Oxford and Area Ontario Health Team

Full Application

Together in Coordinated Care

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.

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.

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

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

- 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.

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: Sandy Jansen
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Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Tracy Phinney
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1. About Your Population

In this section, you are asked to demonstrate your understanding of the populations that your team intends to cover in Year 1 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:

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The attributed population for our proposed OHT is 103,012. Our population is a rural-urban mix consisting predominantly of residents of Oxford County, accounting for approximately 72% of the total. Geographies surrounding Oxford County contributing significantly to the attributed population include residents of Norfolk County (8.6%), London/Middlesex County (4.4%), and Elgin County (4%). This geographical distribution is consistent with our Primary Care and Hospitals' experience.

Population health data provided indicates an "older" population, with those over the age of 65 accounting for 20.3% of the population compared to a provincial average of 17.6%. The top 3 Health Profile Groups (HPG) for our region are Dementia, Acute Palliative, and Heart Failure, which account for 20% of our expenditures, and less than 2% of our population. The top 10 HPGs for our attributed population account for 34% of expenditures, and 7% of the population. **A large portion of the health dollars spent in our proposed OHT are attributed to individuals with life-limiting illnesses related to Coronary Artery Disease, Metastatic Cancer, Dementia and individuals with Diabetes; the majority of those expenses are Hospital related.**

Within our region there are 750 individuals residing in one of the 8 LTC homes and another 410 people waiting in Hospital or home for a LTC bed. Approximately 5,500 individuals receive Home Care each year, equating to 316,000 visits from Nursing, PSWs, Therapies, and LHIN Care Coordinators. There are 139 funded beds in Assisted Living and Supportive Housing, 210 Adult Day Programs spaces with 200 resident days for overnight respite. There are 10 Residential Hospice beds that support 180 people per year. Mental Health and Addiction services assist 8,747 individuals yearly. Dementia Services provide 5,925 support visits per year.

At maturity, our OHT expects to provide a full continuum of integrated care, supported by inter-agency coordinated care planning and leadership. Building an integrated system of team based care for all Primary Care Providers will be a focus. Centralized coordinated intake, 24/7 navigators for complex and vulnerable populations, and a commitment to community-based care will be our priority.

Over the course of our OHT engagement, our patients and partners have highlighted how challenging the current system is for Patients and Providers to navigate due to the many siloes of care. This is compounded by a lack of community resources including LTC beds, Assisted Living, Supportive Housing and Adult Day Program spaces, and community based PSWs and Nursing. These challenges create a fragile system where Patients and their Caregivers cannot access the care they need in the community. Frustrated and confused, Patients and Families default to the only option they feel they can rely on, namely the Hospital Emergency Department. This pattern is clearly reflected in data including increasing avoidable ED visits and Hospital admissions, long waits for Home Care and LTC placement, and a high proportion of patients receiving low acuity care within Hospitals. Many of these Hospital visits could be appropriately managed in the community, either in person or virtually, which will be the focus of our OHT redesign.

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).

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We have reviewed all material and available data related to the attributed population accessing health care in our area. We heard from Acute Care, Community Providers, Primary Care Providers, Patients, and Caregivers to provide context and validate the data and identify barriers and opportunities.

In addition to a large and inclusive OHT Coordinating Committee, multiple "Action Teams" have been established to focus on OHT planning. Our Year 1 Population Action Team and Patient Engagement Action Team have been actively involved in the development of our Year 1 Priority Populations. The following Year 1 Populations have been identified:

1. Attributed people at risk of hospitalization due to Chronic Disease
2. Attributed people experiencing a life-limiting illness that would benefit from Palliative Care
3. Attributed people experiencing challenges related to Mental Health and Addictions across the lifespan

The following key data points drove the decision to move to these three populations.

Chronic Disease and Palliative Care:

- 5.4% of our residents have four or more Chronic Diseases (5,600 patients).
- Oxford Hospitals have an 18.3% readmission rate for Chronic Diseases. In the fiscal year 2018-19, this equated to 350 readmissions (within 30 days of discharge), with an average admission LOS of 6.2 days.
- Approximately 2,400 patients per year receive Home Care in our area and are defined as "chronic" or "complex" by LHIN definition. Patients typically advance from "chronic" to "complex" as their disease process becomes more unstable, as conditions become more unpredictable, and as risk of hospitalization increases. Of note, approximately 75% of complex Patients are designated as "Palliative".
- People receiving Home Care and defined as "chronic" or "complex" are high users of Hospital Emergency Departments. Approximately 15% of chronic patients and 18.5% of complex Patients experience one or more ED visits.

Mental Health and Addictions (MH&A):

Oxford County has a number of assets that support MH&A needs. Despite this, there remain significant barriers to accessing MH&A services in Oxford County. Barriers include a lack of resources, lack of affordable housing, lengthy waitlists, transportation, proximity, privacy, anonymity, stigmatism, isolation, market volatility, and most recently COVID-19 impacts.

The attribution data reveals the following opportunities related to MH&A*:*

- Frequent ED visits (4+/year) for MH&A – crude Readmission Rate:
  - Oxford and Area Network: 7.8%
  - Province: 9.5%
- Rate of Repeat ED visits within 30 days for Mental Health & Substance Abuse conditions:
  - Oxford & Area Network: 18.6%
  - Province: 24.8%

However:

- Inpatient Mental Health active case rate per 1,000 population:
  - Oxford & Area Network: 6.0
  - Province: 4.5

The development of an integrated care model will address the unique MH&A needs including availability, timely access, early identification, improved outcomes, efficient transitions, and collaborative care efforts, which will improve the patient experience fostering a sense of belonging.

The need for care coordination and system navigation for the identified priority populations is evident based on the challenges Patients and Caregivers experience navigating transitions in and out of the Hospital setting and working with multiple Community Providers. They are the most likely populations to benefit from an integrated care team approach.

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.

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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. 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.

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

There are a number of sub-populations that bring equity considerations across our population, including Amish, Mennonite and Low German speaking communities, Temporary Foreign Workers, older adults with frailty and the marginalized.

Oxford County has several Old Order Amish, Mennonite, and Low German speaking communities accounting for approximately 1,050 individuals in total. This population is not uniform, and is made up of multiple small faith-based communities with varying social structures and practices and often low literacy levels. These communities pose unique challenges that have been highlighted during the COVID-19 health crisis. Close-knit large families, many of whom speak English as a second language or not at all, are typical within these communities. Additionally, some of these communities do not participate in any technology-enabled communication (phone, internet). Individualized and specialized health outreach and support is required to provide health teaching, and health care. Some communities elect not to utilize OHIP based health insurance, which presents a unique challenge for those requiring publically funded healthcare. The Oxford and Area OHT will endeavor to engage and build pathways to healthcare for these populations using the established expertise from the Public Health sector.

Temporary Foreign Workers are another unique population within our OHT area. These individuals form an integral part of the Oxford County rural landscape for approximately 6 months of the year, primarily supporting the large agricultural sector. The specific number of individuals in this population is difficult to quantify, as illegal trafficking is a reality in this sector. Currently, there are 78 registered farms located within Oxford County with a total of 691 Temporary Foreign Workers employed. Temporary Foreign Workers are faced with language-related barriers, crowded living conditions, lack of transportation, undiagnosed health conditions, and fear of repatriation which may prevent access to and use of health care services. This presents unique challenges for Physicians and other Health Care Providers. With a second wave of COVID-19 probable this fall, and with the absence of a proven vaccine, we need to ensure that we are providing as much support as possible to this vulnerable population or face the possibility of large-scale outbreaks as seen in our neighbouring municipalities. Public Health agencies have been working to provide interventions and support to specific populations vulnerable to COVID-19 during the pandemic, and our OHT will work closely with Public Health to understand the health challenges, tailoring our supports to this group.

Approximately 20.3% of the population of Oxford County are over the age of 65. In 2018, targeted engagement with older adults, caregivers and health care providers in Oxford has confirmed the need to develop an integrated system of care, for older adults with frailty, which streamlines access, facilitates easier communication and collaboration across services, and simplifies navigation. The need to identify, understand and find solutions to sub-regional system gaps has also been identified.

Low income/marginalized/precariously housed/homeless individuals make up approximately 10.8% of our population based on the low-income measure after-tax (LIM-AT), which equates that an individual earning $22,133 per year or a two-person household earning $31,301 per year would be considered low income. Our region has a lower percent of people living in low income when compared to Ontario (10.8% vs 14.4% respectively). However, this population faces significant health challenges and health instability. Specific Oxford County estimates include:

- 11,835 (10.8%) residents are living in low income
    - 3,260 (27.5%) are children under the age of 17
- 4,270 (4.3%) residents live on an income too low to cover basic needs (e.g. food, shelter, and clothing).
- 2,620 Oxford County residents 18 years and older are "working poor"

The aforementioned indicators provide a clear indicator of the extent of the poverty issue in Oxford and those at severe risk and warrant significant consideration in any health system planning or restructuring.

Two sub-populations that have not attained as much focus in our region include Francophone and Indigenous peoples. Reasons for this include:

Only 1.2% of our population report French as their first language. All organizations adhere to the French Language Services Act. Interpretation services are available across all sectors and several organizations employ French-speaking clinicians. A French Language system navigator is in place at Addiction Services of Thames Valley, which serves our region.

There are no First Nations Communities within the proposed OHT geography. According to South West LHIN Sub regional data, approximately 1.8% of the population identify as Indigenous. There are several regional supports available to support health and system navigation of Indigenous people accessing health care including the Regional Cancer Program Indigenous Program Specialist/ Navigator, the South West LHIN Indigenous Health Committee, the Southwestern Ontario Aboriginal Health Access Centre (SOAHAC). As part of the predecessor Oxford Sub Region Integration Table, all members were provided Indigenous Cultural Safety Training through the South West LHIN.

The above information was primarily sourced from updated 2019 Sub-regional data from the South West LHIN, and the 2019 Southwestern Public Health "Understanding our Communities" report. As with many populations experiencing health inequities, we acknowledge that the numbers listed above are likely an under-representation of these populations due to inherent challenges in capturing data for marginalized populations.

2. About Your Team

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

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

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

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

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

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

2.2. Confirming Partnership Requirements

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

Team Member	**Other Affiliated Team(s)** *List the other teams 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 addictions 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.

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The health and human services sector within Oxford County and Area have a long history of working collaboratively, predating the OHT model. Multiple OHT tables including our Coordinating Committee, Steering Committee, six Action Teams (Collaborative Governance, Communications and Community Engagement, Digital Health, Patient Engagement, Year 1 Population and Primary Care Engagement) have collaborated over the past 18 months and include the full continuum of care providers in our region, as well as Patients and Caregivers at every level of decision-making.

As COVID-19 hit Ontario, our OHT planning transitioned to collaboratively prepare for the pandemic. The relationships we have established over years of working together proved valuable and we opted to continue to bring the OHT coordinating table together, repurposed as an "Oxford COVID-19 Response Team". This team worked collaboratively to identify and mitigate risks.

The team has highlighted several examples of cross-sector integrated teamwork. In previous OHT submissions, we have listed various tables and partnerships that exist in our region. There are numerous examples that could have been included in this section, however, word count has limited us to the following:

Palliative Care Outreach Team (PCOT)

The PCOT, established in 2014, is a long-standing example of integrated care in our region. An integrated team of Community Palliative Physicians, Primary Care, LHIN Care Coordinators, Nurse Practitioners, Visiting Nursing, PSWs, Spiritual Care, Volunteer and Bereavement services, and Residential Hospice come together from multiple different employers and sectors to collaborate and provide Community Based Palliative Care to a rostered group of Patients. This team has a singular focus of avoiding unnecessary hospitalizations and enabling Patients to die in their place of choice. The team's reach expanded in 2019 to include CBI Home Health's Enhanced Therapy Palliative Care Team, and in 2020 to include Community Paramedicine. Oxford County Paramedic Services provide Community Paramedicine in home comprehensive assessments and treatments for Patients with a palliative illness with urgent and emergent pain and symptom management needs. Under the direction of the Oxford PCOT Physicians, Paramedics administer medications and treatments to help resolve symptoms and prevent a visit to the Emergency Department during the pandemic.

COVID-19 Long-Term Care (LTC) /Retirement Home (RH) Support in Oxford

LTC and RHs have been particularly vulnerable during this pandemic. In Oxford, there are 11 RH and 8 LTC homes. During the pandemic, 3 of these homes experienced an active outbreak of COVID-19. Staffing challenges, that in many cases pre-dated the pandemic, were magnified over the last 6 months. As an example of unprecedented collaboration, the local Hospitals, Southwestern Public Health, LHIN Home and Community Care, CarePartners, and Paramedics worked to ensure that:

- Required testing was supported;
- Staff were deployed both short and longer-term to mitigate staffing crises;
- A process for emergency personal protective equipment (PPE) was available;
- Infection Prevention and Control (IPAC) education and support has been offered to the homes.

Further, an evacuation plan was developed to support rapid and safe transfer of patients in the event of a large-scale outbreak. It has been a true collaborative effort among these organizations to ensure that patients from our most vulnerable sector are supported during this pandemic.

Woodstock Short-Term Transition Unit

To improve Hospital capacity during the pandemic, a 10-bed short-term transitional care unit began on April 9, 2020 in partnership with the SW LHIN, local Hospitals, CarePartners, and Caressant Care RH. It has since grown to 15 beds based on the success of the initiative. Collaborative planning amongst partners enabled quick establishment of the unit and supporting health and safety protocols. CarePartners provides 24/7 nursing and PSW care to Patients decanted from Hospital to the RH while they await Long-Term Care placement, in addition to Community Crisis admissions assessed by LHIN Care Coordinators. This program helps to reduce ALC pressures and unnecessary Hospital admissions.

Community Paramedicine Collaborations

In support of the response by Southwestern Public Health and Ontario Health-West to the pandemic, Oxford County Paramedic Service has served as one of the lead agencies in supporting the community and local health care providers in Oxford County.

- Oxford County Paramedic Services are operating 3 PPE HUBs for the coordination and distribution of provincial stores and donated PPE to area health care providers/agencies. As of July 23, 2020, the PPE HUB has filled 67 individual orders and distributed over 76,000 PPE items to community agencies.
- In response to needs for COVID-19 assessment and testing for vulnerable populations, Community Paramedicine provides COVID-19 testing at LTC homes, RHs, Congregate Living settings and Shelters, as well as residents of Oxford County who require testing but are unable to attend an Assessment Centre. To date, Oxford County Paramedic Services have tested approximately 1,900 individuals for COVID-19.

Coordinated Care Plans (CCP)/Healthlinks

Since 2015, Coordinated Care Planning has brought together multiple providers, the patient/client, and their informal supports to enable the development of a care plan that best supports the patient/client goals and needs. In Oxford County, CCPs continued post-project funding and were sustained throughout the pandemic virtually via cross-sector participation. The Working Committee work plans and continued CCP local training will commence in September 2020.

- Lead Partners: LHIN H&CC, Woodstock Hospital, and Oxford County Community Health Centre Co-Chair the Working Group

Oxford Situation Table

A large team of agencies established in 2015, guided by an MoU, meet weekly to address presented situations of individuals/families with complex care needs in Oxford, and develop *immediate* integrated responses through mobilizing resources and action for selected lead agencies – provide services and assistance "in the moment":

- Woodstock Police Services, OPP, Oxford County CHC, CAS Oxford, SW LHIN Home & Community Care, Woodstock Hospital, Addiction Services Thames Valley, Oxford County Human Services, Domestic Abuse Services Oxford, CMHA Oxford, Oxford County Paramedic Services, Assertive Community Treatment Team, St Joseph's Health Care, Thames Valley District School Board, Wellkin, Victim Assistance Services Oxford County, CSC Providence School Board, MCCSS Youth Probation, Woodstock Adult Probation Services

The partnerships across these various initiatives are generally long standing ones, although new programs and initiatives have strengthened these relationships, and brought new partners together, across all sectors.

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

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In response to the pandemic, there have been a number of changes to care provision, in addition to new services offered in the community.

New services in the community include:

- Two COVID-19 Assessment Centres were rapidly established in our region, both affiliated with local Hospitals and operated on Hospital grounds. The Hospitals and Public Health have worked collaboratively to determine capacity needs in each community depending on local

cases. Additionally, Oxford County Paramedic Services and Southwestern Public Health have provided mobile testing services in the community to support individuals unable to access assessment centres. Testing centres and teams will be required for some time, and will continue as long as the need is there. This strategy has been helpful in minimizing ED visits and supports the large scale testing required to manage this pandemic.

- A Primary Care mobile outreach support team is being established to provide healthcare to Temporary Foreign Workers. Neighbouring counties have faced large-scale COVID-19 outbreaks in this vulnerable population. Aiming to prevent similar happenings within our region, our OHT partners, along with the financial support of Oxford County, developed a Temporary Foreign Worker support program if farms go into an outbreak situation or require mass testing. The workers will be supported by Home and Community Care Nursing and/or Community Paramedicine. An on-call virtual Physician group will be available 24/7 to provide medical advice and direction as needed to support our frontline workers and escalate to acute care when necessary.
- Southwestern Public Health COVID-19 health teaching and promotion has been provided through a number of channels to the public, with a focus on reaching all populations including those requiring special consideration related to health equity.

Changes to how services are provided in the community have been significant with a rapid and large-scale shift to virtual care, discontinuation of in-person group-based care and interventions, implementation of physical distancing measures within care settings, and the implementation of COVID-19 screening and testing protocols. In many instances, Health Professionals and Patients are reporting improvement in accessibility and convenience with virtual care offerings, and greater efficiencies.

- Virtual care is being offered across multiple platforms, ranging from low tech (landline telephone calls between patient and provider) to high tech (Webex, Zoom, MS Teams, Telus Virtual Visits, OTN).
- Within a client-centred framework, Community Support Services continued to operate utilizing a multi-pronged service-delivery approach. Innovative adaptations include mobile Adult Day Programs, food security, and activities to reduce social isolation. With these adaptations, clients continued to receive services, such as dialysis transportation, allowing them to remain safely at home. Many services transitioned to virtual models where appropriate.

We anticipate continuation of the new programs outlined above as long as the pandemic generates a need, and will focus on further integration between partners to serve our population. Ongoing offerings of virtual care options will be a priority as part of our digital health plan. A focus on digital equity, and consideration of the challenges of accessing virtual care for marginalized populations, will be crucial.

4.0. How will you transform care?

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

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

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

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

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

Please complete this table in the Full Application Supplementary Template

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.

Word Count: 493 (Maximum Word Count 500)

The pandemic has accelerated the adoption of virtual care across multiple sectors within our proposed OHT. Patients and Providers have readily accepted the adoption of this change as a necessity of staying safe. The current virtual care strategy is varied with several platforms utilized across multiple sectors, presumably due to the rapid nature of virtual care adoption in our region.

The population in our proposed OHT is varied, and digital equity will be a critical consideration, requiring a strategy that operates on a continuum, from low to high-tech while ensuring privacy and security of health information. Evaluation of the penetration and sustainability of virtual care will be a key deliverable.

Examples of virtual care platforms and strategies include:

Phone

- Primary Care Providers in our region are reporting that much of their interactions are occurring by phone between Patient and Provider. New OHIP virtual care billing codes have made this feasible for fee for service Physicians. Approximately 80% of primary care visits have been managed by phone throughout the pandemic.
- Home Care Providers have offered some of their visits through phone. Close to 100% of social work and speech therapy visits, approximately 50-60% of nutrition, Occupational Therapy and Physiotherapy visits were managed virtually.
- Hospital based consultations (Surgical, Internal Medicine Consults) and Hospital based chronic disease management programs (Diabetes Education, Cardiac Rehabilitation, Outpatient Psychiatry, Speech-Language Therapy) report completing the majority of virtual visits by phone.
- BounceBack Ontario**:** Designed to help adults and youth 15+ manage low mood, mild to moderate depression and anxiety, stress or worry.

- ReachOut: 24/7 information, support, and crisis web/chat based service for people living with mental health or addictions concerns in Elgin, Oxford, and Middlesex Counties.
- Dementia Caregiver Support Groups are being offered via teleconference when technology access is a barrier.

Videoconference

- Primary Care, Home Care, CSS, Mental Health and Addictions and Hospital-based chronic disease management report managing some virtual visits through videoconference. Platforms currently include WebEx, Zoom, Telus Virtual Visits, Microsoft Teams, OTN, and FaceTime.

Remote Patient Monitoring

- Some utilization of remote Patient monitoring through the current LHIN Telehomecare program.
- Chronic disease management programs, Primary Care, Home Care Providers and Hospital based specialists report working with a limited number of patients who own health monitoring equipment (Fitbit, electronic blood pressure cuff, scales, pulse-oximeter, blood sugar monitor) and report results during phone or video calls.

E-mail, Text, written communication:

- Chronic disease management programs, Primary Care, Community-Based Care, and Hospital-based specialists report supporting a limited number of Patients with email/text communication to relay health conditions.

Prior to the pandemic, our proposed OHT Digital Health Action Team was established. This team will work to develop a standardized and consistent virtual care strategy and develop a future state integrated care strategy anchored in current provincial assets (CHRIS, E-Notification, Clinical Connect, e-consult), working with local Acute and Primary Care EMRs. Patients accessing their own health records will be enabled through the Patient-facing portal MyChart, already available in all acute care settings in our proposed OHT.

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: Craig Hennessy
	Title: ehealth Lead
	Organization: South West Local Health Integration Network
	Email: craig.hennessy@lhins.on.ca
	Phone: 519 641 5838

4.3. How will you address diverse population health needs?

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

respect the role of Indigenous peoples, racialized communities and Francophones in the planning, design, delivery and evaluation of services for these communities.

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

4.3.1. How will you work with Indigenous populations?

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

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

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

Word Count: 241 (Maximum Word Count 1000)

Based on the Ontario First Nations Map of Indigenous communities, our attributed population does not include First Nation communities, and approximately 1.8% (based on 2019 South West LHIN updated Sub Region data) of our population identify as Indigenous. Nonetheless, we remain committed as an OHT and member organizations to deliver culturally appropriate and safe care to all communities served. Where appropriate, we will partner with and/or seek advice from Indigenous health service providers to deliver services.

Our Oxford and Area OHT members have been active supporters of Indigenous Cultural Safety as demonstrated by 182 staff members across our OHT organizations taking the Indigenous Cultural Safety training. Indigenous Cultural Safety training is an online program focused on supporting Indigenous Health transformation as part of the overall health and social service systems transformation underway in Ontario. The overarching goal of the online training course is to begin an important educational journey that will contribute to improved patient experiences, access to health services, and improved health outcomes for Indigenous people. All health service providers will be encouraged to continue to engage all staff in the Indigenous Cultural Safety training offered via the South West LHIN.

Our Oxford and Area OHT also includes a member with specialized certification, having successfully completed the OCAP (ownership, control, access, possession) Training Course and exam through the

First Nations Information Governance Centre. This is certification in understanding how First Nations data should be collected, protected, used, or shared.

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.

Word Count: 423 (Maximum Word Count 500)

In Oxford County less than 1.2% of our population report French as their first language. All organizations adhere to the French Language Services Act and report annually on French Language Services (FLS), as set out in accountability agreements.

Oxford and Area OHT recognizes that there are barriers that the Francophone population may face when accessing services. Many OHT partners have French language capacity and will leverage this as we engage the Francophone community including patient/client, caregiver, advisor, and other stakeholders' voices. To ensure that the needs of the Francophone population are better captured throughout the continuum of care, work needs to be done around identifying needs and gaps, as well as capacities, and developing strategies and solutions to efficiently meet the needs identified. Thus, Oxford and Area OHT partners will continue to strengthen the local engagement with Francophone stakeholders and members in our communities including the Erie St. Clair (ESC)/South West (SW) French Language Health Planning Entity and the local French Language Services Coordinator in the planning, design, delivery and evaluation of services to meet the care needs of the Francophone population.

Oxford and Area OHT partners will also work to ensure that there is a process for Oxford Francophones 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. Translation services are also available across all sectors, and several organizations employ French-speaking clinicians as well as Interpretation services through staff at the Ingersoll Nurse Practitioner Led Clinic. Hospitals across the region keep lists of all staff who speak languages other than English as part of their Human Resources data. Combined Tillsonburg District Memorial Hospital, Alexandra Hospital Ingersoll, and Woodstock Hospital have 24 staff members that possess intermediate to advanced level French language skills and are available as interpreters. Sharing French Language resources and/or staff as required across the system is encouraged by all members of the Oxford and Area OHT.

Oxford and Area OHT will also leverage the Ministry of Health guidance to requirements and obligations relating to French language health services (2017), Ontario Health service toolkits, lessons

learned and training opportunities such as the Online Cultural and Linguistic Sensitivity Training (launching in Fall 2020), and Healthy Communities Link recommendations when developing engagement strategies to ensure that our Francophone stakeholders and members in our communities feel included, valued and stay healthy.

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

Word Count: 500 (Maximum Word Count 500)

Taking a population health approach we will aim to deliver proactive and preventative care in addition to treatment to improve the overall health of our population and reduce inequities. We will offer a suite of services that address the multiple determinants of health by taking care into the community and leveraging our inter-sectoral partnerships.

In proactively planning broader access to ongoing health supports for our Year 1 Population, Mental Health and Addictions (MH&A), low income/marginalized/vulnerable will be a key priority population. Specifically, actions will include:

Expand & Strengthen for Year 1 Target Populations:

- **Virtual Care (phone/video/messaging):** Building on the pandemic experience, continuing to anchor virtual care as a proven method to reach individuals who may not otherwise have reached out in the past for face-to-face MH&A services, while minimizing traditional transportation barriers in a rural setting.
- **Virtual Hub Children & Youth** (established during pandemic): Expand awareness and access to a Virtual Hub intended as a safe space for all youth to connect to mental health, employment, housing, and addiction resources.
- **MH&A Walk-In Counselling:** Consolidate successful but separate walk-in counselling services as a "one-stop" point of access for easier navigation and service coordination.
- **Rapid Access Addiction Medicine (RAAM) Clinic:** Expand RAAM on-site services to Ingersoll and Tillsonburg. Prescribed medications are Suboxone, and now Sublocade (an injectable every 28 days rather than weekly prescriptions for clients who fit criteria) for Opioid Use Disorder, and Naltrexone for Alcohol Use Disorder. Hepatitis-C services will also be introduced.
- **Peer Support Transitional Discharge Program:** A joint initiative with CMHA and Woodstock Hospital. Increase presence of Peer Support and improve continuity of care, making timely and appropriate connections for MH&A patients, alongside referrals to Peer Resource Networks across Oxford.
- **Mental Health Engagement and Response Team (MHeart):** Strengthen continued partnership between CMHA's mobile crisis team, Woodstock Hospital, Woodstock Police, and Oxford OPP by providing greater access, and reducing wait times, for comprehensive community-based crisis response.

New Program Implementation & Evaluation for Year 1 Target Populations:

- **Mobile Health Outreach Bus**: Mobile health care and wraparound services meeting individuals "where they are at" throughout the community at familiar, consistent locations County-wide. Services include acute-episodic care, IPAC, health education, wound/vein care, harm reduction, foot care, COVID-19 testing, MH&A counselling, housing stability, system navigation, food security, and basic hygiene supplies.
- **Oxford County Drug Treatment Court:** Proven alternatives to incarceration, including special court processes which will take a comprehensive approach intended to reduce crimes due to drug dependency through judicial supervision, substance abuse treatment, drug testing, incentives/sanctions, clinical case management, and social services support.
- **Integration of Mental Health and Addiction Agencies:** Goals of agency integration between CMHA Elgin Middlesex, Oxford, and Addiction Services Thames Valley include greater reach into the community, creating easier access across the geography and within specialized populations by implementing teams of MH&A specialists serving local communities.

Additionally, we will continue to collaborate with Southwestern Public Health to develop strategies that will support the previously mentioned populations of temporary foreign workers and Old Order Amish/Mennonite/Low German speaking faith based communities.

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

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

Word Count: 500 (Maximum Word Count 500)

COVID-19 exacerbated the existing inequalities in accessing healthcare and support services for those at-risk even prior to the pandemic. Gradual re-opening of services with many restrictions will continue to compound health behaviours, mental health challenges, addictions, isolation, anxiety, and conflict management.

Over the course of the past several months, several strategies have been developed to address populations at elevated risk for COVID-19 related to physical setting and IPAC challenges. Public Health guidance has been the backbone of these initiatives, which all involve partnerships across sectors. These include:

Temporary Foreign Worker Primary Care Outreach: Neighbouring counties have faced large-scale COVID-19 outbreaks within their Temporary Foreign Worker population on farms. Aiming to prevent similar happenings within our region, our OHT partners, along with the financial support of Oxford County developed a Temporary Foreign Worker support program if farms go into an outbreak situation or require mass testing. The workers will be supported by Home and Community Care Nursing and/or Community Paramedicine. An on-call virtual Physician group will be available 24/7 to provide medical advice and direction as needed to support our frontline workers and escalate to acute care when necessary.

Oxford Pandemic Response Protocol/Team for Vulnerable Individuals: Partnership between Oxford County Human Services, Southwestern Public Health, Salvation Army, The Inn (Shelter), Oxford County Community Health Centre, Dr. Rachel Orchard, and Oxford County Paramedic Services was established. Focus to develop pandemic response protocols and plans specific to vulnerable individuals within the region including screening and testing protocols, strategies for outbreak within shelter settings, provision of food and shelter during pandemic.

Congregate Settings:

Evacuation Protocols: Early in the pandemic, evacuation protocols were developed for congregate settings in our region including shelters, RHs, LTCs and residential hospices. Partnerships between Municipalities, Hospitals, Congregate Settings, Public Health, Home Care, and Primary Care were established to plan for physical location of affected individuals and health care provision.

Assisted Living Network: A partnership of Assisted Living (AL)/Supportive Housing (SH) providers across the SW LHIN, in collaboration with Ontario Health West, developed a repository of MoH funded spaces to support effective risk identification and mitigation strategies during COVID-19. A risk dashboard is populated weekly by provider organizations, identifying risk levels with respect to PPE, HHR, and IPAC. Communication protocols have been implemented to ensure timely risk identification and response.

Long Term Care Reduction of Ward Rooms: Directive 3 for LTC homes under the Long-Term Care Act (June 10, 2020) required LTCs to eliminate ward rooms from their settings. This required partnerships between Hospitals, LHINs and LTC homes to manage waitlists differently, hold patients for extended periods in the community or Hospital while these changes are made.

Hospice based Palliative Care Services offered in the community: With the cessation of group-based support programs for Caregivers of terminally-ill Patients or bereaved loved ones, Residential and Community Hospice Programs have moved to providing 1:1 residential and community outreach services rather than group sessions, virtually and in person. Virtual group support programs are in being developed, alongside other strategies to effectively support this population.

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

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

Word Count: 799 (Maximum Word Count 1000)

Three audiences will be engaged in care redesign under the Oxford and Area OHT: the General Public, Patients/Families/Caregivers, and Patient and Family Advisors. Each of these audiences provide a critical perspective on redesigning care towards an integrated approach. To hear from each audience we are planning a variety of engagement methods that will create a continually improving system - one that learns from, and evolves, based on ongoing feedback from those most impacted by care.

General Public
The General Public will be engaged through three different approaches.

First, they will be informed how the OHT model of care works through Newsletters, our Website, and Social Media. The purpose will be to inform and build trust about the overall purpose and structure of the OHT model.

Second, we will consult with the General Public through Virtual Town Halls across our community. The purpose of this will be to inform and build trust about the overall purpose and structure of the OHT model and seek broad priorities for visioning and broad direction of the work.

Finally, we intend to involve the public in strategic planning activities to ensure overall strategy and vision of the OHT meets local needs, values, and priorities.

Patients/Families/Caregivers from Year 1 Subpopulations (Chronic Illness, Palliative, Mental Health and Addictions)
Patients, their Families, and their Caregivers will all have a critical perspective of how care redesign is working and whether it is meeting their needs. Patients/Families/Caregivers from Year 1 Subpopulations will be engaged through three different approaches.

First, they will be informed about the overall purpose and structure of the OHT model and, more specifically, about the care redesign for their subpopulation. This information will be delivered by brochures, our website, and social media. Beyond sharing details of the overall OHT model, information will also be shared with this group about how to navigate care and how to access their 24/7 contact and digital platforms. We will develop health literacy materials to help this group be active members in their care.

Second, we will consult with this group through check-ins at regular intervals (3, 6, 9, 12 months) to assess both patient experience and patient outcomes. Patient reported experience and outcome measures will evolve pathways for each Year 1 priority population. A patient relations process will also be created that enables Patients/Families/Caregivers to voice concerns, including safety incidents, and seek resolution.

Third, we will collaborate with this group so that they can have access to peer support and tap into experiential knowledge of people having lived, or currently living, through a health condition of similar nature.

Finally, we will provide resources, including peer support resources, where Patients/Families/Caregivers can receive assistance by tapping on the experiential knowledge of those who have experienced, or are currently experiencing care of a similar nature.

Patient and Family Advisors (PFAs)
PFAs will be engaged through four different approaches.

First, at an involve level, we have already learned from, and build solutions around, the experience of PFAs through patient journey mapping. This information has helped our Year 1 Action Teams generate a redesigned model of care.

Second, at a collaborative level, PFAs have helped to shape the overall Oxford and Area Ontario Health Team application and the pathway defined by each Year 1 Action Team so far. They developed a Patient Engagement Framework to ensure the voice of patients inform care redesign in accordance with the Ontario Health Team.

Third, at a co-design level, in addition to already having two PFAs on our Coordinating Committee, we recently explored the role of patient leadership to have full participation of patients at all levels of decision-making within our Oxford and Area OHT. Our PFAs developed criteria for the qualities of an effective leader on the Steering Committee and we recently had a PFA join this group to guide strategic decision-making.

Going forward, we are committed to creating a Patient and Family Advisory Council drawn from Patient and Family Advisors from across member organizations that will guide the Oxford and Area OHT in its future operations.

Evaluation and Measurement
Critical to understanding whether patients feel their input in redesign is valued, an evaluation program will be launched, tailored towards each audience and which method their input is gathered. For example, for less engaged audiences, we will start with simple evaluation surveys to evaluate process and outcome indicators. As we engage people in greater depth, we will conduct focus groups and in-depth interview evaluations. This will help us assess whether we can adjust our engagement methods and create opportunities that match with individual expectations.

Patient Declaration of Values
As stipulated by the OHT model requirements, each organization within an OHT shall base a Declaration of Values on the Provincial Patient Declaration of Values. This will help to empower patients and ensure they play an active role in care redesign.

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.

Word Count: 863 (Maximum Word Count 1000)

The members of the Oxford and Area OHT are fully and completely committed to achieving the vision of enhanced, more connected care for the people and communities we serve and we have continued to work collaboratively toward that goal. The COVID-19 pandemic presented challenges to all of us beyond anything we have imagined, but the strength of our relationships, trust and commitment to patient care allowed Oxford to respond seamlessly to the challenges faced. Having identified the

"silver linings" and lessons learned over the last six months, we will build new processes into our existing work to ensure we are planning for the "next normal" at future state.

As we learn to live with COVID-19, now more than ever, our healthcare systems are called upon to reach beyond individual-level care and address the health of the population as a whole and we will continue to seek out innovative approaches to healthcare planning and decision-making that apply the population health approach. COVID-19 has shone a spotlight on the multiple determinants of health, many of which lie beyond the traditional scope of health systems. Accordingly, we recognize the importance of inter-sectoral partnerships at the community level, across and amongst different levels of government, and between Health Care Providers and other Professionals who have a role in influencing health.

Time Frame:

A. Pre-Approval Phase

After our Full Application is submitted and prior to approval, we will continue to refine our model and implementation plan.

Priority Deliverables:

i. Establish our Collective Decision-Making Arrangement (CDMA). A great deal of work has been done by the team to clearly articulate our vision and our shared commitment to achieve the quadruple aim which will serve as a launching point for completing this critical work.
ii. Refine Year 1 care pathways for our priority populations with a focus on those populations identified as having distinct healthcare needs in our geography (Temporary Foreign Workers, Old Order Amish, Mennonite, and Low German speaking, older adults, Low income/marginalized/precariously housed/homeless).
iii. Integrate and formalize care pathways developed during the early stage of the pandemic including Wave 2 planning for disease surge in our communities (Hospital Wave 2 Plan, Community Paramedicine, Primary Care support for vulnerable in the community).

COVID-19 Impact: This phase will occur in the Fall. There is high probability of this work occurring in the context of anything from localized outbreaks to full countywide surge in cases.

B. Post Approval

PLANNING PHASE

Day 0 to Day 30

i. Finalize CDMA terms and accountabilities.
ii. Establish Board-to-Board reference group.
iii. Expand reach into the communities we serve to ensure fulsome and meaningful engagement through visioning sessions. This will serve to solidify commitment and engagement to creating a better health care system for Oxford and Area.
iv. Establish detailed project plans for implementation of Year 1 care pathways. The project plans will include the principles of change leadership and a change management plan. Project plans will be essential both in using a population-health management approach to move the needle on quadruple-aim metrics for Year 1 priority populations and in putting in place the eight OHT building blocks.
v. Formalize and broaden communications plan.

vi. Expand our Patient Engagement Action Team to include members of the Old Order Amish, Mennonite, and Low German speaking, community.
vii. Review membership of all Action Teams and Councils to ensure broad and diverse representation and recruit as necessary.

Milestones:

- CDMA 75% complete
- Visioning session complete
- Project plans complete
- Communication plan complete
- Action Teams populated

Day 30 to Day 90

i. Continue to conduct detailed and extensive partnership engagement opportunities throughout planning process.
ii. In alignment with the Provincial Patient Declaration of Values and utilizing principles of co-design together with our Patients, Families and Caregivers will create detailed workflows, and pathways for implementation, including navigation and patient relations processes.
iii. Establish key performance metrics with the assistance of a decision support action team.
iv. Initiate development of digital solutions (resources required) and planning for future.

Milestones:

- Additional community engagement session held
- Co-design sessions complete for each Year 1 priority population
- Performance metrics identified and initial data pull completed
- Digital solutions identified and procurement process initiated

Day 90 to Day 180

i. Develop patient experience measurement tool and patient reported outcomes tool.
ii. Begin prototyping of new care models including system navigation.
iii. Develop detailed performance scorecards and key performance indicator dashboard.
iv. Rapid cycle learning and continuous improvement to ensure course correction.
v. Ongoing Stakeholder feedback/engagement sessions.
vi. Establish service-level agreements, as needed.
vii. Establish data sharing agreements as needed.
viii. Establish Home Care Agreement.
ix. Establish Risk Matrix.

Milestones:

- Patient Reported Experience Measures (PREM) and Patient Reported Outcomes Measures (PROM) identified
- Dashboard developed
- SLA and DSA drafted
- Risk matrix established with mitigation strategies implemented
- Home Care Agreement details finalized

IMPLEMENTATION PHASE
Day 180 to Day 365

i. Implement digital coordination tools.
ii. Implement a care pathway for each priority population.
iii. Begin development of the first Strategic Plan.
iv. Ongoing Stakeholder engagement/feedback sessions.

Milestones:

- Digital tools in testing phase
- Care pathways initiated – one per priority population
- Home Care contracts finalized
- Strategic planning initiated, building upon the Vision established for the Oxford and Area OHT in the Planning phase.

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

Word Count: 31 (Maximum Word Count 1000)

- During the pandemic, the ongoing Ministry of Health guidance documents have proven valuable across many sectors. We would hope for these resources to continue throughout subsequent pandemic waves and during recovery.

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.

Word Count: 477 (Maximum Word Count 1000)

Significant lack of affordable housing alternatives in Oxford County: < 2.5% vacancy rate in Oxford County. A balanced rental market is considered 3% or higher. Average rent in Oxford County exceeds that of London and surrounding areas. Housing is a key social determinant of health and will affect our success in healthcare transformation for distinct target populations.

Client fee structure: Many health and community services require a client co-pay or full pay. Many low-income seniors cannot afford the fee attached to these services and therefore are unable to access these benefits.

Service maximums: Recommend the development of a clear and consistent policy framework to ensure an equitable and client-focused, cost-effective approach to address the removal of service maximums.

Privacy Legislation Current State: Current PHIPA legislation has constraints that will make data and information sharing across sectors next to impossible. Amendments of this legislation to support integrated teams and OHT models will be required.

Public Sector Labour Relations Transition Act (**PSLRTA):** Current labour legislation is restrictive related to integrations across sectors.

Access to Family Physicians in Oxford County:
This has been a significant historical barrier to our Patients receiving true continuity of care. The problem has been exacerbated by recent population expansion and slow growth of the Physician pool. As a result, Oxford County has been recognized as an Underserved Area by the Ministry of Health. Uncertainty in the future of current Physician funding models, and the financial hardship related to opening community practices, poses challenges to recruiting new Physicians into the community. Endeavouring to provide long-term predictability of funding, supporting Physicians in new practice, and providing support for Physicians to take on leadership roles will remove many barriers to Physicians, and allow them to join our community and provide excellent care.

Other systemic barriers:
- PSW and Nursing shortage.
- Wage disparity across sectors.
- Volunteers needed for delivering services and many volunteers have declined or unable to support.
- PPE shortages and costs.
- Technology requires investment to enable virtual services, for both Clients/Patients and Providers.
- Organizations requiring fundraising to support operations are challenged at the best of times. COVID-19 has impacted fundraising ability significantly.
- Lack of funding in general to support organizations.
- MRP Data capture issues with Nurse Practitioner and CHC Physicians as these practitioners do not bill to OHIP.
- Patients that are not rostered to a Nurse Practitioner creates difficulties if the Patient has received care elsewhere. This results in poor continuity of care and additional costs to the healthcare system, such as duplicate testing.
- Fee-for service structure can create barriers when patients are forced to attend ED if unable to be seen by family Physician
- The current Physician services funding model places a financial disincentive on the utilization of urgent care clinics

Virtual Care funding (OHIP billing codes) for Physicians
- The availability of this funding has enabled virtual care to happen. This must be maintained to sustain these gains.

Oxford and Area Ontario Health Team

Supplementary Template

INSTRUCTIONS

This template requires your team to identify the individual primary care physicians, specialists, health care organizations/providers, and other organizations (e.g. social services) that form the current membership of your proposed Ontario Health Team. Additionally, information on proposed performance measures to be monitored and tracked should be completed within this template.

Overview:

Tab 2.1.1

Requires information on your primary care physician or physician group members.

Note: If your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as members, please also list them and their specialty in the table. This information will be used to assess primary care representation and capacity/coverage and informs the attribution network for physicians. **Examples on how to complete this section have been provided within the**

Tab 2.1.2

Requires information on your member organizations (not including physician(s)/physician groups).

Please note the following as you complete this section:

- Physicians and health care organizations **should only be members of one Ontario Health Team**. For example, a hospital provider cannot participate in more than one OHT. *Please see Section 2 of the Full Application for exceptions*.
- A requirement for approval 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).

Tab 2.2

Requires information on members that have signed on or otherwise made a commitment to work with other teams.

Tab 4.1

Requires information on performance measures your team plans to monitor and track success in Year 1.

2.1.1 Primary Care Partnerships

NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column E).*	PHYSICIAN NAME (Last name, First name) *Providing the full list of your partner physicians will be critical for identifying which OHT attribution network the physician or PEM is affiliated and level of physican engagement*	PRACTICE MODEL *Select model type from dropdown list. If 'other' is selected, please specify model type in Other .*	PARTNERED WITH ANOTHER TEAM *Y/N - Confirm that this physician partner is not signed onto another team. If members of your team have signed on or otherwise made a commitment to work with other teams please complete tab 2.2.*	OTHER *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here. Note here if a FHT is a member but not its associated physician practice(s) and vice versa.*
PEM - ALLIANCE FHO	Bonnett, Jennifer	FHO - Family health organization	N	There are 9 physicians in the PEM, 3 are partnered to the OHT Application
PEM - ALLIANCE FHO	Orchard, Rachel	FHO - Family health organization	N	There are 9 physicians in the PEM, 3 are partnered to the OHT Application
PEM - ALLIANCE FHO	Tamachi, Shameena	FHO - Family health organization	N	There are 9 physicians in the PEM, 3 are partnered to the OHT Application
PEM - INGERSOLL FHO	Baker, Kimberly	FHO - Family health organization	N	There are 12 physicians in the PEM, 1 is partnered to the OHT Application
PEM - PERRY STREET FHO	Nichols, Jeffrey	FHO - Family health organization	N	There are 7 physicians in the PEM, 1 is partnered to the OHT Application
OTHER, PLEASE SPECIFY	Sondhi, Jitin	Other	N	FP, Palliative Medicine, Sakura House Hospice
OTHER, PLEASE SPECIFY	Hons, Ian	Other	N	Woodstock Hospital, Hospitalist, applied to become part of Alliance FHO
OTHER, PLEASE SPECIFY	Hamilton, Joel	Other	N	Oxford County CHC Physican
OTHER, PLEASE SPECIFY	Surkont, Michael	Other	N	Pain Physician, Tillsonburg District Memorial Hospital
PEM - RIDOUT FHO	Cheng, Will	FHO - Family health organization	N	There are 10 physicians in the PEM, 1 is partnered to the OHT Application

2.1.2 Home and Community Care and Secondary Care Partners

NAME OF ORGANIZATION *Provide the legal name of the member organization*	TYPE OF ORGANIZATION *Select type from dropdown list, if 'other' please specify type in column C*	OTHER ORGANIZATION TYPE	FACILITY SITE(S) *(For all of your hospital and Community Health Center partners please identify all of the specific sites that are partners ex. Quinte Healthcare, Belleville General Hospital site)*
Addiction Services Thames Valley	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Alexandra Hospital Ingersoll	HOSPITALS		Only 1 Site
Alzheimer Society of Oxford	COMMUNITY SUPPORT SERVICES		
Canadian Mental Health Association, Oxford	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
CarePartners	HOME CARE SERVICE PROVIDER ORGANIZATION		
CBI Home Health	HOME CARE SERVICE PROVIDER ORGANIZATION		
Indwell	OTHER, PLEASE SPECIFY	Affordable Housing	
Ingersoll Nurse-Practioner-Led Clinic	NURSE PRACTITIONER LED CLINICS		
Oxford County - Woodingford Lodge Long Term Care	LONG-TERM CARE HOMES		
Oxford County Community Health Centre	COMMUNITY HEALTH CENTRES		2 Satellite Sites - Ingersoll and Tillsonburg
Oxford County Paramedic Services	MUNICIPALITY		
Oxford Human Services	OTHER, PLEASE SPECIFY	Human Services	
peopleCare Tavistock	LONG-TERM CARE HOMES		
Saint Elizabeth Health Care	HOME CARE SERVICE PROVIDER ORGANIZATION		
South West Local Health Integration Network (LHIN)	OTHER, PLEASE SPECIFY	H&CC	
Southwestern Public Health	OTHER, PLEASE SPECIFY	Public Health	
Thames Valley Family Health Team	OTHER, PLEASE SPECIFY	Primary Care, FHT	
Tillsonburg District Memorial Hospital	HOSPITALS		Only 1 Site
Victoria Order of Nurses	COMMUNITY SUPPORT SERVICES	*operates VON Sakura House Hospice	
Wellkin Child and Youth Mental Wellness	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Woodstock Hospital	HOSPITALS		Only 1 site

2.2 Confirming Other Team Partnerships

If members of your team have signed on or otherwise made a commitment to work with other teams, please identify the partners below:

Team Member	Other Affiliated Team(s)	Reason for affiliation
	List the other teams that the member has signed on to or agreed to work with	*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)*
Thames Valley Family Health Team	Western Ontario Health OHT	FHT has 2 Satellite FHO's located within the Oxford and Area OHT – Alliance FHO and Perry Street FHO

4.1 Performance Measures

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).

Performance Measures	Purpose/Rationale	Method of Collection/Calculation
1. Percentage of OHT attributed population who had a virtual health care encounter in the last 12 months	**Consistent with Public Health measures related to COVID, focus on provision of virtual care across all health settings including Home and Community Care, Hospital, Primary Care, Community Support Services.**	**Fee for Service physician Virtual Billing, Home Care Service provider billing codes (CHRIS), Group Practice data collection from EMR**
2. Frequent ED visits (4+ per year) for mental health and addictions	**20-30% repeat unscheduled ED visits within 30 days for substance abuse across all acute care sites Evaluate year 1 interventions for Mental health and Addictions population.**	**Integrated Data Store (source) using crystal reports to extrapolate with MHA diagnose**
3. 30-day inpatient readmission rate for Chronic, Palliative, and Mental Health and Addictions Populations	**Oxford Hospitals have an 18.3% readmission rate for chronic conditions. In the fiscal year 2018-19, this equated to 350 readmissions (within 30 days of discharge), with an average admission LOS of 6.2 days. Currently experiencing high levels of 30-day admission for chronic disease and Palliative care. Evaluate impact of Year 1 Integrated Care interventions (i.e. Nurse Navigator model)**	**Integrated Data Store (IDS) for all Oxford hospitals for identified CMGs**
4. Patient reported experience and outcome measures and provider experience measures	**Overall evaluation of patient and provider experience**	**To be developed- Surveys, provided in various formats (i.e. digital, paper, verbal)**

Oxford and Area Ontario Health Team

Membership Approval

Membership Approval

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

Team Member	
Name	**Linda Sibley**
Position	**Executive Director**
Organization	**Addiction Services Thames Valley**
Signature	**See Letter of Support**
Date	**September 15, 2020**

Team Member	
Name	**Al Lauzon**
Position	**Board Chair**
Organization	**Alexandra Hospital Ingersoll**
Signature	Allan Lauzon Digitally signed by Allan Lauzon DN: cn=Allan Lauzon, o=University of Guelph, ou=SEDRD, email=allauzon@uoguelph.ca, c=CA Date: 2020.09.15 09:28:10 -04'00'
Date	**September 15, 2020**

Team Member	
Name	**Glen Harrop**
Position	**Board President**
Organization	**Alzheimer Society of Oxford**
Signature	
Date	**August 24, 2020**

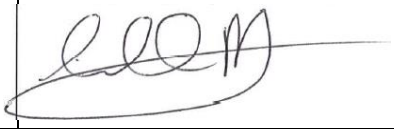
Team Member	
Name	**Lynn Wardell**
Position	**Interim Executive Director**
Organization	**Canadian Mental Health Association, Oxford**
Signature	**See Letter of Support**
Date	**September 15, 2020**

Team Member	
Name	**David Fry**
Position	**Chief Innovation and Operations Officer**
Organization	**CarePartners**
Signature	
Date	**August 25, 2020**

Team Member	
Name	**Bernie Rilling**
Position	**VP Finance**
Organization	**CBI Home Health**
Signature	
Date	**September 15, 2020**

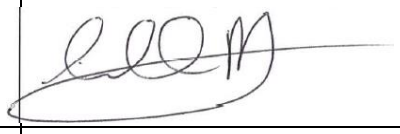
Team Member	
Name	**Alice Plug-Buist**
Position	**Board President**
Organization	**Indwell**
Signature	
Date	**September 11, 2020**

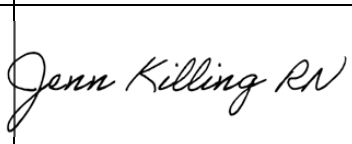
Team Member	
Name	**Lisa Penner**
Position	**Board Chair**
Organization	**Ingersoll Nurse-Practioner-Led Clinic**
Signature	
Date	**August 24, 2020**

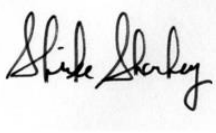
Team Member	
Name	**Michael Duben**
Position	**Chief Administrative Officer**
Organization	**Oxford County - Woodingford Lodge Long Term Care**
Signature	
Date	**September 17, 2020**

Team Member	
Name	**Alisha Stubbs**
Position	**Board Chair**
Organization	**Oxford County Community Health Centre**
Signature	
Date	**September 9, 2020**

Team Member	
Name	**Michael Duben**
Position	**Chief Administrative Officer**
Organization	**Oxford County Paramedic Services**
Signature	
Date	**September 17, 2020**

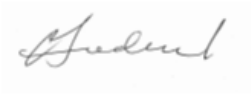
Team Member	
Name	**Michael Duben**
Position	**Chief Administrative Officer**
Organization	**Oxford Human Services**
Signature	
Date	**September 17, 2020**

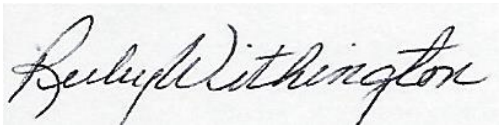
Team Member	
Name	**Jennifer Killing**
Position	**Vice President, Quality and Innovation**
Organization	**peopleCare Tavistock**
Signature	
Date	**September 16, 2020**

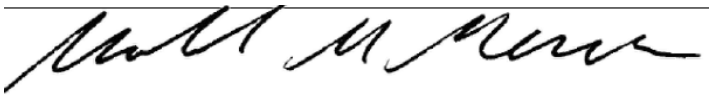
Team Member	
Name	**Shirlee Sharkey**
Position	**Director**
Organization	**SE Health**
Signature	
Date	**September 16, 2020**

Team Member	
Name	**Daryl Nancekivell**
Position	**Vice President, Home and Community Care**
Organization	**South West Local Health Integration Network (LHIN)**
Signature	
Date	**August 31, 2020**

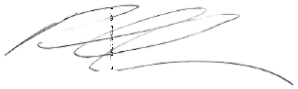
Team Member	
Name	**Larry Martin**
Position	**Board Chair**
Organization	**Oxford, Elgin, St. Thomas Board of Health**
Signature	
Date	**August 24, 2020**

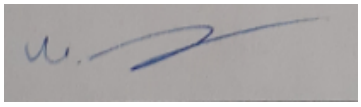
Team Member	
Name	**Cathy Frederick**
Position	**Board Chair**
Organization	**Thames Valley Family Health Team**
Signature	
Date	**September 16, 2020**

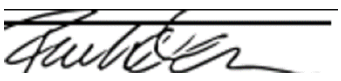
Team Member	
Name	**Ruby Withington**
Position	**Board Chair**
Organization	**Tillsonburg District Memorial Hospital**
Signature	
Date	**September 15, 2020**

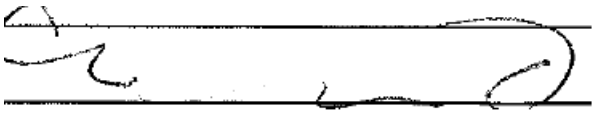
Team Member	
Name	**Malcolm Mercer**
Position	**Board Chair**
Organization	**Victoria Order of Nurses for Canada – Ontario Branch**
Signature	
Date	**September 14, 2020**

Team Member	
Name	**Mary Roberts**
Position	**Board President**
Organization	**Wellkin Child and Youth Mental Wellness**
Signature	
Date	**September 14, 2020**

Team Member	
Name	**Rick Shaheen**
Position	**Board Chair**
Organization	**Woodstock Hospital**
Signature	
Date	**August 26, 2020**

Team Member	
Name	**Dr. Michael Surkont, M.D., ACCAPM, CSME**
Position	**Secretary/Treasurer, Professional Staff Association, TDMH** **Chair, OMA Section on Chronic Pain**
Organization	**Tillsonburg District Memorial Hospital, OMA**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Dr. Rachel Orchard**
Position	**Primary Care Physician**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

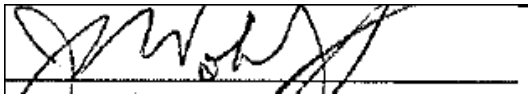
Team Member	
Name	**Dr. Shameena Tamachi**
Position	**Primary Care Physician**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

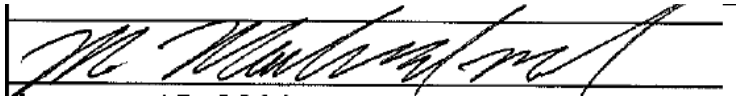
Team Member	
Name	**Dr. Kimberly Baker**
Position	**Primary Care Physician**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Dr. Jitin Sondhi**
Position	**Palliative Medicine Specialist**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

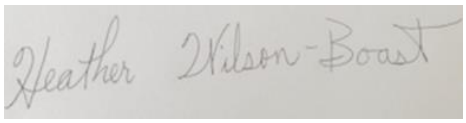
Team Member	
Name	**Dr. Ian Hons**
Position	**Physician, Hospitalist**
Organization	**Woodstock Hospital**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Dr. Joel Hamilton**
Position	**Primary Care Physician**
Organization	**Oxford County Community Health Clinic**
Signature	
Date	**September 9, 2020**

Team Member	
Name	**Dr. Joel Wohlgemut**
Position	**Chief of Staff**
Organization	**Alexandra Hospital**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Dr. Malcolm MacLeod**
Position	**Chief of Staff**
Organization	**Woodstock Hospital**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Dr. Will Cheng, M.D.**
Position	**President, Medical Staff, TDMH and Primary Care Physician**
Organization	**Tillsonburg District Memorial Hospital** **Primary Care Physician, Tillsonburg**
Signature	
Date	**September 16, 2020**

Team Member	
Name	**Heather Wilson-Boast**
Position	**Patient Advisor, OHT Steering Committee**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

Team Member	
Name	**Mr. Ernie Hardeman**
Position	**MPP, Oxford County**
Organization	**Member of Provincial Parliament**
Signature	**See Letter of Support to the Honourable Christine Elliott**
Date	**September 11, 2020**

Team Member	
Name	**Valerie Joyce**
Position	**Patient Advisor, OHT Coordinating Committee**
Organization	**Not Applicable**
Signature	
Date	**September 15, 2020**

Addiction Services
of Thames Valley | Services de toxicomanie de Thames Valley

200 Queens Avenue, Suite 260, London, Ontario N6A 1J3
t. 519-673-3242 f. 519-673-1022 adstv.ca

May 14, 2019

Randy Peltz, Executive Director
Oxford County Community Health Centre
35 Metcalf Street, Unit 301
Woodstock ON N4S 3E6
rpeltz@oxchc.ca

Re: Oxford County Ontario Health Team (OHT) Application Process

Dear Health System Partner:

Thank you very much for the opportunity to participate in the discussions about the development of the Ontario Health Team in our area. It is so encouraging to see mental health and addiction services included in such a prominent way in the essential elements of the OHT planning. There is no doubt that those we serve will benefit greatly from this holistic approach to health care.

I am writing to indicate our support for the Oxford County OHT in this application process. We strongly endorse the spirit of partnership and the focus on the community needs that are reflected in the application. However, at this time, we are not able to sign the formal application because of the work currently underway to integrate our four organizations (Addiction Services of Thames Valley, CMHA Elgin, CMHA Middlesex and CMHA Oxford). Our primary focus is strengthening the mental health and addiction service system so that we may better serve all Ontario Health Teams in our area and thus improve the process and outcomes for those we serve. We anticipate that in the coming months, we will be in a much better position to partner with the OHT.

We wish you much success in the application and look forward to working with you as the teams develop.

Best regards,

Linda Sibley.

Linda Sibley, Executive Director
Addiction Services of Thames Valley
V: 519-673-3242 ext. 226 E: lsibley@adstv.ca

cc: Sandy Jansen, President and Chief Executive Officer, Alexandra Hospital Ingersoll and Tillsonburg District Memorial Hospital, sandy.jansen@tdmh.on.ca

Serving London, Middlesex, Elgin and Oxford

Canadian Mental Health Association
Oxford County
Mental health for all
Charitable Registration #118834217

Association canadienne pour la sante mentale
Oxford County
La sante mentale pour tous
Enregistrement charitable #118834217

United Way Oxford

May 14, 2019

Oxford County Ontario Health Team
c/o Sandy Jansen
President and Chief Executive Officer
Alexandra Hospital Ingersoll and
Tillsonburg District Memorial Hospital

Dear Oxford County Ontario Health Team Partners:

Thank you very much for the opportunity to participate in the discussions about the development of the Ontario Health Team in our area. It is so encouraging to see mental health and addiction services included in such a prominent way in the essential elements of the OHT planning. There is no doubt that those we serve will benefit greatly from this holistic approach to health care.

I am writing to indicate our support for the Oxford County Ontario Health Team in this application process. We strongly endorse the spirit of partnership and the focus on the community needs that are reflected in the application. However, at this time, we are not able to sign the formal application because of the work currently underway to integrate our four organizations (Addiction Services Thames Valley, CMHA Elgin, CMHA Middlesex and CMHA Oxford). Our primary focus is strengthening the mental health and addiction service system so that we may better serve all Ontario Health Teams in our area and thus improve the process and outcomes for those we serve. We anticipate that in the coming months, we will be in a much better position to partner with the OHT.

We wish you much success in the application and look forward to working with you as the teams develop.

Best regards,

Lynn Wardell, BA, BSW, MSW, RSW
Interim Executive Director

522 Peel Street,
Woodstock ON N4S 1K3
Tel: 519-539-8055
Fax: 519-539-8317

40 Brock Street West
Tillsonburg ON N4G 2A2
Tel: 519-842 8869
Fax: 519-842 9425

C/o Ingersoll Nurse Practitioner-Led Clinic
19 King Street East, Ingersoll ON N5C 1G3
Tel: 519-928-6752
Fax: 519-539-8317

Ontario
LEGISLATIVE ASSEMBLY

ERNIE HARDEMAN, MPP
Oxford

Constituency Office:
12 Perry Street
Woodstock, ON N4S 3C2
Tel: (519) 537-5222
Fax: (519) 537-3577

September 11, 2020

The Honourable Christine Elliott
Minister of Health
College Park 5th Flr,
777 Bay St.,
Toronto, ON
M7A 2J3

Dear Minister Elliott,

It is my pleasure to express support for the application by the proposed Oxford and Area Ontario Health Team – one of the 17 teams recently invited to complete full applications.

Recently, the Oxford and Area OHT outlined the framework for its application, focusing on plans to improve care for three priority populations. Based on data reviewed by the proposed Oxford team, the application will detail plans to improve care for people with multiple chronic conditions; people with palliative care needs; and people experiencing challenges related to mental health and addictions.

The group of individuals that have come together to form this proposed OHT have successful record related to collaboration to improve care for patients and all are committed to working together on the OHT.

Minister, the proposed Oxford and Area OHT has provided all the information required to indicate the team is dedicated to building a connected health care system centred around patients, families and caregivers.

I believe this is a positive application and hope that you will review it and consider its benefit to the residents of our area of rural Southwestern Ontario.

Thank you, Minister, for your consideration of the application by the proposed Oxford and Area Ontario Health Team.

Best regards,

Ernie Hardeman
MPP Oxford