Friday December 18, 2020

Dear Deputy Premier and Minister Elliot,

RE: Elgin Ontario Health Team Full Application

We are pleased to submit our full application to become an Ontario Health Team.

The Elgin OHT partners are well positioned to provide a full continuum of services to our population at maturity. Our partners represent acute care, primary care, home and community care, long-term care, community support services, mental health and addictions, palliative care, and public health providers who serve our population within the geography of Elgin County and beyond. The Elgin partners will continue to engage with health and human service provider organizations to expand the integrated care offerings to our attributed population.

Our partners have a strong history of working together to provide care for our community and have been working collaboratively for the past 18 months through multiple committees focused on the development of the OHT, its guiding principles and values to drive the OHT development, as well as shared branding, a website and logo. In this work we have actively engaged patients, families, caregivers, staff, physicians, the Mennonite community, and other partners to develop a shared vision for the OHT to meet the needs of the communities we serve.

Our Year 1 target population will be focused on patients with respiratory health concerns, particularly Chronic Obstructive Pulmonary Disease (COPD), aged 65 years and older, as this population represents a significant burden of disease and demonstrates poorer outcomes within our attributed population. The Elgin OHT is well positioned to provide effective supports to this population and develop a sustainable model that can be scaled and spread effectively across our full attributed population.

We look forward to transforming healthcare in the Elgin region and beyond, for our patients, families and caregivers, providers, and community members.

Sincerely,

Judith Wiley,
CEO, Central Community Health Centre
On behalf of the Elgin OHT Partners

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: Judith Wiley
	Title: Chief Executive Officer
	Organization: Central Community Health Centre
	Email: jwiley@centralchc.com
	Phone: 519-633-6930 ext. 403
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Judith Wiley
	Title: Chief Executive Officer
	Organization: Central Community Health Centre
	Email: jwiley@centralchc.com
	Phone: 519-633-6930 ext. 403

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

Based on the modelling information provided by the Ministry, the attributed population of Elgin OHT includes 69,118 individuals, with most residing within Elgin County, in St. Thomas (29,800), Central Elgin (8,547), Malahide (5,549), and Aylmer (5,526). About 15% of the attributed population live in communities outside Elgin County, including in London, Middlesex, and Oxford. This geography aligns with utilization patterns in Elgin identified in the Ministry's attribution model.

Based on Ministry population data and Statistics Canada's 2016 Census of the Population, Elgin's population characteristics vary slightly from Ontario. Residents of Elgin tend to be older than in the rest of Ontario. Elgin's population has an average age of 42.3 years, compared with 41.0 provincially. The age cohort over 65 represent about 20.9% of the population compared with 17.6% provincially, and this age cohort is expected to increase by 60% by 2031.

Elgin has a lower percentage of their population with no knowledge of English (0.7% versus 2.5% in Ontario), and has a smaller Francophone population (1.1% in Elgin vs. 4.3%). About 3.5% of Elgin OHT's population is Low-German speaking, compared with 0.3% for Ontario. Elgin also has fewer individuals self-identifying as Indigenous compared to Ontario (2.3% vs. 2.8%), and a lower portion of visible minorities or recent immigrants in Elgin compared to Ontario (3.0% vs. 29.3%). While there is higher percentage of the population with no high school education compared to Ontario (17% vs. 10.4%), fewer people live with low income in Elgin compared to Ontario (5.7% vs. 9.8%).

The greatest driver of healthcare costs for Elgin's attributed population is acute palliative care ($18,731,576), of which most costs are incurred through inpatient hospital care ($7,085,078), long-term care ($3,994,167), and home care ($1,872,287). The second greatest cost contributor is respiratory failure with and without heart failure, which combined account for $9,230,111 of population expenses. This is incurred predominantly through inpatient hospital care ($5,388,716), home care ($1,211,622), and specialist fees ($760,166). Other significant cost drivers are heart failure with coronary artery disease/arrythmia and significant co-morbidities, acute myocardial infarction with heart failure and co-morbidities, and dementia

with co-morbidities.

The OHT partners are well positioned to provide a full and coordinated continuum of services to our population at maturity. Our partners represent acute care, primary care, home and community care, long-term care, community support services, mental health and addictions, palliative care, and public health providers that serve our population within the geography of Elgin County and beyond. Elgin partners will continue to engage with health and human service provider organizations to expand the integrated care offerings to our attributed population. Elgin OHT is also well-positioned to build upon its strong primary care attachment rates and other health and social care system entry points to provide its population with seamless, person-centric care that encompasses physical, mental, and social needs.

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

Year 1 Population Target: Patients with respiratory health concerns (particularly Chronic Obstructive Pulmonary Disease - COPD) aged 65 years and older.

The Year 1 target population for Elgin OHT will be people who are 65 years and older with COPD or other respiratory health issues. Based on data from Statistics Canada's 2015-2016 Community Health Survey, the estimated prevalence of COPD in Elgin County is 7.7%, meaning that approximately 5,322 patients in Elgin County are living with diagnosed or undiagnosed COPD. Elgin OHT partners identified this target population as it represents a significant burden of disease and demonstrates comparatively poorer outcomes within our attributed population:

- The prevalence of COPD in the population is 7.7% compared to 4.1% for Ontario[1].
- The rate of hospitalization due to COPD was higher in Elgin County compared to Ontario, at a rate of 312.5 per 100,000 people compared with Ontario's rate of 171.8 per 100,000 (data from 2016)[2].
- The mortality rate due to COPD was higher in Elgin St. Thomas than in Ontario overall. In 2016, the mortality rate due to COPD in Elgin St. Thomas was 44.1 per 100,000, significantly greater than Ontario's average 26.6 per 100,000[2].

- 18.1% of Elgin County population is 65 years of age or older, whereas 16.7% of Ontario residents fall into the same age category[3]. Further, in within a time frame of the next 15 years (from 2016 to 2031), the growth in the 65+ age cohort is projected to be 60%[4].
- More residents of Elgin St. Thomas have poor health behaviours such as higher prevalence of smoking (18.5%) and rate of obesity (36.5%) in 2016 compared with Ontario's rates of 16.7% and 26.2%, respectively[1].
- The current care for patients with respiratory health issues contributes significantly to the overall costs of care in the region, representing the second greatest cost contributor at $9,230,111 annually[5].

The Elgin OHT partners are well positioned to address these issues by expanding and scaling existing integrated programs and services serving our attributed population, such as the PREVENT program which provides coordinated care planning upon hospital discharge for patients admitted for respiratory conditions, and Best Care, a provincial program based in primary care focused on prevention and management of COPD. By focusing on the respiratory health of patients over 65 in Year 1, Elgin OHT can both provide different and effective supports to this population and develop a sustainable model through a smaller sub-population with greater needs that can be scaled and spread effectively across the full population, incorporating lessons learned.

Sources:

1. Statistics Canada, Canadian Community Health Survey, 2015 – 2016.
2. Elgin St. Thomas Public Health Status Report, 2015.
3. Statistics Canada. 2016. 2016 Census of the Population.
4. Ministry of Finance, Spring 2018 Release.
5. Ministry of Health Data Package, Network 1 Expenses by Care Type HPG.

[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.

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

Elgin's population includes vulnerable groups who traditionally have experienced barriers of access to care. These groups include:

1. **A large Low-German speaking population.** 3.5% of Elgin OHT's population is Low-German speaking, compared with 0.3% of Ontario's population overall[1]. This population experiences barriers to care for multiple reasons.
    a. **Language barriers**. Many members of the Low-German population are not fully fluent in English, challenging the ability of care providers to serve the population. Although translation services are available in the region, provided by Mennonite Community Services and through some health care providers who speak Low-German, many members of the Low-German speaking population rely on family members as interpreters, which is not always effective as certain topics (such as sexual health) may be difficult to talk about with family, and family members may not be fluent in English themselves. Further, Low-German is a spoken-only language, which inhibits this population from benefitting from written instructions, reminders, or supportive materials.
    b. **Cultural sensitivity of care approaches.** The Low-German population often has specific cultural considerations that should be treated with sensitivity. In particular, end-of-life care, mental health, gender roles and norms, and sexual health practices are all influenced by cultural norms. Often, traditional medical care may not be culturally sensitive to the views and norms of Mennonite and Amish communities, and poor experiences and biases create barriers to access for this population.
    c. **Poor health literacy**. Many members of the Low-German population are not health literate, and do not take part in certain health promoting behaviours. It is common for members of the population to have poor diets, not take part in physical exercise, and have a poor understanding of chronic disease.
    d. **Lack of access to technology.** Many members of this population do not use

or do not have access to the internet or telephone. Members of the population may share telephones between households. This challenges the ability of this population to receive care virtually, a particular challenge under COVID-19.

2. **Communities with more First Nations**. There is a greater population of individuals self-identifying as Indigenous in West Elgin (3.5%).[1] Barriers for this population include:
    a. **Historical racism and ongoing unconscious bias**. The significant history in Canada and specifically Elgin, of racism and subjugation of First Nations, and ongoing racism, unconscious bias, and prejudice challenges the access of this population to care, contributing to poorer health status and outcomes for this population. In Elgin there was a residential school that closed in 1946, only 74 years ago, during the lifetime of our target population.
    b. **Three First Nations are neighbours of Elgin County on the Northern border**. They, along with the Southwest Ontario Aboriginal Health Access Centre are working toward 'Indigenous Health in Indigenous hands', a principle supported by the Elgin OHT.
3. **Self-injury and suicidality.** There is a greater rate of suicide, self harm, and self injury in St. Thomas, Elgin, and surrounding regions (3.5%) than the province overall (0.3%)[2].
    a. **Sensitivity of care providers to mental health challenges.** Many members of this group experience insensitivity when accessing supports. This insensitivity, and poor experiences over a patient's history, challenge their ability to access the care and supports that they need.
    b. **Availability of services**. There is a lack of sufficient mental health services in the region to be able to adequately support the population in a timely manner. Many mental health services have significant wait times due to a disproportionate ratio between the volume of people accessing services and capacity of the services available.
4. **Poorer level of education**. 17.0% of Elgin's population between the ages of 25 and 64 have not completed high school, compared with 10.4% of Ontario's population overall[1].
    a. **Literacy challenges**. Members of the population with low literacy may experience communication challenges with their providers, and may not benefit from supportive resources to help manage their health.
5. **Populations living in rural areas**. Many members of the Elgin OHT population live in rural areas with limited access to connectivity infrastructure. This population experiences barriers due to:
    a. **Travel to receive care**. Populations living in rural areas must travel greater distances to access care, increasing the time required to receive care and the cost incurred in travelling to receive care. Those without access to transportation in particular experience barriers in arranging transport to receive care.
    b. **Connectivity and infrastructure challenges.** Many individuals in rural areas of the region do not have sufficient infrastructure and connectivity to access virtual care, increasing the barrier in accessing care particularly given COVID-19.
6. **Those without health cards.** Elgin region has a relatively large proportion of migrant workers, of Old Order Amish and Mennonite, and other individuals who either choose not to access or do not have access to health cards. This can cause challenges when this population requires care, particularly for the subset of this population who have no government-issued identification.

7. **Francophone Population.** Elgin County has a small Francophone population. As few providers offer services in French, patients may be directed to London or other locations to obtain French language services.
8. **Differences between practices to access team-based care.** There are equity issues between practices who do not have access to team-based care (i.e., FHO and solo practices compared with FHTs and CHCs).

Elgin OHT anticipates building on existing initiatives targeted at vulnerable populations such as their Outreach Services that provide care to Elgin's most vulnerable populations. This includes mobile teams of nurses and physicians from community health centres which visit rural and Mennonite populations, leveraging paramedic teams to provide mobile COVID-19 testing clinic in vulnerable communities, and providing at-home follow-up services post discharge from hospital for vulnerable and immobile patients.

Sources:

1. Statistics Canada. 2016 Census of the Population.
2. St. Thomas Elgin Environmental Scan, September 2018

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.

[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.

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

The OHT partners have been working collaboratively for the past 18 months through multiple committees focused on the development of the Elgin OHT. The partners have collaborated to develop a shared vision for the OHT, guiding principles and values to drive the OHT development, along with shared branding, website, and logo (www.elginoht.ca). The application process was guided by the Steering Committee and five Sub-Committees and is supported by a smaller Coordinating Council responsible for planning and coordinating activities.

Long-standing cross-sector integration examples:

- **PREVENT Program:** Hospital-based program utilizing a coordinated planning approach of facilitation and communication among hospital, primary care and home care providers to improve continuity of care for patients with CHF and COPD, and to reduce hospital readmissions and ED visits. The program provides follow up to patients with COPD post hospital discharge by an outreach coordinator who coordinates and refers patients to appropriate services in the community.
- **Best Care:** Best Care is a comprehensive chronic disease management program embedded in the primary care practice. Best Care is a complete guideline knowledge translation module that utilizes team care with a Care Coordinator/Certified Respiratory Educator and a provider to deliver evidence-based care including standardized high-impact best practice. Best Care addresses all elements of Quintuple Aim including an interdisciplinary care model, an electronic care delivery and evaluation system. This program can bring a respiratory therapist to practices that may not have access otherwise and collect data about the COPD population across our geography, regardless of primary care model.
- **Palliative Care Outreach Team:** An interdisciplinary group of providers who deliver palliative care to patients, which is led by South West LHIN and delivered by a collaborative team of community-based physicians, LHIN Care Coordinators, Nurse Practitioners, Nurses, Personal Support Workers, and other providers. This team provides 24/7 coverage for palliative patients, including members of the target population who are in the palliative stage of their disease. The team has been successful in increasing the capacity of primary care providers to provide palliative care and acts as a consultative service to those may need advice from a more experienced provider. The team has also offered LEAP and Serious Illness Conversation training to help providers integrate advance care planning into their care
- **Elgin Hospice and Palliative Care Collaborative:** Supported by the LHIN, the Elgin Hospice and Palliative Care Collaborative is a regional group supporting the delivery of person-centred, interdisciplinary palliative care, based on the direction of the Ontario Palliative Care Network. Members include representatives across palliatives services in hospital, home care, community, and hospice to advance the goals of the palliative care network to fill system level gaps and make improvements in the local system. Recent initiatives include an extensive inventory and mapping of palliative care services in the region, to allow for gaps to be identified and addressed.
- **Central Intake for Community Support Services:** Led by VON in collaboration with community support services in Elgin which provides a central intake process which then links patients with the appropriate services in the community, which is looking to connect more directly with primary care through e-referral.
- **Situation Table:** Collaboration between sectors to identify and connect high-risk patients to resources and supports in the community.
- **LHIN Care Coordinators in Primary Care:** LHIN Care Coordinators are aligned and embedded in primary care practices, conducting monthly case reviews with primary care providers for their patients receiving home care.
- **Transitions Working Group:** Working group with the hospital and long-term care to improve transitions by developing SOPs, forms, and other tools to support smooth transitions and improve communication between long-term care and hospital.
- **Behavioural Support Outreach Team:** Hospital team supporting patients and long-term care facilities throughout the transition from hospital to long-term care, managing responsive behaviours, ensuring smooth transitions, and reducing emergency department utilization.
- **Elgin Mental Health and Addictions Network**: Collaborative initiative to improve

transitions for patients accessing mental health services. Includes hospital-based addictions transition coordinator to facilitate warm transitions to community care. The table includes hospital, primary care, community mental health agencies for adults and children, community addiction services, tertiary mental health services.

- **Child and Youth Mental Health Referral Pathways**: Elgin and Oxford's Lead Agency, Wellkin, is participating in a referral pathways project with primary care as a pilot site with local pediatricians and family physicians and the ED.
- **The Elgin Primary Care Alliance: I**ncludes family physicians (regardless of practice model), nurse practitioners, FHT and CHC administration, pharmacists, and pediatricians to meet regularly to address issues impacting patients and providers.
- **The St. Thomas Elgin Health Recruitment Partnership:** This partnership City and Municipal, hospital, and community-based partners to actively recruit primary care physicians to Elgin. It has created a culture of succession planning for retiring physicians and ensures new physicians are oriented, supported by the Partnering for Quality Program/HFO to ensure high levels of primary care attachment, recruitment, and retention.

Below are examples of collaborative initiatives that are more recent and related to COVID-19 response:

- Emergency Management Operations Committee (EOC): Community response team initiated during COVID-19 to plan and respond to issues around supply chain of medical supplies including PPE, vaccine distribution, COVID-19 testing, resource issues, issues impacting schools, businesses, and providers. The EOC includes many OHT Partners (EMS, Hospital, LHIN, Primary Care, Home Care, Long-Term Care, Public Health, etc.).
- Formation of multiple working groups and tables throughout the community to address population needs and supports in relation to COVID-19, including the Elgin Triad (includes hospital, primary care, public health, long-term care, and support from Ontario Health West).
- ARCHES has eased the ALC crisis which was exacerbated by loss of long-term care ward rooms in Elgin. 10 transitional care beds were created in retirement home space to accept patients from hospital or crisis patients from the community while they await long-term care beds.

Elgin OHT will build upon the strong foundation of collaborative initiatives across the region, providing a platform for all partners to plan and coordinate initiatives, and ensuring that effective programs, services, and models can be spread and scaled to reach all Year 1 patients, and population at maturity.

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

The response to COVID-19 in Elgin has included both intra-organizational and extra-organizational effort to support the delivery of care to the patients, families, and caregivers of Elgin region.

There has been a large shift to provide virtual care services to patients to maintain access to care. With limited access to in-person care, almost all Elgin OHT partners shifted to provide virtual care services by phone, Zoom, OTN or other virtual care tools to meet the needs of their patients. Virtual care initiatives include:

- Leveraging remote monitoring to support patients in their homes. South West LHIN manages a telehealth program which allows patients to receive home monitoring kits to manage chronic conditions such as COPD and CHF. This program could be expanded to other chronic conditions or patient populations. All the partners will continue to provide these services to their patients into the future.
- A remote patient monitoring program for COVID-19 positive patients has been activated, providing remote monitoring for patients in their homes with mild to moderate cases of COVID-19, reducing the need for in-person contact and minimizing risk for both patients and families, and providers.

There was discussion among the partners that these initiatives directly contribute to the work of the OHT, and there is a strong desire to broaden in terms of scope and improve processes and experiences for both patients and providers.

In addition to virtual care services that were introduced due to the pandemic, many new services were introduced in the community:

- A COVID-19 assessment centre which was rapidly established in the region through the collaboration of the St. Thomas Elgin General Hospital and public health
- Additional COVID-19 testing for residents in Elgin provided collaboratively by Southwestern Public Health and Central Community Health Centre, including mobile testing in rural regions in West Elgin. Emergency Medical Services also provided mobile testing in long-term care homes and on farms/in rural areas.
- Trauma Support Line provided by Canadian Mental Health Association (CMHA) and West Elgin Community Health Centre to provide trauma response to support clients in relation to stress or anxiety around COVID-19
- Holly's House was implemented by Addiction Services Thames Valley in partnership with CMHA, My Sisters Place, City of London, and others. The program has 13 rooms at the Holiday Inn in St. Thomas for women experiencing homelessness and/or at risk of domestic violence with low to moderate health or addictions concerns. The program has been developed with the goal of being able to be sustained and scaled to provide

additional services beyond COVID-19.
- CMHA partnered with West Elgin Community Health Centre to support people living in a Seniors' residence in West Elgin who were traumatized by the impact of COVID-19 on fellow residents in wave 1

Beyond individual initiatives, the COVID-19 pandemic fostered the development and strengthening of many relationships across organizations, and across sectors. This increased mutual understanding, coordination, and communication will be carried forward into the Elgin OHT, where partners anticipate working collaboratively to deliver improved care and experience in the region.

4.0. How will you transform care?

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

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

- Number of people in hallway health care beds
- Percentage of Ontarians who had a virtual health care encounter in the last 12 months
- Percentage of Ontarians who digitally accessed their health information in the last 12 months
- 30-day inpatient readmission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions
- Patient reported experience and outcome measures and provider experience measures (under development)
- ED physician initial assessment
- Median time to long-term care placement
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready
- Caregiver distress
- Time to inpatient bed
- 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

With reduced access to in-person care, most Elgin OHT partners shifted to provide access virtually, and will continue to provide virtual services into the future.

- Phone Calls – Many providers use phone calls to provide care, particularly for patients with limited access to internet or computers.
- Video Conference Solutions – Primary Care, Community Support Services, Mental Health and Addictions, Acute Care and Long-Term Care implemented video conferencing solutions such as OTN, Zoom, etc.
- Remote Patient Monitoring Tools – Some providers leveraged remote monitoring tools to help monitor patients in their own home, particularly those with chronic conditions.

Specific strategies or initiatives to provide and improve access in Elgin include:

- Virtual Care program in shelters – On-call coverage and availability of virtual visits to individuals in shelters, partnering with the City of St. Thomas and the local homeless shelter.
- Dedicated Low-German Speaking System Navigator – Recommendation to improve access and reduce hesitancy accessing healthcare services and to build trust between the patients and providers. A partnership between SWPH and Mennonite Community Services ensured Low-German public health messages were disseminated via De Brig Radio Station.
- Leveraging recommendations from the South West Frail Strategy – Many members of the population may lack access due to the shift to virtual care, due to discomfort with technology, lack of access due to financial or infrastructure reasons, or other causes. The South West Frail Strategy provides recommendations for senior friendly virtual care, including creating a virtual care environment suitable for older adults with frailty.[1]
- The Southwest Self-Management program in the SWLHIN offered public workshops for patients living a healthy life during COVID-19.

The partners discussed strategies to improve secure information sharing which are aligned and consistent with the directions outlined in the Ministry's Digital Health Playbook, across the partners and with patients.

Opportunities to improve information sharing between the following sectors and with patients:
Primary Care and Other Sectors:

- Primary Care, Long-Term Care and the Hospital – All long-term care partners in Elgin use PointClickCare. Connecting to ClinicalConnect will improve information sharing.
- Primary Care and Community Support Services – Different reporting requirements complicate information sharing. There is work underway to get VON on eReferral to allow for centralized eReferral pathways. There is an opportunity to expand this to integrate Community Support Services and Home and Community Care to refer directly to one another.
- Primary Care and Home and Community Care – Many providers do not have access to CHRIS and HPG which would be helpful to access shared care coordination plans for patients. A CHRIS-Ocean integration will be available to other LHINs in the new year which could better integrated home and community care and primary care to improve information sharing.

The Hospital and the Community

- Extending the uptake of Clinical Connect across Community Support Services partners, Primary Care, Adult and Child Community Mental Health, Long-Term Care, Emergency Medical Services

Patient access to health information

- Leveraging MyChart and Pocket Health to expand access to patients own health information.

Sources

1. Recommendations for Senior Friendly Virtual Care, Regional Geriatric Program of Toronto

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: Naresh Singh
	Title: Chief Information Officer
	Organization: St. Thomas General Hospital
	Email: naresh.sing@stegh.on.ca
	Phone: 519-200-5791

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?

[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.

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

About 2.3% of Elgin County's overall population self-identifies as Indigenous, although this proportion is higher in West Elgin where just under 4% of the population self-identifies as Indigenous. Indigenous people in Elgin County largely live off-reserve in both urban and rural communities, with about 53% of individuals identifying as Indigenous living in the City of St. Thomas. The Indigenous population in Elgin County is younger, with children and youth accounting for almost 40% of the population and older adults age 65 and over accounting for just 6.3% of the population.[1]

There are three First Nations communities near the Elgin County border in neighboring Middlesex County, including the Oneida Nation of the Thames, the Munsee-Delaware Nation and the Chippewas of the Thames First Nation. Members of these communities access health and human services within the Elgin network, as do Indigenous peoples living in urban and rural communities in Elgin Country.

The Elgin OHT partners recognize the importance of culturally safe health care and service for Indigenous peoples, and the importance of meaningful engagement with First Nations communities. The London District Chief's Council (LDCC) has recently released the First Nation Health Policy for Health Care Providers, which guides OHTs in engaging meaningfully and appropriately with First Nations. Elgin OHT partners recognize that different First Nations may have different preferred approaches to engagement and are committed to building the required relationships to support effective consultation and collaboration. The OHT Partners are reviewing the First Nation Health Policy to guide their approach to building stronger relationships with First Nation communities and recognizes that this is a longer-term process that must be built on learning and trust. The Elgin OHT supports the principle of Indigenous Health in Indigenous Hands.

The Southwest Ontario Aboriginal Health Access Centre (SOAHAC) is a member of the Elgin OHT Steering Committee. SOAHAC provides wholistic health and wellness services by sharing and promoting traditional Indigenous and western health practices. Services are provided to Indigenous people and their families, living on and off-reserve, in rural areas, and the urban Indigenous communities in London, Windsor and Owen Sound, as well as the First Nation communities near the Elgin County borders. As a Steering Committee member, SOAHAC provides guidance on Indigenous health issues and priorities, as well as ongoing advice on developing engagement strategies with First Nations communities.
Elgin OHT partners are active supporters of Indigenous Cultural Safety and staff members across our OHT organizations have completed or are planning to complete the Indigenous Cultural Safety (ICS) training. The Indigenous Cultural Safety program focuses on supporting

Indigenous Health transformation through fostering a climate where the unique history of Indigenous peoples are recognized and respected in order to provide appropriate care and services in an equitable and safe way, without discrimination. All OHT partner organization will be encouraged to continue to engage all staff, physicians and Boards in the Indigenous Cultural Safety training offered via the Ontario Health West.

Sources:

1. Aylmer Elgin St. Thomas Community Safety Plan Data Package, July 2020

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

Approximately 1.1% of individuals living in Elgin County report French as a first language, although the proportion of individuals reporting French as a first language is slightly higher (1.9%) in West Elgin.[1] Although the impact of linguistic minority status on Francophones' state of health in Ontario is not well documented, studies indicate that language and cultural barriers make it more difficult to access health services, and impede on effective diagnosis, treatment and compliance leading to poorer outcomes for patients and increased costs to the health system.[2] The Elgin OHT partners recognize the importance of addressing the language needs of the Francophone population as a part of health service planning to support equitable access and will continue to work collaboratively to better understand the needs of French-speaking individuals in our attributed population and develop strategies to address these needs.

Many of our OHT partners have staff with French language capabilities that are routinely engaged to deliver care and services in French, or to provide translation support. The OHT will provide a platform to better identify and leverage these resources across the continuum of care and services, as required to better meet the needs of the Francophone population. Many of our HSP partners adhere to the French Language Service Act, and report on French Language Services as set out in their accountability agreements.

The Elgin OHT partners will also work to ensure that there is a process for Francophones in our attributed population to be connected to other culturally sensitive services in French with the Regional Francophone Hub in London (Accès Franco-Santé London). The regional hub has an OTN suite and services such as the French Language MHA System Navigator and access to psychiatry, psychotherapy, and social services in French for the South West region.

The Elgin OHT partners have engaged with the Erie St. Clair (ESC)/South West (SW) French Language Health Planning Entity in the initial planning phases of the Elgin OHT and will continue to work with the organization in the planning, design, delivery and evaluation of

services to meet the care needs of the Francophone population, including support in engaging with Francophone patients, families and Caregivers.

Sources

1. Statistics Canada, 2016 Census
2. French Language Health Planning Entity Erie St. Clair/South West Final Report- February 12, 2020

4.4. 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

Two additional populations with unique health needs have been identified as a focus in Year 1. These populations include the Low-German speaking Mennonite and Amish populations, and the vulnerable and at-risk population experiencing homelessness or precarious housing and/or mental health and addictions, or those living in congregate settings. Both populations have strong intersections with the respiratory health focus of Elgin in Year 1.

1. Our Low-German speaking population has poorer health literacy than the general population, and often experiences barriers to access due to the limited access to or awareness of Low-German interpretation services in the region. Further, as Low-German is a spoken-only language, this population does not benefit from health education materials or other reference materials that may otherwise support their self-management and health maintenance.

In order to support the Low-German speaking population, Elgin OHT partners are exploring the following strategies:

- Employ additional Low-German speaking health providers in the roles of system navigators and care coordinators
- Build upon the success of the Central Elgin Community Health Centre's mobile primary care unit that currently provides services on-site in Mennonite and Amish communities.
- Continuing and increasing the ability to provide COVID-19 testing on-site in Low-German speaking communities currently delivered through collaboration between Central Community Health Centre and Southwestern Public Health

2. Our vulnerable and at-risk population of Elgin is at greater risk of respiratory illness often due to poorer environmental conditions and health behaviours, such as increased rates of substance use and smoking[1]. This population is often also underserved, experiencing

poorer health overall and a decreased quality and length of life[2].

In order to identify and support the vulnerable and at-risk population, Elgin OHT partners are exploring the following strategies:

- Earlier identification and diagnosis of members of the vulnerable and at-risk population with respiratory illnesses (particularly COPD). This will be done through collaboration with primary care; St. Thomas Elgin General Hospital; and mental health, housing support, and other social support services in order to meet this community where it accesses services.
- Building on COVID-19-driven collaborative initiatives that provide virtual on-call primary care services in shelters, retirement homes and other congregate living settings and expanding locally on the partnership between the Canadian Mental Health Association and Southwestern Public Health to offer smoking cessation resources and referrals on-site.
- Central intake for community support services, through Victorian Order of Nurses as the lead agency, to provide a central access mechanism for community services in the region, and help reduce barriers to accessing services for this population.
- Build on the primary care outreach service that were implemented through the Central Community Health Centre, to identify members of this population, and coordinate OHT work through the currently developing proposal by Central Community Health Centre for the new Mental Health and Homelessness Outreach Program.

Sources:

1. Snyder, L., & Eisner, M. 2004. Obstructive Lung Disease Among the Urban Homeless. Doi: https://doi.org/10.1378/chest.125.5.1719
2. Schanzer, B., Dominiguez, B., Shrout, P., & Caton, C. 2006. Homelessness, Health Status, and Health Care Use. Doi: https://doi.org/10.2105/AJPH.2005.076190

4.4.1. 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

Over the course of the pandemic, many OHT partners further strengthened their partnerships to deliver a coordinated emergency/pandemic response. Several strategies were developed and deployed to address at risk populations who are at elevated risk for infection. Some of these initiatives include:

Emergency Management Operations Committee (EOC):

- The EOC is a community response and planning team initiated during COVID-19 to plan and respond to issues around supply chain of medical supplies including PPE, etc. The team includes OHT partners including EMS, Hospital, LHIN, Primary Care, Home Care,

long-term care, public health, etc. To continue to respond to the ongoing COVID-19 pandemic and address the risk of other infectious illnesses, the EOC's work is continuing, with its membership expanding to include representatives from community support services.

Working Groups and Tables

- During the first wave of COVID-19, many working groups and planning tables within and across sectors were developed to address population needs in relation to COVID-19. Partners include: mental health, public health, acute care, and primary care, among others. The work of these tables is ongoing, and is expected to continue providing support for populations and settings identified as vulnerable to COVID-19 and Influenza.

Direct Support for Long-Term Care and Congregate Settings:

- Long term care facilities in partnership with public health have provided on-site COVID-19 testing for patients to help reduce barriers in access to testing facilities, and to help reduce outbreaks among patients and staff.
- Southwestern Public Health provided infection prevention and control support to long-term care facilities in the region throughout the pandemic. It is expected that this support will continue to support the ongoing COVID-19 response.
- Certain long-term care facilities have implemented successful practices to maintain their residents' access to care and access to essential caregivers while under COVID-19 restrictions. One example is the onsite use of virtual tools to connect a Nurse Practitioner physically present within the long-term care facility to care providers elsewhere. This has been successful in maintaining patients' access to care and diverting patients from having to be sent to the emergency department for assessment. These initiatives will be maintained and may expand to ensure that patients in these settings receive the care that they need, while minimizing emergency department utilization where possible.
- Under Directive 3 for long-term care facilities (Long-Term Care Act), long-term care facilities must eliminate ward rooms to minimize the spread of COVID-19. To maintain system capacity, the SWLHIN, St. Thomas Elgin General Hospital, and local long-term care facilities, retirement homes and primary care providers formed partnerships to support patients and manage waitlists appropriately.

It is anticipated that the Elgin OHT will serve as a platform to support the ongoing work of the planning tables and working groups, allowing for their more centralized coordination across the region through the OHT partners. Elgin OHT also anticipates that partners will continue the initiatives and responses put in place to address the COVID-19 pandemic and support vulnerable populations, with the opportunity to scale and spread successful initiatives and lessons learned across the OHT.

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

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

Max word count: 1000

Patients, families, and caregivers are an essential stakeholder group in the planning and development of Elgin OHT. Three patient partner representatives sit on the Elgin OHT Steering Committee and have participated in establishing the vision and priorities for the Elgin OHT, with the intention to co-design our local system. Patient partners also participate in various sub-committees that support planning and development of the OHT. This has included input into the Stakeholder Engagement and Communications Plans, along with the development of the OHT website and logo.

The Elgin OHT partners recognize that the health care system has historically been more provider-centric than patient-centric. The Elgin OHT partners are prepared to re-design our local health care system in a way that better meets the needs of both patients and providers. The vision for the Elgin OHT developed collaboratively by our partners (including patient partners) reflects a model that puts patients, families and caregivers at the centre, and includes them as part of the care team. The future state Elgin OHT model reflects an approach that adopts a focus on prevention and addresses the whole needs of the individual, including the social determinants of health.

The Elgin OHT Partners have engaged patients, families, and caregivers through a series of dedicated virtual focus groups targeted at COPD patients, community patients and families and specific engagement session for Mennonite/Low-German speakers. Patients, families, and caregivers will continue to play an important role in the OHT planning in Year 1 and continue towards maturity. We anticipate engaging patients, families, and caregivers in the following ways:

- Elgin OHT Steering Committee – Patients, families, and caregiver representation on the steering committee will be important to provide a formal role in co-designing care and overseeing the work of the OHT partners.
- Sub-committees – Patients, families, and caregivers be included on sub-committees that will be established by the Steering Committee (e.g., digital health, transitions, etc.) The role of the sub-committees will be focused on developing plans based on Year 1 commitments and priorities.
- OHT Stakeholders – The OHT plans to engage a broad range of stakeholders, including patients, families and caregivers that are representative of the population Elgin OHT serves. These patients will be kept informed through various channels on the planning and progress of the OHT and will also be engaged to provide input and feedback to inform the OHT development.
- Leverage existing patient/client council rounds that currently exist to promote and leverage for feedback and ideas to improve care. Where there are gaps in peer supports, we will look to facilitate support to grow these.
- The South West LHIN has a Self-Management program which offers workshops for patients and caregivers which we will promote and can leverage to address our target population. Workshops for providers also deal with caregiver burnout among professionals and teach providers about communication and health literacy to improve the patient experience during their health care journey and can teach providers skills like motivational interviewing to help patients in their health behaviour change.

To ensure that patients are meaningfully engaged, the OHT partners will ensure that participants:

- Know the purpose of their involvement
- Have comprehensive information to support their participation
- Can freely voice their ideas and concerns

- Know that the Elgin OHT partners are committed to integrating the perspectives and contributions of patients, families, and caregivers
- Are kept informed about the decisions made and how their involvement informs decisions
- We will embed metrics relevant to patient/caregiver experience in our work and ensure what we are measuring is meaningful to patients and caregivers

Elgin OHT will measure the success of patient engagement on the Steering Committee and Subcommittee through client satisfaction surveys or community engagement surveys such as the use of the Canadian Index of Wellbeing survey to understand whether clients feel their input in the OHT development is valued. Elgin OHT will ask for feedback during patient engagement sessions, as well as through the distribution of surveys to evaluate the OHT engagement process and outcomes.

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

After the application is submitted to the Ministry, the Elgin OHT partners will continue to develop plans for the development of the OHT. A key enabler will be to establish a Collective Decision-Making Arrangement between the partners to ensure a smooth transition once the Elgin OHT is approved to become a designated OHT. With this, the Elgin OHT plans to develop implementation plans for 4 key areas including: 1) Collective-Decision Making Arrangements for Year 1, 2) Care Transformation, 3) Digital Health, 4) Performance and Quality

Post Submission of Full Application

1. Refresh or establish sub-committee groups which are responsible for developing OHT technical components (e.g., digital health, privacy, population health, CDMA, etc.)
2. Develop draft Terms of Reference for each group (e.g., Digital health, Privacy, CDMA, etc.)

Workstream 1: Collaborative-Decision Making Arrangements
0 to 3 months

1. Extend the current governance work to develop final Terms of Reference, decision-making structures, and principles for the CDMA working group
2. Develop draft CDMA framework – informed by continued stakeholder consultations with the community, P/F/C, physicians and other clinicians
3. Develop Year 1 operational budget, leveraging Ministry implementation funding for OHTs that addresses transformation of care models for Year 1 target population, physician and other clinician leadership and engagement, patient, family and caregiver engagement, project leadership and management, performance measurement and quality improvement and digital health/virtual care

Deliverables:

- CDMA working group Terms of Reference
- Decision-Making Structures
- Draft CDMA Framework (addressing resource allocations, information sharing, performance, etc.)
- Year 1 Budget

3 to 6 months

1. Develop supporting governance tools and mechanisms – create mechanisms such as agendas, reporting templates to support effective decision making and communication
2. Finalize CDMA Framework – finalize negotiations and sign agreements among members and affiliates
3. Develop draft integrated strategic plan based on continued stakeholder engagement (i.e., COPD patients, primary care physicians, Indigenous, etc.)

Deliverables:

- Final CDMA Framework
- Governance tools and templates
- Draft Elgin OHT Vision, Mission, Goals

6 to 9 months

1. Finalize OHT strategic plan – finalize strategic plan including performance metrics and benchmarks

Deliverables

- Final Strategic Plan

Workstream 2: Care Transformation for Year 1
0 to 3 months

1. Continued stakeholder engagement with priority population, Mennonite and Amish communities, and Indigenous groups to verify priorities for care transformation
2. Confirm transition, service coordination and system navigation priorities for Year 1 (based on work and initiatives identified in sub-committee work)
3. Develop workplan for deliverables in Year 1

Deliverables

- Terms of reference for care transformation working group
- Workplan for Year 1

- Year 1 Target Project Groups

3 to 6 months

1. Based off transition priorities, develop future state transitions and system navigation delivery model for COPD patients
2. Identify gaps from future state to current state (e.g., human resources, supports, digital health tools, etc.)

Deliverables

- Future state transitions and system navigation delivery model for COPD patients
- Gap Analysis and Resource Identification

6 to 12 months

1. Identify Year 1 Target projects to implement transitions goals for year 1 population
2. Develop change management plan to guide transformation of healthcare initiatives
3. Develop protocols and supporting materials to guide transition and care coordination for COPD patients

Deliverables

- Year 1 Target Project Initiation
- Change Management and Training Documentation
- Protocols and Supporting Materials

Workstream 3: Digital Health
0-3 months

- Finalize Terms of Reference for Digital Health working group
- Confirm digital health priorities (ensuring digital health priorities reflect and support transition priorities, and enable information exchange among patients and with patients
- Develop workplan for year 1)

Deliverables

- Terms of Reference for digital health working group
- Workplan for Year 1

3-6 months

1. Develop digital health strategy and roadmap for year 1
2. Develop gap analysis and resource model

Deliverables

- Digital Health Roadmap for Year 1
- Gap Analysis and Resourcing Model

6-12 months

1. Develop change management and training resources
2. Execute on specific activities outcomes in the roadmap

Deliverables

- Change Management and Training Resources

Workstream 4: Quality and Performance

0-3 months

1. Confirm and establish key performance metrics for Year 1
2. Identify mechanisms for data gathering and analysis that is aligned across partner organizations to ensure quality data collection among OHT partners

Deliverables

- Key Performance Metrics for Year 1 – including data gathering and analysis mechanisms

3-6 months

1. Develop harmonized information management plan – plan to govern health information amongst the Elgin OHT members, including information governance, protocols, etc.
2. Develop privacy manual – development of a privacy manual to safeguard patient information across the Elgin OHT

Deliverables

- Harmonized Information Management Plan
- Privacy Manual

6-12 months

1. Monitor ongoing performance against quality metrics and benchmarks
2. Develop plans for optimizing and improving on metrics

Deliverables

- Monitoring report against quality metrics
- Plans for optimizing metrics

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

Remove legislative barriers

- Members of the OHT are challenged in sharing Personal Health Information (PHI) with non-HIC Members despite their being critical service delivery partners. MOH should enable disclosure based on implied consent through PHIPA. MOH should work with IPC/Ontario to clarify the status of LHIN-funded CSS providers under PHIPA.

Reduce barriers to digital health tools

- Obtaining access to provincial digital tools is challenging. They have differing participating and enrollment processes which are challenging to navigate. For example, consuming OLIS data into systems requires eHealth Ontario to conduct a

time-consuming PIA. Additionally, access requirements do not mirror how organizations use the tools. For example, ConnectingOntario can be used by clinicians but not assistants, despite their key role. Physicians' access in many cases depends on their organization and so when working in multiple settings they often do not have the same access.

- Due to COVID, the Ministry has allowed physician billing for physicians using any virtual care tool. It is important to continue to allow physicians to bill for virtual care services.
- Another barrier for information sharing between Primary Care, Long-Term Care and Hospital includes the year-long process to set up Clinical Connect, and the fees in Point-Click Care to set up new integrations. Primary Care and Specialists offices need access to practice facilitation support to integrate tools at the practice level.

Streamline data sharing agreements

- Providers sign agreements for each data sharing initiative in which they participate. The agreements are costly to develop and have differing commercial terms and conditions (e.g., indemnity, insurance) requiring the providers to engage their own legal counsel for review. Streamlining agreements would reduce the administrative burden and legal requirements required to sign.

Support cost sharing models for sharing patients between OHTs

- Although we will provide the full range of health, community and social services in our OHT, patients have a full choice in healthcare providers and may seek services from providers attached to other OHTs. Obtaining support from MOH in developing the cost sharing models when patients move amongst the OHTs would benefit us to ensure that Elgin OHT partners are not required to negotiate them on a case-by-case basis with each different OHT.

Aligned reporting requirements

- Currently OHT partners are required to report to a variety of funders on differing and sometimes competing metrics, requiring considerable data collection and analysis work. Aligning the reporting requirements would significantly reduce the effort required.
- Physicians in primary or specialty care need access to data analytic support and quality improvement support.

Ability to reinvest

- LHIN and Ministry-funded organizations must return unspent funds at the end of the year. These organizations should be allowed to re-invest into the OHT to enhance other areas of care. Key to this change would be some flexibility within certain budget lines in order to shift funds as needs change within the budget year or emergent needs arise.

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

OHT planning participants have identified various systemic barriers that will hinder the progress of OHTs.

Funding

- Physician compensation for OHT development – Physicians are expected to have a significant role in developing and overseeing the OHT but do not receive compensation for doing so. Fee-for-service physicians in particular are extremely challenged in devoting the time required to plan for the OHT as it directly impacts their revenue, especially compared to physicians in other service models (i.e., FHTS, etc.) In addition to not being compensated, participation also incurs significant costs in both time (to see the patients at other hours) or in costs to cover a locum to cover their clinical duties.

Human Resources

- There is a shortage of human resources in Elgin region, particularly personal support workers. This has been exacerbated due to the pandemic, as many patients do not want multiple PSW's entering their home to provide them with care.
- There are currently wage disparities across sectors (i.e., salary of nurse in hospital versus community support services) which will make it difficult to share resources across the OHT.

Policy

- OHIP Billing for Virtual Care – The availability of this funding during COVID-19 has enabled physicians to provide virtual care to their patients. This funding must be maintained in order to continue providing virtual care services to patients.
- Existing Home and Community Care Contracts – SPOs have a fee for service model with assigned market share and estimated volume awards that limit ability to create new H&CC interprofessional care teams. More flexibility should be offered for the development of contracts for home and community care SPOs, including the ability to leverage outcomes-based remuneration, and other value-based contracting mechanisms
- Challenges in providing care to patients without health cards – Many healthcare providers have identified challenges in providing health care to patients without health cards (i.e., some Mennonite and/or populations, vulnerable, etc.). The Ministry should provide recommendations and protocols on how to best provide care to these patients.
- Shortage of long-term care beds – Even with increased community supports to support more patients at home, there continues to be a shortage in long-term care beds compared to the high acuity population that requires them.
- Challenges related to waitlist management for long-term care and how retirement homes are used in the system should be reviewed. A person could qualify first medically for what level of care they need, and then financial subsidies could allow those who are at RH level to live in that setting with financial support rather than going

to long-term care.

Technology

- Access to CHRIS – CHRIS has care coordination tools that could be used to support broader care coordination but is only available to certain sectors and users. Allowing for expediated and expanded access would benefit care collaboration in OHTs.
- Technical Support – Several of the smaller providers do not have the financial capacity to procure the technology and supporting services required to effectively utilize or implement digital health tools. Many of those who implemented IT solutions have not had budget increases for over a decade, which limits their ability to use the full functionality of the systems and raises other risk concerns. This impedes their ability to participate fully in the digital health strategy. Technology and expert support would enable these providers to participate more fully.
- Practice Facilitation and QI support such as that provided by the SWLHIN Partnering for Quality program can be grown to provide supports to practices and organizations in the Elgin OHT geography to identify and implement changes.
- It would be beneficial if the partners could leverage a centralized referral to facilitate system navigation and handle wait lists for diagnostics and consultative services across Elgin OHT and partner with neighbouring OHTs to ensure access to specialty care in our region through e-consult, e-referral offering patients choice of the shortest wait versus a specific location or provider. These processes reduce administrative work in both primary and specialty care and give the patient transparency about their care.

Privacy

- Privacy issues in patients circle of care – Some types of service providers (e.g., PSWs) are not HICs and therefore the providers cannot reply on implied consent to disclose PHI to them. PHIPA should be amended to enable disclosure of PHI with implied consent to any service provider within the OHT, assuming that the service is for the benefit of the patient. Note that prescribing the OHT as a single HIC would not address this issue because some of the OHT members are likely not to be HICS on their own and therefore cannot be designated as part of the single HIC.

Other Barriers include:

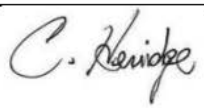
- Personal protective equipment shortages and costs
- Limited high speed internet connectivity in rural areas that limits the ability to implement eHealth solutions
- Inadequate support of the Social and Environmental Determinants of Health in a rural environment
- The lack of digital equity for many of the lower income residents in Elgin who cannot afford to access eHealth solutions
- The physical capacity limitations that many organizations face to limit the spread of COVID-19. Many providers have had to reduce the volumes of clients served in person due to COVID-19, which challenges their ability to provide equitable access to those who cannot or are not comfortable accessing care virtually

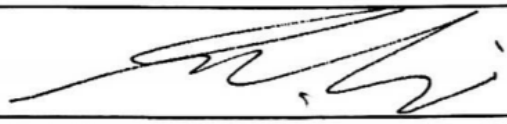
Membership Approval

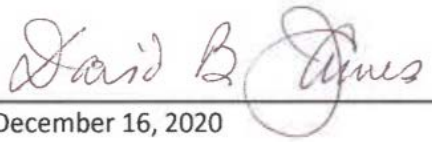
Please have every member of your team sign this application. For organizations, board chair sign-off is required. By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Community Health Centres

Central CHC

Team Member	
Name	Chris Herridge
Position	Board Chair
Organization (where applicable)	Central Community Health Centre
Signature	
Date	Dec. 15, 2020

Team Member	
Name	Mohammed Ziada
Position	Family Physician
Organization (where applicable)	Central Community Health Centre
Signature	
Date	Dec15,2020

Team Member	
Name	David James
Position	Board Chair
Organization (where applicable)	West Elgin Community Health Centre
Signature	
Date	December 16, 2020

Community Mental Health and Addictions Providers

Addictions Services Thames Valley

Team Member	
Name	Dennis Lunau
Position	ADSTV Board Chair
Organization (where applicable)	Addiction Services of Thames Valley
Signature	Dennis Lunau
Date	December 15 - 2020.

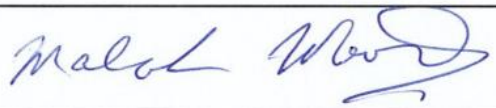
Canadian Mental Health Association – Elgin Middlesex

Team Member	
Name	Beth Mitchell
Signature	Beth Mitchell
Position	CEO
Organization (where applicable)	Canadian Mental Health Association, Elgin-Middlesex
Date	December 14, 2020

Team Member	
Name	Heather Bishop
Signature	H. Bishop
Position	Board Chair
Organization (where applicable)	Canadian Mental Health Association, Elgin-Middlesex
Date	December 14, 2020

Community Support Services

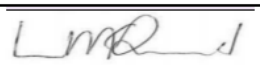
Alzheimer Society Elgin

Team Member	
Name	Dr. Malcolm Wood
Position	President
Organization (where applicable)	Alzheimer Society Elgin – St. Thomas
Signature	
Date	December 15, 2020

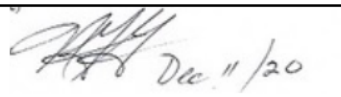
Cheshire Independent Living Services

Team Member	
Name	R. GRANT INGLIS
Position	PRESIDENT
Organization (where applicable)	Cheshire Homes of London Inc.
Signature	
Date	December 17, 2020

Closing the Gap Healthcare

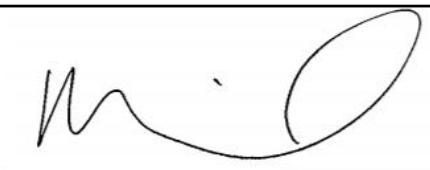
Team Member	
Name	Leighton McDonald
Position	President and Chief Executive Officer
Organization (where applicable)	Closing the Gap Healthcare
Signature	
Date	14 December 2020

Dale Brain Injury Services

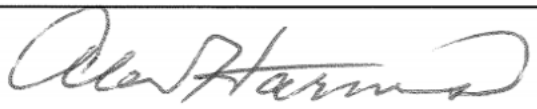
Team Member	
Name	Nigel Gilby
Position	Board Chair
Organization (where applicable)	Dale Brain Injury Services
Signature	
Date	December 11, 2020

Hospice of Elgin

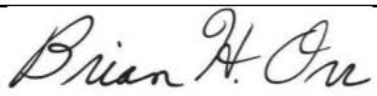
Team Member	
Name	John Callaghan
Position	President
Organization (where applicable)	Elgin Residential Hospice (Hospice of Elgin)
Signature	
Date	December 14, 2020

Team Member	
Name	Richard Corneil
Position	Director
Organization (where applicable)	Hospice of Elgin
Signature	
Date	December 14, 2020

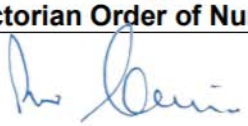
Mennonite Community Services

Team Member	
Name	Abe Harms
Position	Executive Director
Organization (where applicable)	Mennonite Community Services
Signature	
Date	December 15, 2020

Participation House

Team Member	
Name	Brian Orr
Position	Board Chair
Organization (where applicable)	PHSS
Signature	
Date	December 16, 2020

Victorian Order of Nurses

Team Member	
Name	**Peter Currie**
Position	**Board Chair**
Organization	OHT Name: Elgin Ontario Health Team **Victorian Order of Nurses for Canada- Ontario Branch**
Signature	
Date	December 16, 2020

Family Health Organizations

Elgin FHO

Michael Toth, M.D., C.C.F.P.
Family Physician

418 Talbot St. West, Unit 6
Aylmer, Ontario N5H 1K9
519-773-5336
Fax 519-773-5337

December 16, 2020

re: Application for the Elgin Ontario Health Team

To the Ministry of Health:

I am the Lead Physician of the Elgin Family Health Organization. Our FHO has 18 full time physicians, all located in Elgin County, and over 27,000 rostered patients. As the Lead Physician, I have been directly involved in the application process for the Elgin OHT.

I have communicated with the physicians of the Elgin FHO and they are aware of the Elgin OHT application, and also of some of the potential benefits of the OHT to our community. Of course, they will require more details, but at this point, I can confirm that there is general agreement that we should support this application. I can confirm that the application is accurate and complete.

As the Elgin OHT matures, the Elgin FHO expects to be a full and vibrant member.

Sincerely,

Michael Toth

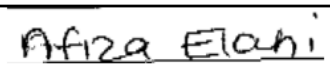
Elmdale FHO

Team Member	
Name	Melissa Tenbergen
Position	Lead Physician
Organization (where applicable)	Elmdale FHO
Signature	
Date	Dec 17, 2020

Elmwood FHO

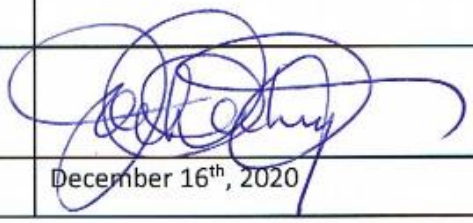
Team Member	
Name	Dr. Kellie Scott
Position	Lead Physician
Organization (where applicable)	Elmwood FHO
Signature	
Date	2020-12-16

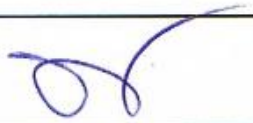
Team Member	
Name	Christian Paradis
Position	FHO Lead Physician – Windemere Family Medical Centre
Organization (where applicable)	Windemere FHO
Signature	
Date	December 15, 2020

Team Member	
Name	Dr. Afiza Elahi
Position	GP
Organization (where applicable)	Windemere Family Medical Centre
Signature	
Date	Dec 16, 2020

Family Health Teams

East Elgin FHT

Team Member	
Name	Jack Couckuyt
Position	Board Chair
Organization (where applicable)	East Elgin Family Health Team
Signature	
Date	December 16th, 2020

Team Member	
Name	Dr. Jillian Toogood
Position	Family Physician
Organization (where applicable)	East Elgin Family Health Team
Signature	
Date	December 16th, 2020

Team Member	
Name	Dr. Brianna Alkenbrack
Position	Family Physician
Organization (where applicable)	East Elgin Family Health Team
Signature	
Date	December 16th, 2020

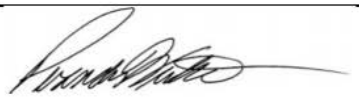
Team Member	
Name	Dr. Michael Fernando
Position	Family Physician
Organization (where applicable)	East Elgin Family Health Team
Signature	M. Fernando / cs
Date	December 16th, 2020

Team Member	
Name	Dr. John Tokarewicz
Position	Family Physician
Organization (where applicable)	East Elgin Family Health Team
Signature	
Date	December 16th, 2020

Team Member	
Name	Cindy Bratt
Position	Executive Director
Organization (where applicable)	East Elgin Family Health Team
Signature	
Date	December 16th, 2020

Hospitals

St. Thomas Elgin General

Team Member	
Name	Peter van der Westen
Position	Board Chair
Organization (where applicable)	St. Thomas Elgin General Hospital
Signature	
Date	December 15, 2020

Independent Physicians

West Elgin Medical Centre

Team Member	
Name	DR. EMIL GAICHOLE
Position	MEDICAL DOCTOR
Organization (where applicable)	WEST ELGIN MEDICAL CTR 171 MAIN WEST LORNE. ONT HOL 2PO
Signature	
Date	Dec 16'20

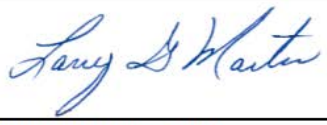
Dr. Darius Ho

Team Member	
Name	Darius Ho
Position	MD
Organization (where applicable)	
Signature	
Date	December 15, 2020

Public Health

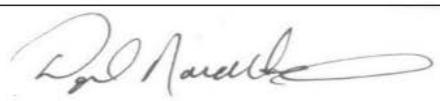
Southwestern Public Health

Team Member	
Name	Cynthia St. John
Position	Chief Executive Officer
Organization (where applicable)	Southwestern Public Health
Signature	
Date	December 15, 2020

Team Member	
Name	Larry Martin
Position	Board of Health - Chair
Organization (where applicable)	Southwestern Public Health
Signature	
Date	December 15, 2020

Local Health Integration Networks

South West Local Health Integration Network

Team Member	
Name	Daryl Nancekivell
Position	Vice President
Organization (where applicable)	Home and Community Care – SW LHIN
Signature	
Date	December 14, 2020

Letter of Support

Ministry of Health
Ms. Helen Angus
Deputy Minister
80 Grosvenor Street, 10th Floor, Hepburn Block
Toronto, ON M7A 1E9

Dear Deputy,

As a signatory to this letter, we are committing our support for the Elgin Ontario Health Team (OHT). The Elgin Hospice and the Elgin Palliative Care Network Collaborative have been engaged in the OHT planning process over the last months, with members contributing to the design and priorities of the OHT. We are committed to the vision and goals of the OHT model in Elgin.

Given the priorities and scope of activities in Year 1, we are committed as supporting partners for the OHT in Year 1, contributing to the ongoing planning and design, and implementation efforts for the OHT's model. We will bring the palliative perspective to care, which aligns well with the OHT's vision of person-centred care. It is an approach for people living with serious, life-limiting illness that aims to relieve pain and suffering, and to improve a person's quality of life by wrapping around the patient, family and caregivers to identify values, goals, needs and preferences. The palliative approach to care that drives the Collaborative's work is particularly important for the Year 1 population of Elgin OHT, many of whom have life-limiting respiratory illnesses. This approach will be increasingly relevant as the OHT moves towards maturity with the inclusion of other populations with life-limiting illnesses (such as heart disease, metastatic cancer, dementia and frailty). We will support the OHT by providing input into current state understanding along with gap analysis, strategies and planning for future, participating in co-design and implementation planning, and potentially implementing re-designed integrated services with a focus on improving the quality of life of the community. We are committing our regional collaborative to continue to support in the planning and design of the Elgin OHT throughout Year 1, and into maturity.

We believe that the Elgin Ontario Health Team partnership will improve patient and population health outcomes provide better experiences for patients, families and caregivers, and improve the value of investments in our local health care system. We look forward to our ongoing collaboration and participation in this process.

Sincerely,

Kevin Mardell, MD CCFP FCFP
Chair, Elgin Palliative Care Collaborative, South West Hospice Palliative Care Network
Lead physician, Elgin Palliative Care Outreach Team
Adjunct Professor, Dept Family Medicine, Schulich School of Medicine and Dentistry, Western University
Family Physician, West Elgin Community Health Centre

Kathleen Garant, RN, BHSc, BSN, CHPCN(C)
Co-Chair, Elgin Palliative Care Collaborative, South West Palliative Care Network
Nurse Educator, Oxford and Elgin Counties, Palliative Pain and Symptom Management Consultation Program of Southwestern Ontario
St Joseph's Health Care, London