Ontario Health Team: Full Application

Introduction

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

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

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

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

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

OHT Implementation & COVID-19

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

Information to Support the Application Completion

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

Identifying the population for which an Ontario Health Team is responsible requires residents to be attributed to groups of care providers. The methodology for attributing residents to these

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

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

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

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

Participation in Central Program Evaluation

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

Submission and Approval Timelines

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

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

[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.

Additional Notes

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

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Theresa MacBeth
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1. About Your Population

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

1.1. Who will you be accountable for at maturity?

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

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

Maximum word count: 500

The Frontenac, Lennox and Addington Ontario Health Team (FLA-OHT) is committed to establishing a team-based health care delivery model centred on the Patient's Medical Home (PMH). PMHs will be positioned within a Patient's Medical Neighbourhood (PMN) that represents a wider network from which primary care practices can coordinate and share responsibility for patient care with other health and social service providers to address a full continuum of care. We recognize that for Indigenous patients this may not be a concept that addresses their worldview. In acknowledgement of a Two-Row Wampum inspired system where we will travel separate paths to reach the same destination of an integrated care system, patients will have an option of the PMH with or without an Indigenous Navigator when our OHT reaches full maturity.

Woven into the PMH/N model will be a region-wide health equity strategy that improves access and quality of care for residents with a strong focus on the social determinants of health, particularly for vulnerable and marginalized populations.

This model of care will be developed in cooperation with primary care, public health, community support services, hospitals, home and community care, addiction and mental health services, other health and social service sectors, patients and their families, residents, caregivers, Indigenous Peoples, Francophone and other equity-seeking representatives.

[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.

Approximately 7% or 15,000 residents in the FLA region are either not attached to a primary care provider or their attachment is unclear or tenuous. In year one, a foundation for the PMH will be developed and capacity will be built through collaboration to meet the goal that all FLA residents discharged from hospital, regardless of diagnosis, who are not currently attached to a primary care provider will be offered the opportunity to be included in a medical home.

This connection to comprehensive care through a main entry point, the PMH (eventually including Indigenous Navigators for Indigenous patients), has the opportunity to ensure that no one is left behind and that timely access to care and improvements in health outcomes can be possible for all people in our communities.

With 21% of our attributable population aged 65 or older (vs. 17.6% for the province), it will be paramount that the functional links within the PMH/N help people achieve their best quality of life in their communities with the support and services they need, when and where they need them.

At maturity, our OHT will be accountable for the full attributable population – currently estimated to include 226,100 individuals primarily from across the FLA region with a minority from surrounding municipalities, such as Gananoque and the surrounding community of Leeds and the Thousand Islands.

1.2. Who will you focus on in Year 1?

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

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

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

Maximum word count: 500

The FLA-OHT has identified three year-one target populations as a focus for service-improvement projects. These projects will test and evolve the collaborative teamwork and decision-making approaches our OHT plans to use in the co-design and redesign

of care. The projects will be grounded and guided by the PMH/N model and will work to build the relationships and services people will experience throughout the FLA-OHT.

The year-one target populations below will each benefit from attachment to a PMH and enable the FLA-OHT to positively shift the performance metrics outlined in section 4.1. Co-design working groups will determine how to identify individuals, develop interventions, set outcome goals, and select evaluation metrics relative to the quadruple aim.

Population 1: Adults at-risk for prolonged hospitalization and long-term care admission

Rationale: Aging-in-place strategies founded in the PMH will maximize the opportunity for patients to continue to maintain independence and comfortable living at home while reducing stress on overburdened caregivers.

The FLA-OHT has an older population that is expected to grow substantially in the near future, and it has more individuals in long-term care (LTC) per 1000 population aged 75+ than the provincial average. This has the potential to increase an already high demand for long-term care and negatively impact a waitlist that currently has 1,206 people waiting in the South East's central region. As well, Alternate Level of Care (ALC) length-of-stay in our region is much longer than the provincial average (32.8 vs. 19.1 days), putting a substantial burden on hospitals as patients remain in hospital waiting to transition to a more appropriate care setting.

Population 2: Individuals discharged from one of three partner hospitals who are not attached to a primary care provider and want to be attached

Rationale: Transitions that include planning and communication between hospitals and the medical home will ensure key follow-up in the community so that people have access to a continuum of care that supports them along their journey to optimal health and wellness and reduces their risk of readmission to hospital. This will ensure that holistic health needs are met.

Population 3: Individuals across the lifespan with mental health and addictions presenting to primary care

Rationale: Mental health care needs in our community are higher than the provincial average. The active inpatient mental health rate per 1000 population is 5.0 vs. the 4.5 average in the province. It is expected that the mental health impacts of the pandemic could be as significant as the COVID-19 virus itself. Anecdotal evidence from a variety of partners has indicated increases in wait times for outpatient care and an increase in

emergency department visits relating to mental health and substance use conditions in the past months.

Primary care is often the first point of contact for patients requiring mental health support. A medical home that includes community addiction and mental health services will ensure appropriate levels of support, along with continuity of communication between providers, and build capacity within primary care to meet patient needs in a timely manner.

1.3. Are there specific equity considerations within your population?

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

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 FLA-OHT is committed to equitable outcomes and addressing barriers to health, not just access to health care, for the attributable population. As such, there are several additional equity considerations among population subgroups within the FLA region that warrant specific attention, including:

Indigenous Peoples
The FLA-OHTs attributable population includes a high percentage of Indigenous Peoples particularly in rural FLA. While 2.8% of Ontario residents indicated Indigenous identity in the 2016 Census, those percentages were much higher in Kingston and the immediate surrounding area (at 3.6%) and particularly in the rural extents of FLA (9.3%). In addition to the Mohawks of the Bay of Quinte (MBQ) and the Tyendinaga Mohawk Territory, there is a high relative number of Indigenous Peoples in the Sharbot Lake region of Central Frontenac. Addressing health and wellness with Indigenous Peoples is a required focus across FLA. Within Ontario, Indigenous Peoples experience higher rates of arthritis, asthma, respiratory problems, mood disorders,

[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.

smoking and alcohol consumption, having one or more chronic conditions and perceived life stress, compared to non-Indigenous identity peoples, whereas rates of immunization, having a regular medical doctor, perceived overall health and perceived overall mental health among Indigenous Peoples are lower compared to the non-Indigenous identity peoples (1). We recognize that there are system barriers to access for Indigenous Peoples and that these barriers adversely impact the health and wellness of Indigenous Peoples in the FLA. In an effort to strive for balance, attempts will be made to integrate Indigenous Navigators across the OHT at maturity.

Francophone population

In 2016, over 3% of residents within the KFLA region identified as having French as their mother tongue. The presence of the Canadian Forces Base in Kingston contributes to an increased francophone population within FLA. Although the health status of this group is not known relative to English-speaking residents, there are gaps in health services for this subgroup that require attention.

Aging population

The FLA attributable population demonstrates a noticeable skew to older age groups (21% of our attributable population is aged 65 or older, compared to 17.6% for the province), particularly within the rural population. The number of residents aged 65 and older in the FLA region is projected to increase over the next 10 years from 21% of the population to over 25% by 2030. The number of residents aged 75 and older is projected to increase by 50% over this time-period.

This aging demographic contributes to higher crude prevalence rates of a range of chronic conditions that relate to an aging population. For instance, the prevalence rate for COPD in adults aged 20 and older in 2017 was 8,147/100,000 population compared to 7,669/100,000 for the province - and this crude rate has increased steadily from 5,697/100,000 in 2003. Similarly, the crude prevalence rate for hypertension has increased steadily from 22,587/100,000 in 2003 to 26,245 in 2017 (compared to a provincial rate of 25,880/100,000).

Though the age-standardized rate may be lower than the provincial rate, the aging profile accounts for a higher burden of illness in the population. This aging demographic reinforces the need for the PMH/N to address health needs that allow our residents to age-in-place within the community (2). To achieve this, aging persons will have to be supported as a whole, inclusive of their medical and non-medical community.

Rural population

The FLA-OHT serves a large geographic area – over 7,200 km2 with an estimated 34.2% of the attributed population living in rural areas. A greater proportion of rural residents identify as current smokers compared to urban residents (22.4% vs. 19.7% respectively) and a lower proportion of rural residents are physically active (28.0% rural compared 31.7% urban).

Economic disparities

Measures of material deprivation indicate particularly high levels of deprivation in the northern extents of our region – the most rural and remote portions of the district. There

are also high levels of deprivation in select portions of the urban core – particularly in the northern extents of urban Kingston. While the percentage of the population living with low income was 14% for the broader Kingston urban area that percentage exceeds 30% in the north-Kingston census tracts (3).

For perspective, across the KFL&A Public Health region, the gradient in poor health outcomes is evident for residents along material deprivation quintiles. Of note, in 2016/17, residents in the lowest material deprivation quintile were:

● 2.4 times more likely than those in the most advantaged quintile to visit emergency departments for mental health conditions (44.8/1,000 vs 18.3/1,000)
● 3.4 times more likely to have alcohol-attributable hospitalizations (1.1/1,000 vs 3.8/1,000)

If residents in the less materially advantaged quintile could mimic the potentially avoidable mortality rate of the most advantaged group, an estimated 356 fewer potentially avoidable deaths could have been realized in a two-year period between 2014 and 2015. The FLA-OHT is committed to reducing that disparity.

According to data provided by KFL&A Public Health, the most deprived populations have the highest rates of inpatient service utilization at 500 stays per 1000, compared to 350 stays per 1000 residents among the least deprived communities. The median length of inpatient stays among most deprived populations is 12 days, compared to just seven days for those in least deprived populations. Additionally, more deprived populations have disproportionately higher inpatient stays related to a respiratory condition, diabetes and depression according the recent KFL&A Public Health report Understanding Health Inequities and Access to Primary Care. Additionally, the most deprived populations have ED utilization rates approximately three times that of least deprived populations.

Other considerations
We are aware there are several other equity considerations in subpopulations, such as transitory and LGBTQ2S+ communities, within our attributed population. Over time, with collaboration and engagement with our partners and residents, we will work to identify and address these.

2. About Your Team

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

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

At maturity, Ontario Health Teams will be expected to provide the full continuum of care to their defined patient populations. As such, teams are expected to have a breadth and variety of partnerships to ensure integration and care coordination across a range of sectors. A requirement for approval therefore includes **the formation of partnerships across primary care** (including inter-professional primary care and physicians), **both home and community care, and secondary care** (e.g. acute inpatient, ambulatory

medical, and surgical services). In addition, to ensure continuity and knowledge exchange, teams should indicate whether they have built or are starting to build working relationships with their Local Health Integration Networks (LHINs) to support capacity-building and the transition of critical home and community care services.

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

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

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

2.2. Confirming Partnership Requirements

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

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

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

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

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

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

Max word count: 1000

There is strong collaboration among FLA-OHT partners demonstrating the team's ability to deliver coordinated services meeting the needs of the attributed population through the PMH model.

Many primary care providers offer comprehensive care where each provider works at their full scope of practice. We will scale this model of team-based, primary care, expanding services so that all people have equitable access to the full continuum of care and there are no unattached patients in our region.

Many of our partners maintain long-standing relationships by delivering various health care initiatives in our region, which can be leveraged to deliver integrated care and address the needs of our year-one population, while preparing for a potential second wave of COVID-19. For example:

● Primary care providers in rural FLA, in partnership Home and Community Care (HCC), have conducted a pilot program to align HCC coordinators with primary care, which has now expanded to Kingston.

● An existing leadership group from all Family Health Teams (FHT) and Community Health Centres (CHC) has partnered with Kingston Health Sciences Centre (KHSC) to connect unattached people receiving care from KHSC@Home to primary care providers. KHSC@Home provides people with up to 16 weeks of the care in order to help them return home after being in hospital.

● Primary care physician leadership, participation has enabled the Primary Care Council, a discussion forum for family physicians in all varieties of practice models, including FHTs and CHCs, to be fully engaged in the FLA-OHT application process. This group is partnered with KHSC and Southeastern Ontario Academic Medical Organization (SEAMO) on a primary care pathways project.

● Our primary care leaders are engaged with regional hospitals to expand the Health Information System that is currently being negotiated. When implemented, this will support our coordinated discharge planning objectives, address hospital flow and increase effective communication with primary care providers and community health service partners.

● Over the past years, primary care providers and specialists have worked together on the adoption of eConsults. This has enabled providers and their patients to receive

specialist advice in a timely manner, and has decreased unnecessary specialist referrals by 47%.

● SEAMO is partnering to identify strategies for primary care and specialist physicians to coordinate services, and identify potential models that support primary care to work within the OHT model, including innovative funding methods.

● Sharbot Lake FHT, in partnership with Northern Frontenac Community Service, Providence Care and Addiction and Mental Health Services (AMHS-KFLA), have a mental health care collaboration that brings together social workers, counsellors, nurse-practitioners, primary care physicians and a psychiatrist to manage cases. Rural Mental Health Rounds help other primary care offices implement a similar integrated mental health model.

● A System Advisory Committee of mental health agencies in the region ensures mental health services are accessible and integrated. Partners include representatives from Providence Care, AMHS-KFLA, KHSC, The Maltby Centre, Resolve Counselling Services Kingston, Queen's University Department of Psychiatry, Kingston Community Health Centres (KCHC) and primary care.

● There is a strong relationship between the Indigenous Health Council and KCHC based on the premise of "nothing about us without us", featuring decision-making that ensures Indigenous voices are heard and respected in any program or service that affects them. Examples include creating various Indigenous positions within CHC: Elder, Community Development Worker and Nurse Practitioner, and making spaces culturally appropriate and safe. In consultation with Indigenous Peoples, we aim to mimic this approach within our OHT.

● The Oasis program, a partnership between Providence Care (PC) and Queen's University, supports older adults to age-in-place by integrating community services and programming within retirement communities. Evaluation has found members of Oasis experience decreased health utilization, less home care, fewer emergency department visits and hospitalizations compared to older adults in non-Oasis communities.

● KFL&A Public Health, in partnership with regional primary care practices have implemented successful public health campaigns and population health initiatives, including smoking cessation programs, the healthy early childhood development strategy, and a universal influenza immunization program that has contributed to the highest immunization rate in the province.

● KFL&A Public Health is partnered with regional hospitals, primary care, community agencies and the SE LHIN to collect real-time data and conduct public health surveillance through the Acute Care Enhanced Surveillance dashboard, ILI mapper and the Shared Health Integrated Information Portal. We aim to leverage these existing infrastructures to expand on these programs to collect useful, real-time feedback and data on service use within our region for evaluation and continuous quality improvement.

● KFL&A Public Health, in partnership with KCHC, Street Health Centre, hospitals, pharmacies, primary care and other community health agencies, developed an opioid strategy group for enhanced opioid-related surveillance, overdose prevention and information sharing throughout the region. A coordinated addiction service is also delivered through partnership between KHSC, SEAMO, the Queen's Department of Family Medicine and Street Health.

● Providence Care, in partnership with community health services, developed the Community High Intensity Treatment Team (CHITT), designed to serve the most vulnerable people in our community who otherwise would reside in an inpatient mental health hospital or be homeless. The ED at LACGH also diverts mental health visits directly to CHITT.

● Napanee Community Health Centre has partnered with the Town of Napanee, community agencies and the County of Lennox and Addington to support tenancy in social housing.

● The proposed FLA-OHT benefited from the collaborations of three Health Links involving primary, community and hospital care, and others, resulting in improved care experiences for patients, families, physicians and allied health workers.

● We have forged new partnerships and leveraged previous ones to ensure timely access and care delivery, as well as COVID-19 information, education and resources to partners and the public. We have also collaborated to ensure effective and accessible COVID-19-related infection prevention and control initiatives throughout the region. New collaborations include the Regional Incident Command with representation from health care and supply chain partners across southeastern Ontario and the development of the COVID-19 dashboard in partnership with public health.

3.0. Leveraging Lessons Learned from COVID-19

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

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

Max Word Count: 500

In responding to COVID-19, we have demonstrated adaptiveness to a dynamic health crisis; capacity for effective communication, transparency, collaboration and decision-making between partners; the value of connectivity through collaborative networks; and the ability to work effectively with Ontario Health, the Ministry of Health (MOH) and the Ministry of Long-Term Care in translating directives and permissions to facilitate integrated care.

COVID-19 highlighted the importance of meaningful relationships with organizations and agencies outside the MOH (LTC, Correctional Service Canada, DND) and exposed the importance of addressing social determinants of health, fragile and marginalized groups and the Quadruple Aim. Local COVID tables brought together regional partners to strengthen relationships within sectors (i.e. primary care, LTC, HCC/CSS). Our ability to be collaborative, transparent, and inclusive, and be effective in addressing the COVID-19 pandemic will be invaluable to developing collaborative governance for the FLA-OHT.

We have collaborated to offer new, innovative services within the community, including COVID-19 assessment centres, efficient laboratory testing, and an accelerated digital health agenda that has shifted us towards widespread virtual care and telemedicine in primary care and specialty practices. COVID-19 has stressed the importance of real-time data, digital platforms and analytics.

We have expanded food and housing services to ensure vulnerable and marginalized people have adequate food and shelter during the pandemic.

We operationalized the COVID-19 assessment centres through partnerships between KFL&A Public Health, municipalities, hospitals and primary care, with public health directing priorities and providing outbreak management, hospitals providing staffing and ensuring adequate personal protective equipment (PPE) supply, and primary care providing physician staffing. These centres have helped with ED diversion for patients with respiratory symptoms and allowed primary care to provide ongoing care in a safe manner.

Health partners have worked across sectors to safely resume care in the community and in hospitals to ensure the continued safety of people within our region, including those in long-term care homes, marginalized communities and students returning for the 2020 school year.

Our experiences with COVID-19 have provided new perspectives on vulnerabilities in the health care system related to patient flow and transitions in care, LTC and retirement homes, addiction and mental health service, PPE supply chain, social determinants of health, digital health and our virtual care capability, occupational health, lab capacity, and multiple and varying system accountabilities. The experience validated the importance of the Quadruple AIM approach and the importance of system partners' capabilities that should be part of our OHT collaboration, including those mentioned above, along with primary care, HCC, hospitals, public health, community support services, Indigenous Peoples, data, and the regional Health Information System. Our pandemic response has demonstrated that everyone requires a medical home, not just vulnerable populations.

Primary care, HCC and patient partners have been involved in all decision-making structures to support the hospitals and LTC throughout our COVID-19 response. Without constructing a formal governance framework, we have been capable of making timely decisions together. We will apply the lessons from collaborative decision-making related to COVID-19 to the implementation of the PMH model.

4.0. How will you transform care?

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

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

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

- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Time to inpatient bed
- Potentially avoidable emergency department visits for long-term care residents

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

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

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

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

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

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

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

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

Max word count: 500

Our vision for digital care is “One patient, one system, one experience.”

The three hospitals in FLA-OHT are part of the network of hospitals in southeastern Ontario that are advancing this vision through our Health Information System renewal. This clinical transformation will take us from siloed systems to a single care system linking patients and providers across our region.

While the HIS will initially connect the six hospitals in the southeast, engagement with primary and community care ensures we create a platform that will eventually connect us all in a seamless, coordinated continuum of care, centred in the PMH, as the foundation for our OHT. Broad engagement of clinicians and patients has been central to our HIS collaborative governance and will continue to be the method by which our digital strategy evolves.

In alignment with the IHI quadruple aim, the clinical transformation enabled by the HIS will:

• Improve patient experience through enhanced quality, safety outcomes and increased coordination and communication;
• Improve population health by addressing chronic disease issues through the use of data analytics.
• Enhance care team experience with innovative care delivery and clinical support tools; and
• Optimize value by reducing paper records, duplicative tests, and being responsive to changing funding models.

As a result, patients will experience high quality, coordinated care and better outcomes no matter where they are located or what their health needs are.

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

Throughout COVID-19, we have accelerated use of technologies that will underpin our HIS with rapid deployment of virtual care, e-referral and e-consult tools, as well as patient-supplied data from home monitoring devices such as blood pressure readings, photos. An innovation group is working to increase capacity by maximizing the efficiency of primary care referrals to specialists and virtual access to specialists. We will continue to leverage these tools in our OHT to support our year-1 populations, enabling us to provide care in peoples' homes, reach people who live with disabilities or in remote areas, and build capacity to care for more patients.

While we pursue our HIS project, the Digital Roadmap Committee is creating a digital toolbox to enhance patient and provider experience and improve quality. The committee includes representatives from primary care, hospital, community and mental health care, patients and caregivers and the Indigenous Interprofessional Care Team. A list of digital toolbox solutions is included as Appendix A.

Considering the needs of our Francophone and Indigenous populations, we will strive to offer virtual care tools in both official languages and deploy them in ways that promote equity, improve access and promote patient self-management.

Although Indigenous Peoples have embraced the shift to virtual platforms for communication and health care due to COVID-19, our Indigenous partners are telling us that virtual tools may not always be a suitable method for care delivery to these communities. Any virtual care provided to Indigenous Peoples must maintain a personal connection and provide a sense of safety, love and respect.

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Dr. Kim Morrison
	Title: Chief of Staff, Clinical Co-Lead, Regional Health Information System project
	Organization: Lennox & Addington County General Hospital
	Email: kmorrison@lacgh.napanee.on.ca
	Phone: 613.354.3301 ext. 430

4.3. How will you address diverse population health needs?

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

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

4.3.1. How will you work with Indigenous populations?

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

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

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

Max word count: 1000

We acknowledge the established health system is rooted in Western beliefs. We are committed to strengthening relationships through trust, respect and meaningful dialogue as allies of Indigenous Peoples. We will honour the Indigenous path of wellbeing and ensure a holistic approach to wellness encompassing mental, physical, spiritual and emotional health. We see this as an area for growth as historical mistrust will take time and commitment to overcome. We are committed to implementing, at maturity, an Indigenous Navigator Program, among other programs, to help bridge the gaps between Western health care methods and Indigenous methods of knowing, healing and wellness.

We have established a mutual commitment with Indigenous partners to work collaboratively to deliver health services within the FLA-OHT model and are engaged in discussions with the Indigenous Health Council (IHC) about how to best incorporate Indigenous Peoples throughout the redesign process. Previously, we have engaged with Indigenous health service providers and participated in two virtual Talking Circle

events pertaining to Indigenous health and wellness in March and August 2020. Participation in these activities has allowed us to better understand of what “health” and “wellness” means to Indigenous Peoples, the supports needed to bring wellness to Indigenous families, how culture and lived experience relate to health and wellness, and how Indigenous partners wish to engage and collaborate in the OHT implementation process and beyond so that Indigenous Peoples unique health needs are being met while ensuring that healthcare redesign does not perpetuate inequalities that exist in the system.

There is a strong relationship between Indigenous partners and KCHC. This relationship starts with the premise of “nothing about us without us”. KCHC has designed decision making processes to ensure Indigenous voices are heard and respected in any program or service that affects them. Examples include creating several Indigenous positions within CHC: Elder, Community Development Worker and Nurse Practitioner. KCHC has also worked to make its spaces culturally appropriate and safe, in the form of sweat lodges, smudging rooms and Indigenous artwork. In consultation with Indigenous Peoples, we aim to mimic this approach within our OHT.

The South East Regional Cancer Program employs an Indigenous Patient Navigator, and an Indigenous Cancer Lead. The aim of their work is to improve cancer services for First Nations, Inuit and Metis peoples in the South East region. This is an example our OHT intends to build upon at maturity.

One of the Indigenous Health Council’s most successful outreach initiatives has been the delivery of a blood pressure clinic for Indigenous Peoples. This outreach takes place anywhere Indigenous Peoples gather. Anecdotally, a healthcare provider recorded blood pressure of individuals at a pow wow over the course of two days. This form of community outreach provides a welcoming, safe and loving environment for community members. We intend to build upon this outreach model as a next step, expanding to other types of medical outreach (i.e. diabetes) based on the needs of Indigenous communities.

Other successful examples of how the IHC has been involved in program planning and decision making to date:

• Formation of the Indigenous Interprofessional Care Team (IIPCT)

• Consultation with Hospice Kingston

• Palliative care Talking Circle

• Application to the City of Kingston regarding EarlyON

• KHSC has the Mamawi room within the hospital which provides a spiritual space where Indigenous Peoples can smudge. The existence of this room provides an opportunity for the general medical community to broaden its knowledge of Indigenous spirituality.

These outcomes provide a foundation for future engagement as we continue to build upon existing relationships and work towards our common goal of breaking down systemic barriers and inequities and building healthy communities for Indigenous Peoples.

We have embraced the Indigenous Peoples' philosophy of the Two-Row Wampum. This means we share a common goal of providing the best coordinated health and wellness care for everyone, but we will travel separate paths on our way to realizing this goal in recognition of the Indigenous worldview and approach to holistic wellbeing. This philosophy will remain as we move forward with the development of our vision to deliver a PMH model for Indigenous Peoples that will provide a safe, respectful and trusting health and wellness environment through the use of Indigenous Navigators. We will work together to ensure the FLA-OHT is reflective of the cultural values and beliefs of the population it serves.

Indigenous partners' vision for health and wellness in their communities is well-aligned with our vision to provide comprehensive care within the PMH model. We intend to collaborate and support the IHC in their goal to implement an Aboriginal Health Access Centre (AHAC), an entity that would serve as the Indigenous equivalent to the PMH model. The AHAC would act as an umbrella organization to cover all influences of health and wellness including housing, food security and poverty.

Additionally, in consultation with Indigenous partners, the following activities were discussed:

• Funding for recruitment and retention of Indigenous health system navigators to help connect Indigenous Peoples with culturally safe services and guide them through their journey within the PHM/N health system.

• Funding for Indigenous community workers and knowledge keepers.

• Work towards equality among Indigenous and non-Indigenous healthcare workers within the PMH/N health system. Currently, there is a feeling of inequity among Indigenous healthcare workers with their peers.

• Cultural training, including modules on Truth and Reconciliation, for all healthcare workers as a method to understand what traditional medicine means to Indigenous Peoples so that it is equally respected within the medical field.

To demonstrate our commitment to provide culturally safe and sensitive care to Indigenous Peoples, Indigenous partners will be represented in all aspects of the health care redesign process. Currently, we have established partnerships with two Indigenous-led entities which include the IHC and the MBQ Wellness Centre. Collaboration with these Indigenous-led organizations will provide us the ability to create our vision in alignment with the Two-Row Wampum philosophy and address the whole spectrum of Indigenous health and wellness needs. This will require the creation of an Indigenous Oversight Committee.

4.3.2. How will you work with Francophone populations?

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

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

Max word count: 500

Kingston is designated as a French language service area under the French Language Services Act. There are ten health organizations within the FLA region that are identified to provide services in French, including: AMHS-KFLA, Alzheimer Society-KFLA, Canadian Hearing Society, Canadian National Institute for the Blind, KHSC, SE LHIN Home and Community Care, Providence Care, the Salvation Army – Kingston Harbour Light, Peer Support South East Ontario – Kingston Support Centre and Victorian Order of Nurses Greater Kingston. Of those identified, seven organizations are currently partners within the proposed FLA-OHT.

Services available to Francophones in the FLA region are limited. However, the FLA-OHT is committed to providing equitable care that meets the needs of our attributed population. We have engaged with the Francophone community through the annual Salon Santé gathering of health service providers to explore ways of improving services to the Francophone community. KCHC has submitted an application to become an identified French language health service provider to better serve the needs of Francophones within the region.

Throughout Year 1 of implementation, we will continue to expand and improve French language services. We will continue to engage our Francophone partners to ensure that health services within the FLA-OHT have the ability to provide linguistically appropriate care, tools and resources within the PMH/N that adequately address the needs of our Francophone population. Specifically, we will:

• Leverage French organizations within the region such as ACFOMI, The Comité des Citoyens etc., to engage in consultation workshops throughout the healthcare redesign process.

• Ensure adequate Francophone representation within working groups.

• Develop all digital health platforms, applications, tools and resources in both official languages.

• Establish partnerships with specialty care outside of the region that have the capability to consult with Francophone clients.

• As a strong partner in the FLA-OHT, Réseau des services de santé en français de l'Est de l'Ontario has proposed to support a Kingston Francophone Health Human Resource Collaborative Table that brings together human resource leaders in the Kingston area to explore methods to facilitate all aspects of recruitment and retention of French speaking staff to the area.

• Recruit and build capacity to better serve the Francophone population ensuring that our partners can provide linguistically appropriate care.

• Explore partnerships with bilingual health service organizations in the Ottawa region to determine how they identify need and offer French language services

Additionally, we will use demographic data collected by Kingston Health Sciences Centre during the patient registration process to provide an accurate estimate of individuals within our region seeking healthcare whose mother tongue and preferred language is French. We will also leverage the OZi database which collects data on all French language services (human resources, policies, etc.) to ensure better planning of health services in French throughout Ontario. A better understanding of the Francophone demographic and current French-language services available in the region, will allow us to target initiatives to better serve the Francophone population within the PMH model.

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

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

Max word count: 500

Contrary to Canada's expectation of equal health outcomes for all citizens despite socioeconomic variations, our data shows evidence that individuals of lower socioeconomic status have worse health outcomes. The priority socio-demographics within our proposed OHT include:

• Mental Health and Addictions - higher rates than province (including ED visits that are more than 1.5 times greater than the province for residents aged 18-44), and the issue is more critical due to increasing anxiety, post-traumatic stress disorder and depression among the following: three post-secondary institutions representing 32,000 students, eight federal and provincial correctional institutions within the FLA region housing 2,186 inmates and employing 2,225 correctional staff, and members of the military at CFB Kingston.

• North Kingston and deep urban core – with a special emphasis on addressing Adverse Childhood Experiences (ACEs) as a means of health promotion.

• Rural areas with limited transportation and higher rates of social isolation.

With this in mind, we plan to take a population needs-based, equity-oriented planning approach to designing services in our community that matches services to those that need them most.

We plan to build on past inequity educational events that were led and supported by system leaders (the Community Foundation for Kingston and Area, KFLA United Way, Queen's Department of Family Medicine, and Kingston Community Health Centres), and exposed health/social service providers as well as the community at large to the negative health impact of issues such as ACEs, discrimination, poverty and social isolation.

Current activities that seek to include or address health or healthcare issues specific to any other population sub-groups:

1. The Community Drug Strategy committee includes every stakeholder in the KFLA region, and serves as a united front to address the opioid crisis.

2. Consumption Treatment Services help address high overdose rates and build relationships to support individuals in their recovery.

3. Multiple partners are working to increase daily access to affordable and healthy food.

4. The Circles program gathers weekly around meals to build community across class lines, teach food skills, and support people in their goals for self-sufficiency.

5. Kingston Immigration Partnership provides leadership in the community to attract, welcome, integrate and retain newcomers in support of a strong and vibrant community.

6. Practical Assistance Worker in place (via KCHC and RFLA Allied Health Team) to address social inequality gaps.

7. Warming centres and a new Integrated Care Hub to address significant gaps related to housing and homelessness.

8. The Mental Health Hub and Spoke model used at Sharbot Lake FHT and elsewhere that takes a team-based approach to managing cases.

We plan to engage clients, patients, families and caregivers to achieve a better understanding for how our OHT can better support those with greater health service needs that wish to remain in home and community care settings.

Beyond Year 1 and at maturity, we aim to create a new unified health equity strategy for our OHT that ties together all of the positive health, social and municipal - but disparate - efforts and initiatives in a more coordinated fashion.

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

Describe how your team intends to deliver supports and coordinated care to communities and settings in which social distancing and other infection prevention and control practices are a challenge.

Max word count: 500

Through partnership and guidance from KFL&A Public Health and in accordance with federal and provincial directives and guidelines, we have continued to deliver safe and effective preventive measures to populations and settings identified as vulnerable to COVID-19 and influenza. Some of the vulnerable populations and settings in the

FLA region that we have worked with already and intend to continue to work with include, but are not limited to:

• Federal and provincial correctional institutions

• Educational institutions, students and teaching staff

• Congregate homes, home and community care workers, older adults, families and caregivers

KFL&A Public Health, in coordination with primary care, community health services and the previously identified institutions have prioritized prevention, surveillance and testing for COVID-19 and Influenza and will continue to do so into the foreseeable future.

There are several ways that we have been working with and will continue to work with communities and settings in which social distancing and other infection prevention and control practices are a challenge. These include:

• Public health surveillance and monitoring of COVID-19 and Influenza cases, prevention and outbreak management.

• Public health measures to continue to prevent spread of COVID-19 and Influenza and protect vulnerable populations, including universal masking, physical distancing, equitable access to safe and effective influenza vaccination.

• Recent and accurate COVID-19 and Influenza information sharing and education regarding effective prevention and management strategies

• Ensuring that adequate supports for LTC and home and community care are available, including access and availability of virtual care, personal protective equipment, food services, social and mental health supports.

• Ongoing collaboration between hospitals, public health, primary care and EMS to ensure assessment and testing and influenza vaccination is available to the entire community through assessment centres and mobile units available to targeted vulnerable areas.

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

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

Max word count: 1000

Throughout the OHT application process, patient advisors with experience contributing to health care service-improvement projects participated on the steering committee and helped guide the direction of the FLA-OHT.

Patients' experiential knowledge is essential to health care redesign. We will continue to partner with patients to better understand their experiences in order to help drive system improvements.

Our OHT will ensure patients are partners at the table, not guests. Patients will be invited and encouraged to join in productive partnerships throughout the co-design process. Early on, we will articulate how patients across the organizations and geography of the FLA-OHT can become involved.

As we move forward, patients will be encouraged to become chairs or co-chairs of working groups. As well, we will further encourage the spread of client/patient advisory groups across all FLA-OHT member organizations, with clear sight lines for collaboration and decision making. This way, our OHT will build patient partnership into all facets of its operation.

Future Approach:

Looking ahead at the redesign and co-design of care involving patients, caregivers and providers, the FLA-OHT will collect and analyze qualitative data such as interviews to understand people's opinions and experiences. This qualitative, experience-based approach will be used to improve the quality and experience of services that people will have access to within their PMHs and PMNs.

The central elements of this approach to co-design will include: 1. interviews and focus groups with providers and with patients and caregivers who have not previously been engaged, 2. the establishment of a collaborative decision-making framework among patients, caregivers and providers, and 3. the establishment of an Indigenous Oversight Committee comprised of Indigenous patients and Indigenous partners. These elements will ensure meaningful and diverse input is integrated into all stages of decision making in order to find collaborative solutions.

The FLA-OHT's quality agenda for co-design will begin with formalizing the existing communication and engagement working group, which will be responsible for steering an engagement project that will effectively involve people from our target year-one population (see section 1.2) in co-design working groups focused on priority areas for service improvement.

As the FLA-OHT takes an experience-based approach to co-design and improving services, the communication and engagement working group will consult with research ethicists to ensure patient confidentiality and informed consent. As well, information and education packages will be developed for those who participate in the co-design process to ensure meaningful collaboration within the working groups.

Recognizing that vulnerable or marginalized groups involved in the experience-based co-design (EBCD) process may need specific preparation and support, or need a different way to be involved, the communication and engagement working group will reach out to special groups of people – Indigenous and Francophone communities – to determine whether or not EBCD is right for them. For example, talking circles with First Peoples is a model for engagement that encourages dialogue, respect and co-creation.

Engagement Activities:

Observations, Interviews and Consultations:
Information will be gathered to identify what is currently working and what needs improvement. Multiple approaches that meet the varying needs of participant groups will be used including one-on-one interviews with providers/staff, patients and caregivers, focus groups and observation sessions. Observation will involve shadowing interested participants as they access specific services and supports, and engaging in informal, impromptu conversations with providers/staff, patients and caregivers about their needs.

Providers and staff who are interviewees will provide diverse views and roles across the entire health pathway and include people who may be skeptical or enthusiastic. Likewise, the patients and caregivers who are identified to be interviewed will provide a mix of both positive and negative experiences.

Patients and caregivers who are recruited for interviews will have a recent (within the past six months to one year) experience upon which to draw. They will also represent the target year-one population (age, gender, location, ethnicity and socioeconomic status) and their experiences will span different aspects of services.

Perspectives and Key Priorities:
Key findings will be presented back to participants from whom information was gathered. This will offer providers/staff, patients and caregivers the opportunity to hear and begin to understand each other's perspectives. From this common understanding will stem the collaborative decision-making process, as participants collaborate on identifying key priorities and narrowing these down to three to four main concerns that can be tackled together to make improvements through the experience-based co-design groups.

Co-design Working Groups:
Participants involved in previous activities will be invited to join one of the co-design working groups that will focus on the area of most interest to them; one group will be organized for each priority area for service improvement. At this time, new participants may need to be recruited: key staff and patients from existing patient advisory groups.

These groups will meet at consistent frequencies to brainstorm and fine-tune solutions. Work will be guided by a facilitator and each group will be asked to maintain a log detailing each solution, activities taken or planned, timeframes, barriers to implementation, and what will happen next and by whom. This includes but is not limited to the Indigenous Oversight Committee.

Evaluation:
Successful engagement will ensure that i) a diverse range of perspectives is obtained, ii) participants feel they are contributing in a meaningful way to the co-design process and iii) solutions are designed that reflect patients, caregivers and providers' perspectives. Ongoing evaluation of engagement strategies will be conducted to continually inform the engagement processes. We will measure this success in a variety of ways, including identifying the number and diversity of participants at each activity, collecting participant experiences through surveys after engagement activities, and by tracking the extent to which services changes have been adopted. Whenever possible, before-and-after surveys will be used to measure whether or not experiences have been improved as a result of changes. As well, before-and-after figures will be calculated when possible to demonstrate efficiency.

5.0. Implementation Planning

5.1. What is your implementation plan?

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

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

Max word count: 1000
We will use focused projects to develop, test and evolve the collaborative decision-making and experience-based co-design approaches we will use in our OHT. Each of the three initial proposed plans for improving and integrating care for our target populations share common objectives and approaches. All are grounded and guided by the PMH model, with work that includes augmenting the services available inside the PHM for each person in our region and in developing seamless flow within a well-connected medical neighbourhood. Draft Driver Diagrams outlining the focused projects with 3, 6, 12-month objectives are attached at Appendix B.

Projects were selected based on the ability to address urgent issues, feasibility and potential for early and sustained improvements in multiple aspects of the quadruple aim and by our commitment to health equity, improved population health and a focus on health, not just health care. Each project will be guided by a working group of interested partners, with patient and caregiver membership, and will connect through a central collaborative decision-making table. All will include patient/public

engagement as described in Section 4.4, and all will be implemented in a carefully planned and staggered manner to ensure that partners are able to engage fully at any point in time and that in the end state each project has been fully implemented for all people served by our OHT.

In the first year we will develop a comprehensive evaluation framework to measure the impact of integrated care, informed by the PMH. This evaluation framework will include additional performance measures, including process metrics in order to evaluate the OHT over time. We will take a learning health systems approach to the evaluation by engaging patients in the evaluation design and building in mechanisms to capture, link and share local data within the OHT. Queen's Health Service and Policy Research Institute, which includes ICES-Queen's, will play a key role in supporting the learning health system through its capacity to produce and distribute research and develop learning and improvement competencies within the OHT. The Institute will lead the OHTs evaluation team.

1) Supporting adults at-risk for prolonged hospitalization and long-term care admission

Objective: To support individuals and caregivers to age-in-place with the supports they require.

Interventions/innovations: Connections to a medical home with high functioning collaborative care-coordination. Initially this will include HCC co-ordinators embedded in medical homes with a focus on age-in-place strategies along with representatives from PC and CSS. The coordinators and representatives will meet monthly with primary care for shared care ageing in place planning. The long-term objective is to create fully coordinated care teams including providers delivering services in the home (PSWs, nurses, rehabilitation therapists, among others). We will work to consolidate online resources to support older adults and families with self-management tools and identify shared tools for the provision of team-based virtual care in the home.

We will also identify neighbourhoods that have a higher proportion of older adults and work with these communities to bring programs (e.g. exercise classes, social activities) to the places where older adults live. The final aspect of this project will be to connect patients without a current source of primary care to an appropriate local medical home. In year 1, the program will target patients currently on the LTC wait list (in hospital and in community) and allow for providers in the medical home to identify patients and caregivers at-risk for LTC placement.

2) Improving coordination of care for individuals discharged from one of three partner hospitals.

Objective: Patients experience seamless transitions in care for planned hospital admissions and all discharges.

Interventions/innovations: The medical home is an equal partner in every hospital discharge so that no people are discharged without their PMH home being aware and participating in discharge planning, and no patients are discharged without having access to a medical home. We will create a mechanism for timely communication and collaborative discharge planning between hospital and PMHs, including the creation of discharge plans in advance for planned admissions. As in project 1, we will work to create fully coordinated care teams to support patients at home. As a starting point we will align short stay HCC co-ordinators, KHSC@Home and CSS with primary care practices to begin development of these teams. A survey of primary care to establish the ability to take on new patients and what resources they need to take new patients and for safe, effective discharges will be required. Online resources and shared tools for collaborative virtual care will also be identified for this project and will be done in collaboration with the other projects.

3) Improving access to Mental Health supports for patients presenting to primary care.

Objective: All patients have access to clearly identified primary mental health supports and to a single-entry point into higher levels of mental health care services through their medical home.

Interventions/innovations: Building on our experiences in Sharbot Lake and Rural Frontenac we will implement hub and spoke processes where the hub is the specialized mental health outreach team and the spokes are the PMHs across the region. To support care coordination, it is recommended that regular care coordination meetings be implemented in each medical home. Specialized mental health clinicians (hub) attend, as well as any member of the primary health team (spokes), and any other relevant partners specific to the area served. These meetings would be held in the location of the primary health provider which is the client medical home. Evidence in the literature supports this process over traditional communication strategies between mental health and primary care providers. During these meetings, more complex referrals may be discussed to determine the most appropriate to engage providers at the right time and utilize optimal resources to support mental health needs. The shared plan of care is developed here and reviewed as required at subsequent meetings. As in the other projects a set of shared online self-management and virtual care tools will also be identified.

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

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

Max word count: 1000

As an OHT moving towards full application, we would benefit greatly from learning from the experiences of those beginning before us. While we do appreciate having access to academic/educational resources through the RISE platform, action-oriented resources would be of most benefit at this time. We are eager to further the development of our governance structure and therefore would benefit immensely from Ministry support with organizational change at a leadership level.

Additionally, we would benefit from resources outlining potential structures, ideally including examples from existing OHTs. There are many collaborative governance structure models used in health care contexts, all of which have strengths and weaknesses. Learning from other OHTs what models they have tried and how they are functioning in their context would be valuable information for planning that we cannot otherwise easily obtain. Along these lines, model pathways for care that have previously been implemented in the province and communication and engagement strategies from other OHTs would also be useful in our ongoing planning.

As this is the maturity state we are now working towards, access to robust templates and structures would be useful. As well, having access to practical template documents in a repository including policies, agreements, and memoranda of understanding which could be modified to suit our local needs would help reduce the duplication of effort across OHTs and also help ensure consistency across the province.

We would benefit greatly from additional information and support from the Ministry to access data, including data from the Health Care Experience Survey and from other ministries to further understand the patient experience across sectors that will be working together within the FLA-OHT and to support the understanding of any existing patterns for patients who require attachment to a medical home. We would also benefit from support to ensure we are meeting data privacy standards.

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

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

Max word count: 1000

Trusted partnerships between patients, families and all health and community service providers are essential to our ability to deliver seamless, high quality care for the people we serve. Stronger partnerships will help us coordinate care beyond that which the system allows us to do today. In the face of ever-changing community needs and evolution in service delivery, the current state is unsustainable. Trust and participation will be enhanced over time as community members and service providers collaborate in developing our OHT through planning meetings, working groups, quality improvement and care redesign initiatives.

New and innovative funding models for physician involvement in our OHT will be critical, particularly for primary care physicians whose current funding models do not provide the financial resources to be optimally involved in the creation of an OHT. Opening up the FHO remuneration model will facilitate the engagement of more family physicians in the team-based care essential to the PMH model. SEAMO has expressed an interest in participating with FLA-OHT to explore innovative ways that specialists can be involved, and to explore potential alternate funding plans for primary care. Given the focus of OHTs on primary care, it will be important to emphasize efforts to strengthen the whole care team, reducing duplication and administrative hassles to free up capacity. As physician remuneration remains outside of the OHT funding envelope, we will need to be aware of the challenges of navigating care redesign initiatives within existing funding structures.

A strong approach to health human resource planning during health system transformation will be essential to matching resources to needs in the population we serve. We anticipate both challenges and opportunities will arise with increased demand for family and personal caregivers in the face of shortages in key providers such as PSWs. Clear and transparent principles should be articulated for service providers during this transformation. There are concerns among members of the prospective OHT that we will struggle to meet staffing demands due to shortages in trained staff such as PSWs and family physicians, particularly serving our rural areas.

With resources siloed in many organizations, incentives do not promote the implementation of tools and strategies to establish truly coordinated services, creating a lack of common IT tools. There is static capacity in needed resources such as long-term care, despite the ever-increasing demand due to chronic disease, insufficient community resources, and our aging community. With coordinated resource allocation across organizations that can be targeted to community needs, tools such as an integrated health record, organized delivery of home and community services, expanded and interoperable virtual care services, and increased care coordination could be provided and aligned with shared strategic plans and resources. The culture of resource allocation needs to shift to accountably address population needs, and this may present a barrier to the OHT particularly before the maturation of the OHT governance and accountability structure.

Without coordination within the system, a lack of trust within communities for services to always be provided accessibly is perpetuated. There are gaps for timely access to primary care, coordinated home care, costs associated with some services, limited patient choice, independent services for Indigenous Peoples, or services to be offered

in French. There are challenges in human resources that limit capacity to respond to population needs. Through shared planning, resource allocation, and utilizing an improved digital platform, we can improve the capacity of the system to deliver the services that each member of our community needs. Improved coordination and resource allocation can help recruitment and retention of human resources to maintain a robust OHT.

Current contracting rules around home and community care impede efficiency. Our lack of adequate LTC spaces, older population, our rural geography and shortage of PSW's point to the need to strengthen home and community care, which could be a significant challenge within existing contracting rules.

There are many challenges in implementing virtual care including: OHIP billing codes which do not remunerate virtual care in a similar manner to in person care, lack of reliable internet in rural areas, the cost of implementing virtual care for those physicians in private practice who do not have access to ministry funding, the lack of IT support for physicians in private practices outside of team based models, as well as the multitude of virtual care options which in most cases are not interoperable and require workarounds to move data across systems. Improved OHIP billing codes which support virtual care through all PHIPPA compliant platforms, government support for widespread high-speed internet, regulations requiring virtual care vendors to provide interoperability, and funding for IT support, would mitigate some of these concerns.

The established system is rooted in Western beliefs and history which disrupts trust for Indigenous Peoples. This is a national issue with calls to action as outlined in the Truth and Reconciliation Committee report of 2015. Recognizing what we can do together locally, the FLA-OHT with guidance from our Indigenous partner representatives, has emphasized the importance of incorporating Indigenous principles and voices in the organizing, planning, production, and eventual delivery of health system transformation.

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.	

Appendix A. Digital Toolkit in Frontenac, Lennox and Addington

The Digital Roadmap Committee is creating a digital toolbox to enhance patient and provider experience and improve quality. The committee includes representatives from primary care, hospital, community and mental health care, patients and caregivers and the Indigenous Interprofessional Care Team. All data sharing is and will continue to be in accordance with PHIPA and MFIPPA.

Digital health tools will support the goals of the OHT and contribute to improving population health by facilitating care coordination across providers, data utilization for program development and quality improvement, and improved access to care. The following digital health solutions and services are either currently in place or planned for imminent implementation to support equitable healthcare services within our OHT. This activity is currently focused in the rural FLA area of our OHT, which is highly automated and connected across health care sectors and services. As our OHT matures and our regional Health Information System project is implemented, we will realize our digital health vision of *One Patient, One System, One Experience*:

Current digital tools:

- A single health record hosted at LACGH and common set of supportive technologies to make a seamless care experience within primary care offices in rural FLA including the associated allied health practitioners.
- Live video streaming of group classes and meetings.
- Regional, standardized content for waiting room digital signage.
- Local primary care website covering all practices in RFLA.
- E-consult with SEAMO provides rapid access to specialist consults for primary care.
- Home monitoring systems for COPD and other chronic conditions
-

Digital tools under consideration for future implementation

- A common patient portal for rural primary care and LACGH that allows for secure access to appointment booking, messaging, uploading patient generated data, viewing of lab results and sharing information within the patients' circle of care.
- Leverage our regional digital health strategy with the new Health Information System (HIS) in partnership with the six hospitals throughout Southeastern Ontario.
- Expansion of existing tools such as E-consult with support from SEAMO and virtual home monitoring systems for patients with chronic disease.
- Implementation of patient portals and other digital tools across FLA-OHT
- Increase availability and connectivity of IT support for primary care offices and homecare workers to have virtual visits with patients.

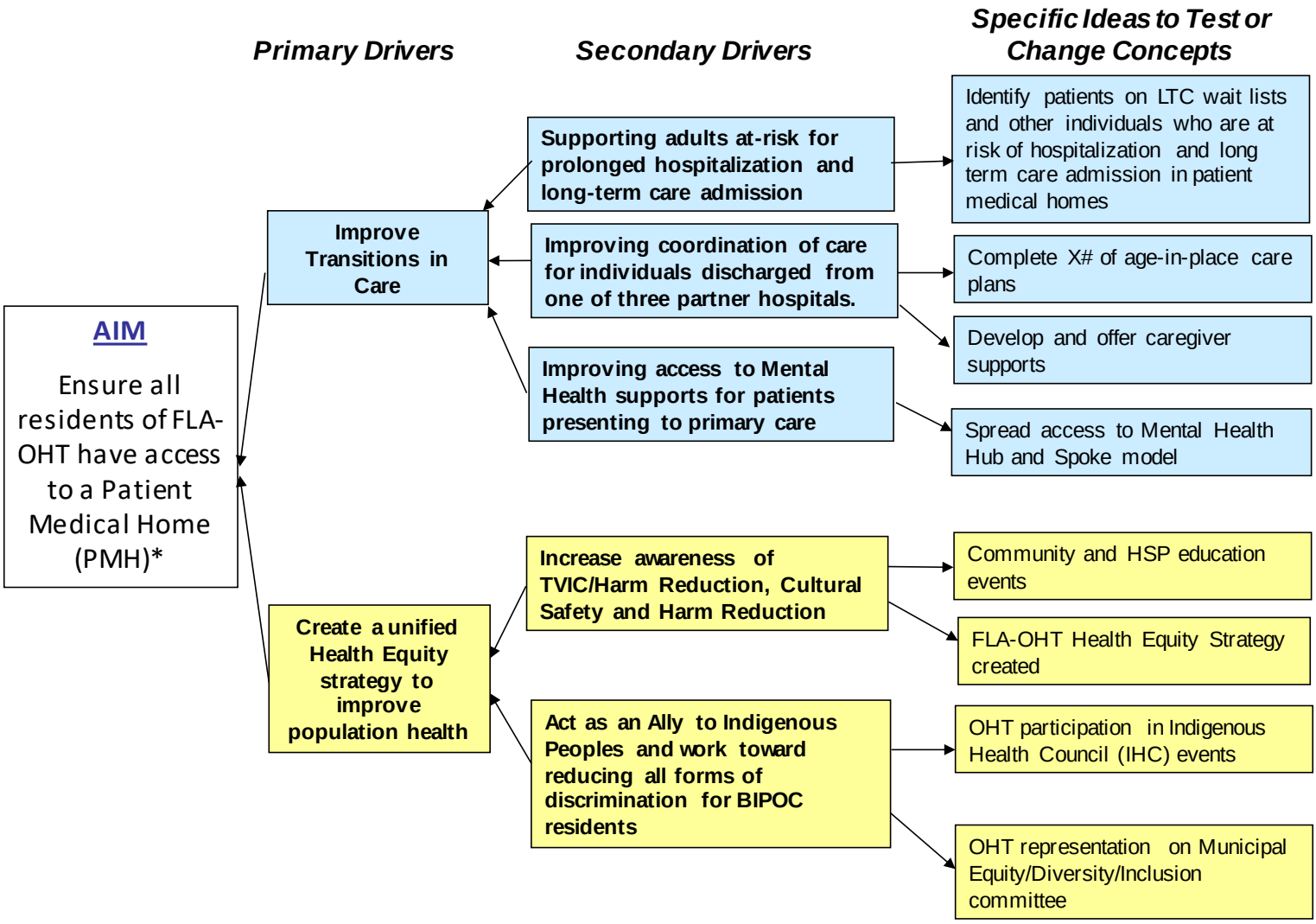
Data sharing and privacy

To ensure patient information is shared securely and digitally across providers within our OHT, the OHT will conform to best practices related to protection of health information for sharing of patient information across providers and all data sharing will be in accordance with Ontario health privacy legislation (PHIPA) and other applicable privacy legislation (MFIPPA). We have been engaged in discussions with regards to privacy agreements and EMR use. We will also conduct and update privacy impact assessments, conduct frequent, unannounced security audits of applications and databases, and ensure compliance with the following principles underlying PHIPA in the context of the FLA-OHT's sharing of health information: accountability, identifying purpose, limiting use, disclosure, retention, accuracy, security safeguards, openness, individual access,

complaint process, challenging compliance. Additionally, we will work with federal, provincial and local health authorities to enhance FLA-OHT data protection practice and tools, conduct training and communicate with OHT members on privacy and confidentiality policies and procedures and use encryption wherever practicable.

Appendix B. Draft 3, 6 and 12-month objectives and draft driver diagram outlining focused project plan

	Month 3	Month 6	Month 12
Population 1	• Identify patients on LTC wait lists and other individuals who are at-risk of hospitalization and LTC admission in patient medical homes • Identify age-in-place teams/home care coordinators in each medical homes • Collect baseline data (qualitative and quantitative data)	• Provide team-based education to PMHs regarding age-in-place resources • Develop centralized digital age-in-place care plan • Develop self-management resources	• Complete X# age-in-place care plans • Develop and offer caregiver supports • Implement care rounds • Collaborate with Public Health to develop an age-in-place campaign
Population 2	• Engage partners to define and describe an effective discharge process • Establish quality improvement process		• All patients discharged from the hospital will have a primary care physician • Primary care providers with shared EMR access or real-time discharge information
Population 3	• All mental health agencies ensure processes and human resources are in place • 20% of entities participating in hub and spoke model	• 60 % of entities participating in hub and spoke model	• 100% of willing entities participating in hub and spoke model



Abbreviations: *PMH* Patient Medical Home; *CSS* Community and Support Services Sector; *HCC* Home and Community Care Sector; *TVIC* Trauma and Violence Informed Care; *IHC* Indigenous Health Council; *FLA-OHT* Frontenac, Lennox and Addington Ontario Health Team

*PMH is a model that prioritizes access to holistic Primary Health Care. It is based on ensuring team-based care through the alignment of allied health, CSS/HCC/MH+A supports, to meet the unique needs of all individuals. PMHs will also include access to Indigenous Health roles.

Appendix C. Abbreviations

ACFOMI Association canadienne-française de l'Ontario Conseil régional des Mille-Îles

AHAC Aboriginal Health Access Centre

ALC Alternate level of care

AMHS Addictions and Mental Health Services

CFB Canadian Forces Base

CHC Community Health Centre

CHEO Children's Hospital of Eastern Ontario

COPD Chronic obstructive pulmonary disorder

CSC Correctional Services Canada

CSS Community Support Services

DND Department of National Defense

EBCD Evidence-based co-design

ED Emergency Department

EMS Emergency Medical Services

FHT Family Health Team

FLA Frontenac, Lennox and Addington

HCC Home and Community Care

HIS Hospital Information System

IHC Indigenous Health Council

IHI Institute for Healthcare Improvement

IIPCT Indigenous Interprofessional Care Team

IT Information technology

KCHC Kingston Community Health Centre

KFL&A Kingston, Frontenac, Lennox and Addington

KHSC Kingston Health Sciences Centre

LGBTQ Lesbian, gay, bisexual, transgender and queer

LTC Long-term care

MBQ Mohawks of the Bay of Quinte

MOH Ministry of Health

OHT Ontario Health Team

PC Providence Care

PHIPPA Personal Health Information Protection Act

PMH Patient Medical Home

PMN Patient Medical Neighbourhood

PPE Personal protective equipment

PSW Personal Support Worker

PTSD Post-traumatic stress disorder

SEAMO Southeastern Ontario Academic Medical Organization

SE LHIN South East Local Health Integration Network

TOH The Ottawa Hospital

Appendix D. FLA-OHT Steering Committee Membership

Co-leads:

Kim Morrison, Chief of Staff, Lennox & Addington County General Hospital, FLA-OHT Co-lead
David Pichora, President and CEO, Kingston Health Sciences Centre, FLA-OHT Co-lead

Membership:

- **Mike Bell**, CEO, Kingston Community Health Centres
- **Wayne Coveyduck**, President & CEO, Lennox & Addington County General Hospital
- **Mary Kate Gazendam**, Loyalist Family Health Team
- **Michael Green**, Queen's Family Health Team, Queen's University, ICES
- **Laurel Hoard**, Director, Sub-Region Planning and Integration, Ontario Health East
- **Elaine Ma**, Frontenac Doctors
- **Theresa MacBeth**, Director Strategy & Communications, Kingston Health Sciences Centre
- **Cynthia Martineau**, Vice President, Strategy, Planning & Integration, Interim Vice-President, Home & Community Care, SE LHIN
- **Don McGuinness**, Senior Manager Decision Support, SE LHIN
- **Kieran Moore**, Medical Officer of Health, Kingston, Frontenac, Lennox & Addington Public Health
- **Jane Philpott**, Dean, Queen's University Faculty of Health Sciences, CEO Southeastern Ontario Academic Medical Organization
- **Chris Simpson**, Vice Dean, Queen's University Faculty of Health Sciences
- **Kerry Stewart**, Patient Experience Advisor
- **Richard Stillwell**, Patient Experience Advisor
- **Bruce Swan**, Supervisor, Addictions & Mental Health Services Kingston Frontenac, Lennox & Addington
- **Cathy Szabo**, President & CEO, Providence Care
- **David Townsend**, Executive Director, Southern Frontenac Community Services Corporation
- **David Walker**, Queen's University, Kingston Health Sciences Centre

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

September 14, 2020

Dr. David Pichora
76 Stuart Street
Kingston, Ontario K7L 2V7

Re: Frontenac, Lennox and Addington Ontario Health Team Partnership

Dear Dr. Pichora:

On behalf of the Canadian Frailty Network (CFN) I would like to express my enthusiastic support as an active partner with the Frontenac, Lennox and Addington Ontario Health Team (FLA-OHT).

There is an ongoing need to build a connected health care system centred around patients, families, and caregivers, and to strengthen local services in the FLA region. As such, CFN supports your application to establish an OHT that will facilitate a new way of organizing and delivering care that is more connected to patients in their local communities.

CFN is a pan-Canadian not-for-profit organization located at Queen's University. We are focused on improving care for older Canadians living with frailty. As you know, frailty is an over-arching health condition of reduced function and health in older people. It often accompanies chronic illness, but not always. Older people living with frailty are more susceptible to serious illnesses from minor health threats like the flu or a fall, and they are more likely to be hospitalized and require need long-term care. Our mission is to improve the health and social care of the 1.5 million older adults living with frailty and to support the 3.75 million family/friend caregivers supporting them. We do this by increasing frailty recognition and assessment, by proving evidence for decision making, by moving evidence into policy and practice, by training the next generation to care for this vulnerable population and by advocating for change in health and social care systems to ensure that the needs of this vulnerable population are met.

The FLA-OHT Year 1 priority population "Adults at-risk for prolonged hospitalization and long-term care admission" is clearly aligned with our work and priority activities in primary, long-term and community care settings. In Canada, 97% of those who died from COVID-19 were over age 60, many over age 80 and most living with frailty in long-term care. Although frailty prevalence increases with advancing age, frailty is **not** an inevitable consequence of aging. Readily available and implementable interventions are available for its prevention and mitigation. These interventions are encompassed in The Canadian Frailty Network's (CFN) **AVOID Frailty-Take Control** public health initiative: **A**ctivity, **V**accination, **O**ptimization of medications, **I**nteract and Socialize, and **D**iet and Nutrition in older adults. AVOID Frailty is a public health, community-based strategy that helps reorient care services towards a more person-centred and coordinated model of care. Evidence shows that the components of AVOID Frailty can prevent or reduce the severity of frailty decreasing healthcare utilization, institutionalization, loss of independence and death.

CFN is currently establishing a pan-Canadian learning health system to rapidly study new health and care innovations based on our AVOID Frailty strategy, through the creation of regional implementation centres. The initial centre for these regional hubs will be based in Kingston ON, where we will investigate real-world implementation of behaviour change strategies for older adults centered around the adoption of CFN's bilingual AVOID Frailty / ÉVITER la Fragilization framework.

One in four older adults in Canada between the ages of 65-84 years is medically frail, and by age 85 that increases to 1 in 2. However, the prevalence of frailty is even more dire for First Nations communities. Approximately 50 per cent of First Nations People over 65 years of age are living with frailty. This is double the national average. As such, CFN is working with First Nations communities in British Columbia, Manitoba and Northern Ontario, to fund co-designed knowledge translation projects aimed at improving the health and wellness of Indigenous people living with frailty and to help keep Elders in their communities as they age.

CFN believes that the development of meaningful and effective clinical practice change takes many years as shown by our ongoing commitment to our Advancing Frailty Care in the Community Collaborative with Canadian Foundation for Healthcare Improvement. As such, CFN has funded important frailty care initiatives and we are committed to supporting the behaviour change intitiavies required to ensure meaningful change and adoption. Those who live with severe frailty require the greatest amount of care and, as a result, consume a disproportionate amount of care resources. It will be our honour to work with Kingston Health Sciences Centre in the implementation of the new Ontario Health Team to reform health care with a commitment to reducing the severity of frailty and chronic illnesses in our community and across the province with a goal of improving the lives of all Canadians as we age.

The Canadian Frailty Network looks forward to participating in this important collaboration with the FLA-OHT. We hope our strong alignment and interest as a partner, reflects positively on your application to become an Ontario Health Team.

Kind regards,

John Muscedere, MD, FRCPC, CFN Scientific Director and Chief Executive Officer
Carol Barrie, BComm, CPA, CA, CFN Executive Director and Chief Operating Officer
Russell Williams, CFN Board Chair, and VP Mission, Diabetes Canada.

Queen's University
99 University Ave
Kingston, ON, K7L 3N6

September 15, 2020

Theresa MacBeth
Director, Strategy Management & Communications
Kingston Health Sciences Centre
76 Stuart Street, Kingston, Ontario K7L 2V7

Subject: Frontenac, Lennox, and Addington Ontario Health Team (FLA-OHT) Application

Dear Mrs. Theresa MacBeth;

The Centre for Advanced Computing at Queen's University (CAC) is pleased to partner with the Kingston Health Sciences Centre and other community partners on creation of the Frontenac, Lennox, and Addington Ontario Health Team (FLA-OHT).

The promotion and advancement of analytics and data-driven outcomes to positively impact our communities are key to CAC. We collaborate with our partners to ensure the privacy and trust of our stakeholders, including patients and participants from vulnerable populations in Indigenous and LGBTQ2+ communities. CAC currently hosts and works with a range of regional and provincial health entities (Institute of Clinical Evaluative Sciences, University of Ottawa Health Institute, Sick Kids, Kingston Health Sciences Centre), provincially-funded or supported not-for-profit centres (Ontario Health Data Platform, Ontario Brain Institute, Tsi Tyónnheht Onkwawénna, University of Toronto Practice-Based Research Network), and national health research entities (Diabetes Action Canada, Canadian Lyme Disease Research Network, Canadian Primary Care Sentinel Surveillance Network).

In collaboration with the FLA-OHT primary care and other community partners, we will provision and enhance digitally enabled care in our region to meet our current and post-COVID-19 environment. Staff development and education will be critical to drive change, including digital literacy, analytics, security, and privacy training. In addition to our existing workshops and certificate programs, CAC will build tailored materials for the FLA-OHT to reinforce practical experiential learning.

We look forward to this partnership, enhancing the continuum of care, and positively impacting our communities. If you have any questions, please feel free to contact me.

Sincerely,

Chris MacPhee
Director, Operations and Partnerships
Centre for Advanced Computing
Queen's University

Human Mobility Research Centre

Queen's University

K H S C

Kingston General Hospital
Kingston, Ontario K7L 2V7

T: (613) 548-2430
F: (613) 549-2529

September 16, 2020

Theresa MacBeth
Director, Strategy Management & Communications
Kingston Health Sciences Centre
76 Stuart Street, Kingston, Ontario K7L 2V7

Subject: Frontenac, Lennox, and Addington Ontario Health Team (FLA-OHT) Application

Dear Mrs. Theresa MacBeth;

The Human Mobility Research Centre at Queen's University (HMRC) is pleased to partner with the Kingston Health Sciences Centre (KHSC) and other community partners on the creation of the Frontenac, Lennox, and Addington Ontario Health Team (FLA-OHT).

The HMRC is a partnership between Queen's University and KHSC and serves as a point of collaboration between health sciences, computer science, engineering, physical sciences, and humanities. The mission and focus of the centre are currently being expanded under my new leadership with significant emphasis on artificial intelligence approaches for the analysis of health data. Specifically, HMRC is strategically aligned with the ministry's overarching goal to provide better patient and population health outcomes outlined in the Digital Health Playbook. This is evidenced by our partnership with the Ontario Health Data Platform (housed in part at Queen's) as well as our commitment to training high-quality personnel through a proposed NSERC CREATE program led by our group (PI: Mousavi), among other initiatives. Queen's has aggressively recruited faculty in the space of artificial intelligence, biomedical computing, and health data in recent years, strategically positioning the HMRC to support digital health activities undertaken as part of FLA-OHT. Taken together, these demonstrate our commitment and resolve to develop digital health resources for the province and to train personnel for future careers in digital health.

Building on nearly 40 years of research excellence, HMRC facilitates interdisciplinary interactions of over forty-eight participating faculty members and more than eighty graduate students. Our centre boasts over 20,000 square feet of translational research space in KHSC. In partnership with the FLA-OHT, we will provide access to space, access to digital health infrastructure, access to digital health specialists (staff and faculty), as well integrated digital health training programs to augment current training opportunities in the Queen's ecosystem.

We look forward to this partnership and impacting patient care.

Sincerely,

Amber Simpson, PhD
Director, Human Mobility Research Centre
Canada Research Chair in Biomedical Computing and Informatics
Associate Professor
Queen's University - Kingston Health Sciences Centre