcome the barriers to meet the same quality and equity as experienced by the rest of the province for expected care.
- Development of tools and resources using cultural and visual context and language that is understandable, so community members feel safe, are aware of what to expect and what is available and continue to have some locus of control over their journey;
- Receive seamless care coordination support from assessment to stabilization;
- Access to required travel for tests, diagnosis, treatments as close to home as possible - meaning that Winnipeg, Manitoba and Kenora, Ontario are targeted as priority facilities over Thunder Bay.
- Coordinate and limit the jurisdictional gaps between OHIP and Non-Insured Health Benefits (NIHB) to facilitate care within the worldview of the Indigenous and non-Indigenous communities, allowing for family and cultural supports throughout
- Access to more comprehensive and wholistic treatment options, including traditional Anishinaabe approaches.

6.2. What is your change management plan?

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

Max word count: 1000

Our change management strategy follows standard change management principles. The first and possibly most important is to engage, engage, engage. This has been a principle of the ANHP over its four years of existence, however in practice it is very difficult. The ANHP is known to do a very good job of engaging up to the leadership group, with quarterly and as needed updates, to maintain communication and ensure

all partners are aligned and moving towards a common goal. Engagement down to communities, patients and caregivers and frontline staff is much more difficult. This again highlights the difficulties of our small population group, with small organizations that lack the mid-management level that normally does quality improvement work. As well, our region includes numerous independent organizations, even within a single sector. Combine that with a diverse population with several remote communities, with a historic lack of trust in the government system, and you find engagement is difficult. The ANHP have certainly tried several strategies, such as transparency with all of our information, regular media updates, and visioning sessions at key stages of ANHP development that have included a diverse group of youth, elders, health centre workers, municipal leaders, as well as ANHP members. However, the ANHP have found that engagement needs to be ongoing, as leaving people out at key decision-making times brings about disengagement and negativity. For front line staff and our own organizations, the ANHP rely on each organization to inform and involve down to the front-line levels and even to communities. For example, the Boards of Kenora Chiefs Advisory and WNHAC consist of either the chief, or an elected community member from each First Nation Community, so there is some reliance on them to share information back to their communities learned from the Executive directors at Board meetings.

Our strategy going forward is similar but should go well as the planning stage for All Nations Hospital and Health System planning are just getting underway. There is funding to hire planners for this, taking some of the burden off of our group leaders temporarily. The first stage of that is engagement with communities, patients and front-line staff so these processes happening in parallel with OHT planning is timely.

The second part of change management follows standard spread and scale measures. This includes the concept of “early adopters” and the “tipping point”. While the ANHP comprise a thorough cross-sector of the health system, and in fact comprise most of the work done in this area, by no means does the ANHP represent all organizations. As the ANHP socialize the concepts of a Patient Centred System, using the 6 definitions of quality from HQO, combined with the Quadruple Aim, suspicious people and groups realize the ANHP are in this for the betterment of our community, and not a power grab by a small group of organizations. Even small organizations find they have an important voice when they join or participate. Thus, the ANHP feel that the early adopter work has been done, and the ANHP may be at or past the tipping point as most major organizations have signed on, and hopefully the smaller ones will feel welcome over the next year. Engagement and information sessions are planned, as well as a Kaizen-type design event for Year one planning for the first quarter of year one.

Engagement of primary care providers is at varying stages. The two key physicians involved with ANHP over the past four years are both physician leaders but have both left the Family Health Network over the past 2 years. Thus, the ANHP has had direct physician involvement and advice over its course, from 2 experienced primary care physicians, but not an active link directly to the current FHN. The current physicians in

the FHN are a stressed group with a very long doctor shortage putting pressure on every aspect of their workdays. There are numerous administrative roles running the FHN, the FHT, and the LEG as well as numerous hospital committees, so adding more to their administrative load is difficult. As well, the current FHN has several older physicians closer to retirement that have less energy for system transformation, plus several new physicians in year one or two of practice, who feel they are not yet ready for a system transformation role. Thus, the majority of the burden is borne by an overburdened few.

Therefore, with the tight timeframes for OHT application, primary care engagement is not yet as robust as is hoped. One-on-one sessions have occurred, plus a CME event to socialize the concept, but a direct meeting with the entire FHN has not. No meeting has occurred with the Nurse Practitioners at the SCFHT; however, engagement has been initiated with the Nurse Practitioners and physicians employed by WNHAC.

However, this is not as disappointing as it seems. It is important to note, that the ANHP are embarking on 3 parallel but overlapping processes in OHT development, All Nations Hospital and System planning. They are inextricably connected. The concept for primary care development is the principles of access and continuity, in the context of a “Patient Medical Home (PMH)” as part of a “Patient Medical Neighborhood (PMN)”. While these words are newer, these concepts – in a small remote and distinct geographic area – are what the FHN, SCFHT, and WNHAC have been practicing for 1-2 decades. So, the ANHP have found that while socializing the concepts of the PMH and PMN, the OHT, the 6 principles of quality, and the Quadruple Aim, the ANHP are preaching to the choir.

Further OHT information sessions are planned. Engagement with the health planners for the All Nations Hospital and Health System will heavily seek involvement from the primary care physicians and NPs. The first-year goal is to have the SCFHN and SCFHT all signed on to the OHT concept by the end of the first year. WNHAC has signed on as signatories to this application.

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

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

Max word count: 500

Our year one population will certainly be the focus initially, as they are the highest in need, and provide the most difficult and therefore best opportunity to learn to integrate and coordinate care, information and data. However, the ANHP all must ‘keep knitting.’ The ANHP team is from across the spectrum of health care, including hospital, physicians, mental health and addictions, public health, long-term care and municipalities and the work will go on.

As you can see from our application, in many areas the area served by the ANHP does not have high-quality care and continuity (i.e. Primary Care, Physician shortage), but the OHT work, in addition to All Nations Hospital and Health System planning is our attempt to improve that. Focusing on the year one population should not take away from the existing levels of care.

There are a couple of issues related to the sunsetting of the LHINs however that make us anxious. First is that the ANHP hope the LHIN continues to manage Home Care for the first year. If it gets devolved yet again, to another management system yet farther away the ANHP foresee even more disaster. Our small team needs the first year to organize and improve and get further into hospital and health system planning to have the capacity to take over Home Care locally. Secondly the LHIN has resources that are just not available otherwise in our small remote system, with small organizations that lack the mid-management layer. For example, one of their data positions is in Kenora and is vital to any type of Ministry data gathering. As well, their Director level does the planning and integration work, using Lean Quality Improvement techniques such as Kaizen-type design events. The ANHP do not have that expertise in our organizations. So, one of our main risks in maintaining care and maintaining our forward momentum is the potential loss of LHIN positions (that are already 5-6 hours away) to an Ontario Health position that is based part way around the globe.

Otherwise, the ANHP already represent the majority of the health system already in this geographically distinct region, so care for everyone goes on, even if they are not a part of the “Year One” population.

6.4. Have you identified any systemic barriers or facilitators to change?

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

Max word count: 1000

1) Primary Care Physician Services:

The ANHP area (the Kenora Health Hub) is in ~ year 18 of a doctor shortage. This has had a profound effect on all aspects of the Health System. The prime driver of efficiency and quality in a system (especially a remote system where GPs provide a majority of services that would normally be provided by specialists or GP-Focus Practice Physicians) is access to a primary care provider and continuity with that provider within the context of a medical home.

The facilitators to change are:

a) The ANHP came together and hired a health professional recruiter over 2 years ago. This has eased the pressure with an adequate physician supply.

b) The SCFHT and WNHAC are multi-disciplinary Primary Care structures that already encompass most of what it means to be a patient medical home. They were (and perhaps still are) somewhat underserviced for the duties required in this remote region, but funding increases in the Ontario First Nations Health Action Plan have increased the team sizes. Distinct organizations – they have now come together as partners in the ANHP and work closely together in projects such as Health Links. The SCFHN and SCFHT are switching to the same EMR as WNHAC to enable further collaboration.

The barriers to this are:
a) An 18-year doctor shortage is not an aberration or an accident. It's indicative of a systemic problem with the payment models available for Primary Care in Remote areas. The area does not have a unique system status similar to other remote, First Nation referral centres such as Moose Factory (Weeneebayko) and Sioux Lookout (Menoyawin) where unique systems were developed specific to those regions.
b) The community is too large to qualify for RNPGA, thus the only available models are FFS, FHN, FHG or FHO.
c) The community physicians abandoned FFS in 2004 which was grossly underpaying compared to Southern Ontario, in 2004 and became a FHG, The FHN was formed in 2007 and is much more rewarding than FFS. The group did not switch to a FHO (like most of Ontario) as our physicians do a lot of the work in the extra bundle and there was not a financial incentive to do so (indicating that for most of Ontario it was a 13% raise if they didn't normally provide those services in the extra basket). Essentially a Northern Doctor has 2 main issues that make a capitation model less rewarding. First is that our patient population is unhealthier (see population statistics). Other regions that look after difficult areas (poverty, immigration, remote) are more successful under a CHC model but these have not been available for application for >20 years. Second is that the ANHP function with little specialty support. Aside from an ongoing general surgery program which has stayed fully recruited, the ANHP lost or struggled with Radiology, Internal Medicine, Pediatrics and Psychiatry (see below). This results in the local GPs doing a large volume of work that is managed by specialists or GP Focus-practice physicians. This is not a bad thing – in fact it's an excellent form of care. However, under the FHN/FHO model, it means you can only carry a much smaller volume of patients and maintain reasonable access, resulting in much lower payment, for what is a higher quality and standard of work.

2) Specialist Physician Services: Specialist services were traditionally provided by keen local providers trained in the 70's, happy to shoulder heavy workloads and continuous on call. Radiology, Internal Medicine, Psychiatry and Pediatrics all followed that pattern. All of these suffered as those legacy physicians retired. The APPs available have had varying degrees of success in recruitment and retention.

The facilitators to change are:
a) The APP office has expressed an interest and a desire to be helpful, now that the OMA-Physician services agreement has been signed (as opposed to limbo for the previous 4 years). They are open to relooking at a modernized Psychiatry APP and helping establish a pediatrics APP.
b) LWDH – the previous hospital administration was reticent to have specialists be hospital based, and lamented lack of any control over the governance of these services. The new hospital administration is a keen partner in the ANHP. They are undergoing new Hospital planning as well as Health System planning alongside OHT planning. They are willing to help establish APPs, even be the signatory and governor of the APPs which may be the only solution for our area, especially for Pediatrics and Psychiatry where the services are currently empty.
c) The ANHP - Through OHT and Health system planning, travel to our more remote First Nations is a key part of our system transformation. The volume of work required for these visits, in combination with becoming more of a regional centre (level 2 referral centre, District Health Campus) can establish a base of work that should support a more recruitable APP number (EG 4-5 physicians per service vs 1-3).

The barriers to this are:
a) Internal Medicine – a new GP extender/Internal medicine APP was established 2 years ago. It has been very successful for the hospitalist/GP extender part but has only recruited 1 full-time Internist. Further work required to fine tune this and expand service to our surrounding communities.
b) Pediatrics – a lack of APP has meant no pediatric services for 10 years. The lack of ongoing work makes it hard to establish a base measurement. Again, community support and being a regional centre would help establish a successful APP.
c) Psychiatry - Our last psychiatrist left in the spring. The schedule 1 facility is being maintained by serial locums. Regional Psychiatry planning is taking place for the entire Northwest is taking place. The old APP was based on a 1990's service model and no longer reflects reality. A complete re-analysis of psych services should indicate a need for much more community visits and a larger volume of outpatient visits, ideally then requiring an APP base of 5-6 psychiatrists, which will be much more recruitable to handle the significantly stressful on-call duties of our region.

3) Barriers to service in Winnipeg: Geographically, there are substantial benefits from receiving specialist/tertiary care from Winnipeg rather than Thunder Bay. The driving distance to Winnipeg is 2 hours while it is 6 hours to Thunder Bay. There are regular reports of patients being blocked from service in Winnipeg. This may be due to a lack of communication to front line staff of the inter-provincial agreement to allow Ontario Patients to receive service in Winnipeg.

4) Inadequate supportive housing: Supportive housing may be necessary to allow recovery of some patients with mental illness or addictions.

5. Alcohol availability policies: There are high rates of alcohol misuse, emergency room visits and hospitalizations in the region. Population level evidence has demonstrated that policies that increase alcohol availability e.g. alcohol sales in grocery stores, alcohol service from 9am etc. increases availability, which increases misuse and the demand on the health care system.

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

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

Max word count: 1000

Physician Services:

The ANHP realize that the OHTs do not have power over the physician service agreements. What the ANHP would find helpful is support from Ontario Health as they go through All Nations Hospital planning and All Nations Health System planning which are occurring simultaneously this year. Support in negotiations with the APP office, and support in discussions with the primary care branch would be helpful as the ANHP try to develop a system that would support a level of care that other areas of Ontario have long come to expect. They also happen to be key drivers of quality and cost-saving through the rest of the health system. If the physician services part isn't done right, then the overall effect of the rest of OHT transformation will be minimized.

Data and Planning:

Thus far Ministry-level data has been inadequate, inaccurate, and cannot be drilled down to the hub level. This is crucial to fully illustrate the ANHP planning context. Furthermore, the ANHP consists mainly of small organizations with little mid-management that rely heavily on LHIN data people and planners, which the ANHP worry will disappear in the move to Ontario Health. Providing direct support, or Ontario Health positions in data and planning located in Kenora would go a long way to helping our system transformation.

Quality Improvement Expertise:
Again, with our small organization size the ANHP have little QI expertise. Design events have been run by the LHIN using expertise from the management layer at Thunder Bay Regional. The ANHP will require ongoing QI teaching and support as they develop their own QI expertise in search of the “Continuous Quality Improvement Culture."

Data and IT:
Differences between federal and provincial reporting systems, plus the lack of health cards and other identification by many of our patients make data tracking in our region difficult. The ANHP are small and do not have a tremendous amount of IT resource and power and have limited access to consultants and products due to our remote location. The ANHP will require IT support or must delay and learn from other successful OHTs.

IT and Infrastructure:
Many of our remote communities still lack IT infrastructure to support what would be considered basic IT requirements for EMRs and OTN/Video.

Rostering:
Difficulties in rostering and the complexity of the partial capitation system with a lack of specialists, plus our unique problem of focus-practice physicians who work within a FHN, make the current rostering system a failure to support a primary care system. Virtual rostering similar to RNPGAs or different payment mechanisms need to be explored.

Other Provincial Resources:
Our remoteness from Southern Ontario and being 5-6 hours from Thunder Bay make it difficult to access help or develop consistent relationships with HFO, HQO, LHINs and Universities. Our HFO regional position has been unfilled for months. Our natural geographic and clinical relationship is with Winnipeg, but we do not have access to any of their provincial planning mechanisms. The other issue is that often these agencies are willing to help, but the ANHP do not have the mid-management layer available, or anyone with the time, knowledge and energy to activate these resources, even when they are available.

Cross-Border Issues:
There is currently an MOU between the provinces, but it is not being enforced on the Manitoba side in many clinical spheres. There is an e-connectivity committee that is making slow improvements. There is a MOU clinical governance and oversight committee, however it lacks local resources to make it effective, especially as the LHINs are sunsetting. There needs to be resources for the All Nations Hospital planning stage to negotiate a service line by service line plan that involves the principles of step-up/step-down care with a known referral group, guided by the care close to home principle. This will require (as above) relooking at specialist APPs and visiting specialist programs, as well as hospital planning for more surgeries to be done locally. This requires support from multiple Ministry departments.

Municipal Issues
Support from other Ministries would be helpful as the City of Kenora seeks to establish funding for homelessness that is available to larger communities and seeks "Hub Status" which would allow for further provincial funding for housing.

Obviously there are many issues, as listed above. The ANHP hope that the status of being an OHT gives new stimulus and energy within the MOH, Ontario Health, and other Ministries to tackle these problems, many of which are unique to our area, in an area of the province that is easy to ignore.

Secondly, the concept of "a lack of mid-management level" comes up repeatedly. The ANHP are keen to see the structures of larger successful OHT applicants to have a look at their managerial design to see where we need further resources.

6.6. Risk analysis

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

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

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

• Regulatory • Other	• Community support • Patient engagement • Other

Risk Category	Risk Sub-Category	Description of Risk	Risk Mitigation Plan
See supplementary Excel spreadsheet			

6.7. Additional comments

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

Max word count: 500

The All Nations Health Partners (ANHP) recognizes that while it may not have all the technological advances and resources akin to colleagues in Toronto and along the 401 corridor, it was established with and for communities based on the principles of inclusivity, reconciliation, and equitable care. It is important for policy and decision makers to truly understand the drivers and root causes for the dichotomy in socio-economic and health disparities that exist between northern and southern Ontario and furthermore between Indigenous and non-Indigenous peoples. Such disparities are contrary to principles of universality of health care. While we applaud the opportunity to participate in the OHT development process, questions remain as to why differences in resourcing exist between the north and south. Many agencies prioritize health equity but little is done in the resourcing to address inequities on the front-line, which arguably makes things worse. Differences between federal and provincial reporting systems, plus the lack of health cards and other identification by many of our patients make data tracking in our region difficult. The ANHP are small and do not have a tremendous amount of IT resource and power and have limited access to consultants and products due to our remote location. We will require IT support along with management/policy/oversight support in order to be comparably equipped to be as successful as the other OHTs. A member of the communities served by the ANHP shared the concept of equity in a few words “Maamowi gaabowititaa - let’s stand together.” It doesn’t take a lot of words to speak the truth. The ANHP is excited to work this new health system and with great optimism to work together so we can all stand together in health and wellness.

7. Membership Approval

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

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

Team Member	
Name	
Position	
Organization (where applicable)	
Signature	
Date	
Please repeat signature lines as necessary (See supplementary Excel spreadsheet)	

APPENDIX A: Home & Community Care

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

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

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

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

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

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

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

Max word count: 1500
The long-term vision for Home and Community Care (HCC) for the Kenora area is to have the All Nations Health Partners (ANHP) deliver and provide oversight of HCC through local providers. Following the review of a system evaluation for Home and Community Care (LHIN) regionally for the OHT catchment area, the ANHP will be

able to plan support for the transition of care from regional providers to local providers. This will address local gaps/opportunities/priorities including but not limited to mental health and supporting all communities (Indigenous and non-Indigenous) for any life limiting illnesses/palliative care.

As noted earlier, the ANHP aims to work with the LHIN in year one, as the Subject Matter Experts (SME) to ensure knowledge transfer to support the transistioning of HCC from the LHIN to a local context (i.e. ANHP Primary Care and other partners like Long-Term Care and Kenora Chiefs Advisory as determined by the ANHP). The long-term vision is to foster the notion of "grow your own and develop your own" whereby there would be opportunities to recruit and train locally in the Kenora, which will support long term sustainablity of health human resourcing (i.e. including PSWs).

The ANHP recognize that up to 78% of patients needing home care are First Nations but current providers don't deliver care on-reserve. This is not only discriminatory in an inclusive health care system, it further exacerbates health inequities in an area that is already known to have inequities resulting in socio-economic/demographic factors as well as the history of documented and United Nations recognized genocide resulting from residential schools and oppressive and paternalistic policies.

The ANHP has reviewed the recommendations from the First Nations Advisory Committee on Home and Community Care, through the Kenora Chiefs Advisory (KCA) – member of the Committee. The ANHP through partnership and membership with the KCA support these recommendations to ensure First Nations and non-First Nations can access equitable, safe and responsible home care. These recommendations can be found below:

Theme #1 – Integration & Seamless Coordination of Care
1. The province should provide ongoing additional funding for the enhancement of home and community care services, including palliative care in First Nations communities. This funding should support more front-line health care providers such as nurses, case managers, care coordinators, personal support workers and homemakers, including consistent access to clinical supervision.
2. The province, First Nations and care partners should encourage the integration of care provider teams to the benefit of First Nations home care clients. This includes identifying strategies to encourage collaboration among primary care and home and community care providers, including among federally- and provincially-funded care providers so that the needs of patients are collectively identified and comprehensive care can be provided.
The province should work with the federal government and First Nations to strengthen communication between federal primary care nurses and home and community care staff and/or other health care providers as determined in the community.
The province should work with LHINs to review home care procurement guidelines for obstacles to First Nations service providers providing home and community care services.

3. Provincial investment should include the flexibility for First Nations communities to provide compensation to attract and retain home and community care professionals and health care providers.
4. First Nations communities should inform spending decisions with a community-based and community-owned assessment (either recent or new) of existing capacity, needs, opportunities and/or risks.

Theme #2 – Discharge Planning
5. The ministry should provide direction to LHINs and hospitals to work with First Nations to improve discharge planning, including establishing a formal communication process with First Nations home and community care services.
6. First Nations patients should have a discharge plan that includes input from hospitals and provincial and federal health care providers from First Nations communities as well as CCACs/LHINs as needed. When possible, planning should begin when patients enter the hospital.
7. Provincial investment should include opportunities to enhance home and community care services to support discharge services at non-regular working hours, including evenings and weekends.

Theme #3 – Palliative Care
8. The province and other care partners should provide flexible funding that supports culturally safe palliative and end-of-life care at home.
-Support for palliative and end-of-life care should include aftercare, bereavement and spiritual care services, and respite care in and out of community.
-First Nations communities should develop resources to help caregivers of First Nations patients understand the range of available palliative care services.
9. The province should continue to provide ongoing funding for palliative care training for health care providers and friends and family that supports traditional practices in First Nations communities. This includes training for culturally safe end-of-life Advance Care Planning.
10. The province and other health care providers should recognize there are different determinations of when a person is palliative, which impact service planning and delivery. The province and health care providers should review those determinations to inform a more consistent approach to accessing services and provide First Nations communities with the opportunity to determine which is most appropriate.
11. First Nations communities and the ministry should support a broader understanding of processes for dying at home, including understanding the role of the police and coroner.
12. The province and/or partners such as the OPCN should collaborate with First Nations communities to identify and support the implementation of flexible hospice models to address palliative care needs including co-location and models to support community members to remain at home.
13. The province and OPCN should encourage the LHINs to collaborate with First Nations leadership in their region to explore opportunities to address First Nations palliative care needs as part of the government's commitment to expand hospice capacity with up to 20 hospices across the province.

14. The province should support the continued provision of training for culturally appropriate and culturally safe care for home and community care professionals and health care providers and service providers in First Nations communities.
- The province should provide funding that enables timely, predictable access to training and development opportunities. The process for funding should enable communities to utilize training throughout the fiscal year. For example, proposals should be due in January, assessed by the end of March and funding should flow in April so communities can access training opportunities through the year.
- Funding for training should support training and development for career advancement as well as knowledge/skills enhancement for First Nations home and community care professionals and health care providers who are located on reserve.
15. First Nations communities should determine how funding is directed to training and development based on their own priorities.
16. Communities of practice among First Nations home and community care professionals and health care providers should be encouraged and supported.
17. The province and First Nations should invite the federal government to a meeting bi-annually to share best practices and priorities for home and community care.

Theme #5 – Data and Reporting
18. The province should work with other funders and LHINs to review and streamline provincial and federal data and reporting requirements for home and community care services. The review of data collection must include First Nations communities in order to develop more relevant metrics to reflect the goals and objectives of the services they provide.
19. The province and the federal government should provide funding for data collection and reporting software that respects the principles of ownership, control, access and possession.

Theme #6 – Clarification of Roles and Responsibilities
20. The ministry should confirm that CCACs, and after transition LHINs, along with the federal government and other home and community care programs, have a responsibility for home and community care in First Nations communities.

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

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

- What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.
- Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives.

- Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the **optional** table below to describe the delivery model.

Role/Function	**Organization**	**Delivery Model** (What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted sevice provider nurse, etc) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.)
Managing intake		
Developing clinical treatment/care plans		
Delivering services to patients		
Add functions where relevant		
See supplementary Excel spreadsheet		

Max word count: 1000
For the planning and changes in Home and Community Care (HCC), the All Nations Health Partners (ANHP) will be engaging present/former regional planners, leaders from promising practices, patients, caregivers, and organizational leadership as well as communities at large on the following activities (at the 30-day, 60-day, 6-month time point):
- By 30-days the ANHP aim to complete mapping exercises accounting for the current supply of HCC support and unmet demand (inclusive of First Nations communities);
- By 60-days, the ANHP will develop options for review and approval to bring HCC into the care of the ANHP. This will include inferences from experts on collaborative models including but not limited to Dr. Harlos and Lisa Streeter from the Winnipeg Regional Health Authority on discharge planning, Holly Prince and the Ontario Palliative Care Network (OPCN) on developing and supporting community-based Home and Palliative Care.
- By 6 months, the ANHP will be looking for direction and resource allocation from the Ministry to start transitioning HCC from the LHIN/regional authority to this OHT.

A.3. How do you propose to transition home and community care responsibilities?

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

Max word count: 1000

Standards of practice should transcend setting so that patients/clients receive consistent quality of care regardless what setting they are in. This is particularly important for:

- Wound care
- Medication management
- Rehab services for strengthening and activities of daily living
- Dietary support
- Catheter management
- Chronic disease care plans
- Palliative care and comfort care plans

There should be performance deliverables that providers must achieve in order to remain a provider. There should be no variability in expectations even if there are different providers providing service.

Funding levels must be sensitive to our context since there will be variable service needs and lost productivity due to our geography, road conditions and the dispersed population which impact travel time.

For new services such as remote monitoring for chronic illnesses such as congestive heart failure and chronic obstructive pulmonary disease, consideration should be given to integrating or connecting this into home and community care for better continuity of care.

The home and community services should report in a digital method that allows information sharing and connection into the hospital and other sector health information systems

A.4. Have you identified any barriers to home and community care modernization?

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

Max word count: 1000

The following are some notable barriers identified by the ANHP:
- Current Service Provider Organizations (SPOs) are centrally managed and sourced
- Often/mostly restricted in servicing the OHT catchment area (i.e. no sunset and ambiguous on standards, safety and quality) also no services on-reserve
- Pay inequities for PSW (further impacting recruitment and resourcing)

Home and Community Care must be viewed as an essential support for ensuring clients have access to required services in the home setting, which is usually their most preferred choice.

The current approach has many challenges, including:
• Many First Nations do not have access to home and community care from the current LHIN providers
• There are service gaps in many areas, some associated with staffing issues
• Federal and Provincial services are not aligned, and funding is often not clear. This impacts service provision
• Inadequate services within First Nation communities and lack of meaningful relationship to address service gaps from provincially-funded Home and Community Care services
• Access to Rehab resources is not consistent in communities
• Home equipment services are sporadic and if required for discharge, not always in place, which extends length of stay in the wrong setting

The current service model has many challenges and under an ANHP solution, would need to demonstrate the following attributes:
• Placement process must be unbiased. It should be viewed as choosing the right setting for the client out of all the available choices to meet the client's needs, including quality and safety, at the best cost for that service
• The service delivery must be sensitive to the local context for solutions
• Home support services must be part of the service mix and appropriately resourced since they enable clients to remain in the most affordable setting, they value most – their home. It is usually the most affordable setting for the system as well.
• Scope of services should be broad and extend beyond traditional home care and community care to include services such as supportive housing, foot care, outpatient rehab in the home setting, equipment support and palliative care
• Placement decisions must be timely and performance expectations on responsiveness should be in place
• Services must be made available in all communities
• Home equipment services should be consistently available to ensure patient discharges requiring these aids are not delayed due to lack of regular service.

APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

Member	**Hospital Information System Instances** *Identify vendor and version and presence of clustering*	**Electronic Medical Record Instances** *Identify vendor and version*	**Access to other clinical information systems** *E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information*	**Access to provincial clinical viewers** *ClinicalConnect or ConnectingOntario*	**Do you provide online appointment booking?**	**Use of virtual care** *Indicate type of virtual care and rate of use by patients where known*	**Patient Access Channels** *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
See supplementary Excel spreadsheet							

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

Curretnly, OTN is used for distance specialty service, but mostly in Lake of the Woods District Hospital (LWDH) or other organizations within Kenora. Very little is done in our more remote communities. A few physicians use e-consult and telederm, but numbers are low. A virtual primary care clinic was proposed for a First Nations community, but IT and connectivity infrastructure were inadequate.

Mental Health and Addictions has access to: Connex Ontario which provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness and/or gambling. This is funded by the Government of Ontario. The system navigation and information service is live-answer 24/7, confidential, and free. Connex Ontario maintains a centralized, up-to-date, and accurate database of detailed drug, alcohol, problem gambling, and mental health treatment service information.

This information includes:
• Where the service is located
• How to access the service
• How long the wait to access the service may be

Information contained in the Connex Ontario database is used for planning purposes by healthcare professionals, and health system planners, managers, and stewards in the province of Ontario. Members of the All Nations Health Partners (ANHP) also have access to the following systems:
- Telepsychiatry for children and youth
- Services via OTN for patients in remote areas
- Apps for patients to manage conditions (for example the Be Safe app for youth)
- Ontario Telemedicine Network
- PCVC
- On-Call Health

Vision:
Virtual Care is a key component of the All Nations Health System vision. However, the primary goal is to provide not just care close to home, but in-person care wherever possible and not just default to virtual care. Engagement with our regional communities indicates a desire for in-person care and continuity, as trust in the established medical system is low. As well, employment needs in our regional communities are staggering, and to default to a centralized model using only technology with employees all centralized denies our communities significant growth opportunities. That being said, to support robust access to some services, and to provide an efficient system for specialty and sub-specialty service lines, virtual care will be a key component.

The 12 First Nation Communities and our regional towns are of varying sizes and distance from Kenora. Each will require an in-depth analysis of demand for each type of service, then ongoing measure of supply and demand to adjust to maintain excellent access. A historic lack of services and lack of trust in the system make measuring current usage data less helpful, so an ongoing strategy is needed.

Here are some examples of the vision:
a) Primary Care: the goal is same-day/next-day access with continuity. In our larger, more distant communities this will likely require a combination of MD/NP in-person in-community with a full time primary care nurse, thus with less need for virtual care. The full-time nurse would have phone or video access to a primary care provider responsible for that community on days where there is none in community, for advice or setting up an urgent video appointment, using cell-phone based OTN. In Kenora and in the regional communities, secure e-consults and texting with a primary care team is possible through secure apps (e.g. Reacts-ITT) to improve access and minimize need for in-person appointments.

b) Specialty Care: expansion of OTN to communities through formal OTN rooms, or through cell phone or tablet based OTN (as our high-speed internet infrastructure is variable and quite poor in several communities). All Nations Hospital planning includes expansion of general specialty Alternate Payment Plans to allow Psychiatry, Internal medicine and Pediatrics to visit our larger, more distant communities. However, volume and resources will dictate some use of virtual care for some of these services, and in between community visits.
c) Sub-specialty care: with a single coordinated system. Most sub-specialty consultations and follow-up should be able to be done through virtual OTN in community, as opposed to travel to Winnipeg or Thunder Bay, or in Kenora through hospital-based OTN.
d) Mental Health and Addictions: Much work is underway establishing coordination of care for crises and ongoing mental health care through our many agencies. A similar analysis of ongoing demand, with a guiding vision of care-close-to-home plus continuity, will require some use of virtual care. Digital apps such as “Big White Wall” and the Be Safe App for youth are already in use.

The target of: “2-5% of year one patients who received care from your team had a virtual encounter in year one” is probably already being met. As a remote community, this is perhaps not a helpful statistic as some remote visits are positive, and some are considered a poor second choice to the ideal system. Primary Care doctors providing “Kiosk” medicine from Toronto when they have no access to local services, tests or information is considered a “Negative” virtual interaction. Addiction medicine from a virtual clinic where the clinic has zero connection with local addictions, counselling or housing services is also a poor use of virtual care. The use of virtual care when it is more appropriate medically, culturally and economically to have an in-person visit is also questionable to mark as a “Positive tick”.Thus, the determination of “Success” of the provision of virtual care needs to be a bit more refined. Patient experience surveys are already used by most members. A subset of these regarding virtual visits will be analyzed for qualitative aspects to focus quality improvement efforts.

The greater determination of success will be in our established measures of the greater system. Looking at our system transformation priorities reveals better measures of the success of the use of virtual care:
1. Primary Care Access data (supply/demand and continuity),
2. Mental Health and Addictions data (Frequent ED visits [4+ per year) for mental health and addictions; Frequent ED visits for MHA/ED visits best managed elsewhere; Avoidable emergency department visits [ED visit rate for conditions best managed elsewhere]),
3. Total Health Care Expenditures (plus transport costs [especially air], ambulance trips, police calls), and
4. ALC/Home Care data (30-day re-admission rates).

2.2 Digital Access to Health Information

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

Max word count: 1000

For year one, the All Nations Partners (ANHP) aims to review options to support interoperability between the existing digital assets and capabilities (see Appendix I). As the ANHP are working to develop pathways and re-align care coordination supports across the ANHP members for the year-one population (i.e. crisis intervention), linking or supporting interoperability between the ANHP members is a critical first step before provisioning patients' access to their health information. Appendix I provides a high-level overview of what a solution could look like as well as a proposal from a potential vendor on a solution for the ANHP OHT. Since the ANHP does not have a budget for any new IT infrastructure or build, Appendix I also serves as a proposal to the Ministry of Health for consideration to support equity across the OHTs in supporting the vision of providing patients access to their health information.

In addition to Appendix I, there would need to be an interface between CMHA Programs and the proposed software. These programs utilized TREAT – which is not linked to MediTech.

The ANHP would also support the inclusion of an alternate proposal of the Clinical Viewer. This system exists and could be leveraged fairly quickly by working with eHealth Ontario. In order for this to happen, the ANHP would need active engagement and partnership with eHealth Ontario regardless of any solution that the ANHP put forward. This system would allow all clinicians to access the patient documents in a read only file across the sectors for the entire province and not just for the Kenora area. Based on the eConnectivity initiative outlined in section 2.3 and in Appendix E, the use and optimization of the Clinical Viewer would also include and support the Ontario-Manitoba patient referrals and care coordination. The ANHP believe there is value in considering this option.

It is worth noting, there are a number of ANHP members that are working on getting their client portal up and running on their client information system (EMHware) in order for clients to have access to their personal health information at all times as well as giving them the ability to keep their demographics up to date and see a digital calendar of future appointments. There are plans to have a pilot with some test clients who would be willing to test the system out. There has also been some implementation of text messaging reminders for appointments as a pilot with a series of test clients.

2.3 Digitally Enabled Information Sharing

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

Max word count: 1000

Details of supporting patient information shared digitally in a secure manner is detailed in Appendix I as well as in section 2.2 of this application. In the short term, the All Nations Health Partners (ANHP) plan to leverage a "Clinical viewer" to optimize and ensure access between providers once the various systems referenced in table B.1 are linked. The ANHP recognize the need to ensure the Ministry of Health and/or Ontario Health to connect with the First Nations and Inuit Health Branch (FNIHB) of the Department of Indigenous Services Canada on their digital strategy to ensure the planning and supports are inclusive of First Nation and non-First Nation communities, as a large catchment of the ANHP is served by FNIHB and is paper-chart based.

Given the close proximity to Manitoba and specifically Winnipeg (vs. Thunder Bay), there needs to be recognition and continued support of the "eConnectivity Between Ontario & Manitoba" initiative (seen in Appendix E) which is aimed at improving healthcare equity for patients in northwestern Ontario and particularly from the ANHP OHT area. Our patients receive care either at a hospital in Manitoba, or by a Manitoba specialist, located either in Manitoba or licensed to practice in Ontario. Following the detailed proposal in Appendix E, "prior to the establishment of the LHIN structure in Ontario with its emphasis on delivering care within the LHIN boundaries, Winnipeg area hospitals were the natural destination for many referrals from northwestern Ontario [especially for the Kenora area]. As the Canada Health Act permits provinces to refuse cross-border patient referrals, there is a need for Ontario and Manitoba to mutually agree upon the manner in which people living in northwestern Ontario can access care that may be more appropriately delivered in Manitoba by Manitoba-based clinicians. In the past, deputy ministers of health from both Ontario and Manitoba formally acknowledged the need to work together to improve health service delivery for the people living in northwestern Ontario."

The recommendations listed in this proposal align and support the vision of the ANHP OHT and the quadruple aim, by providing access to Ontario-based digital and virtual tools for Manitoba-based physicians caring for Ontarians. These digital and virtual tools include:

1. ConnectingOntario Clinical Viewer: Provide Winnipeg-area hospital staff with 'view' access to the ConnectingOntario Clinical Viewer so that providers in Manitoba have access to comprehensive patient health records when caring for Ontario patients.
2. OTNhub: Provide access to the OTN Directory, Videoconferencing12, Scheduling, educational events, archives, and to one of two eConsult solutions (in collaboration with the eConsult Centre of Excellence);
3. eConsult: Manitoba physicians could utilize eConsult to engage in secure, electronic dialogues with Ontario physicians to manage patient care (e.g., Ontario physician could request a consultation from a Manitoba specialist and could use it for follow up with Manitoba physicians for their patients who received care and were discharged from Winnipeg-area hospitals).
4. eNotifications: Winnipeg-area hospitals could send eNotifications to Ontario physicians and nurse practitioners through HRM so that Ontario physicians are aware of their patients' admissions and discharges.
5. HRM: Winnipeg-area hospitals could deliver hospital reports directly to Ontario physicians and nurse practitioners' EMRs through HRM.

As illustrated in Appendix E, a sample of the benefits of supporting the eConnectivity Initiative consists of benefits to population health, care experience, continuous quality improvement, and system costs and benefits.

Implementing new partnerships and collaborations using digital services between Ontario and Manitoba would benefit the ANHP population as well as the Ontario healthcare system by:
• Reducing service duplication, minimizing costs, and addressing waste in the healthcare system - healthcare providers can invest these savings to improve access to services and serve the northwestern Ontario population better; and
• Improving decision-making at every level so that greater focus is put on patient experiences and health outcomes making the healthcare system more sustainable.

Benefits associated with both health systems (Manitoba and northwestern Ontario) leveraging Ontario digital health solutions include:
• A potential reduction in emergency room visits in the North West LHIN which are huge cost drivers on the healthcare system. Note that the northwestern Ontario region has the highest rate of acute hospital use in the province and the number of repeat emergency department visits are 28% higher than the provincial average.
• A potential reduction in use of Winnipeg area hospitals by northern Ontario patients through better care management in the community.

• A platform for specialists to exchange educational material with referring physicians, from either Ontario or Manitoba, providing “just-in-time” education that can be applied right away. This allows the referring physician to remain the most responsible provider for his/her patients.
• Cost savings due to ease of technical integration with North West LHIN, as the entire region is using a single Health Information System (HIS) instance.

Patient Benefits resulting from leveraging the use of digital and virtual assets will lead to:
• Improved access to quality care respecting in-person referral patterns.
• Minimizing the need for travel, especially considering inclement weather conditions.
• Better access to information by providers will improve patient safety.

2.4 Digitally Enabled Quality Improvement

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

Max word count: 500

1) CMHA Kenora Branch has completed the following Quality Improvement Initiatives that drive quality and performance improvement by using data within the organization’s EMR:
- Prospective Analysis related to Client Safety Incidents of the organization. This has led to two projects: one related to Medication Management due to high missed medications within the mental health and addictions population, as well as the redevelopment of the agency’s Suicide Strategy due to high number of suicide disclosures and attempts of clients of the organization.
- Counselling & Treatment Team Stepped Care Model was created due to high number of referrals and the implementation of the HQO, Major Depression Standards.
- ACTT Fluidity Project was created by the high numbers of individuals serviced by the ACT Team by using of the Level of Care Utilization System and the ACT Transition Readiness Tool.
- Implementation of Family Intervention Therapy to meet the HQO Standards of those with Schizophrenia living in the Community or Hospital.

2) LWDH uses many digital tools to drive quality and performance improvement:
- Reports to CCO for wait-times in ED, Diagnostic Imaging for CT scanning, and patients designated as ALC. ALC reporting also monitors the discharge destination of patients to quantify the type of bed that we most need for our patients to be discharged. The Surgical Department utilizes three systems: one measures wait-times for all procedures but is

primarily focused on the waits for orthopedic and cataract surgeries; the second measures unique surgical cases in terms of time management; the third system is integrated to physician and specialist offices to allow improved case management of surgical cases from referral to completion. The wait-times are monitored by management to ensure that targets are met.
- LWDH's QIP is set annually and targets are monitored quarterly. There are various committees and departments that review the QIP annually.
- KPI's generated regularly to monitor departments' performance. All data to support this work is pulled from the various clinical and financial reporting systems.
- RL6 software is used to report incidents and feedback from patients, visitors and staff. Each case is investigated, resolved and reported on as a means to make quality improvement to our services and systems.
- LWDH provides orthopedic procedures and bundled funding is managed regionally though the regional orthopedics program, dialysis treatment and systematic treatment for cancer. All of these procedures/treatments are reported in separate clinical systems for monitoring and funding by the MOHLTC. Regular monitoring of this data is necessary for performance standards and funding, and operational policies are informed by this data.

3) Primary Care uses MyPractice reports, Cancer SAR data and internal data to drive projects for their QIPs.

4) First Nations data is poor and irregular from the federal system. As well, there is no data on "work not being done". What has been more valuable has been qualitative work. Enclosed in our extra information is an article on Kenora Chiefs Advisory's Family Wellbeing program, that demonstrates this.

5) Note: all digital systems and QI projects are separate and exist only within individual organizations. There has been little system or community QI projects to date with the likely exception of Health Links.

As per our QI plan in section 5, we hope to enable a community-wide QI team, as no one organization has that capability. Data gathering and accuracy is a key component of our learning for year one, especially as our year one population is very difficult to track, often with a lack of I.D. and health cards. Developing an accurate data system with a single identifier for each patient will be key to success of any group data analysis, to begin to work on community-wide and system-wide QI projects.

As Dr. Demings said, "In God we trust…… all others must bring data!"

2.5 Other digital health plans

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

Max word count: 500

The All Nations Health Partners (ANHP) acknowledge that relative to their provincial counterparts, clinical providers in on-reserve health centres lack access to even the most basic digital health tools widely used across Canada to support clinical documentation, clinical decision making, patient safety, circle-of-care coordination, and reporting. Most communities still have paper-based documentation systems for their various program needs. Each area potentially maintains their own client/patient files so that multiple files exist for the same client. There are examples where electronic health records are in use (GHL Project, Garden River, Akwesasne, Six Nations, etc.,) but these examples continue to be in the minority. First Nations partners in the ANHP need to be included and ensure provincial counterparts (i.e. Ontario Health) are involved in First Nations Health Information Management in Ontario planning, led by the First Nations Inuit Health Branch of the Department of Indigenous Services Canada.

As noted in section 2.4, the eConnectivity (Ont-MB) initiative is integral to ANHP OHT and broader Health System planning work. It is also important to note, primary care groups and members of the ANHP are working with Lifelabs to address the reporting challenges with reporting lab results into Practice Solutions (EMR).

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

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

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