Ontario Health Team

SELF-ASSESSMENT SUBMISSION

Oxford Region OHT

May 2019

Ontario Health Team
Self-Assessment Form

Part I: General Information and Commitments

Who are the members of your team?

Please identify the list of health care providers and/or organizations that would partner to form the proposed Ontario Health Team. Please explain why this group of providers and organizations has chosen to partner together.

KEY MESSAGE: As equal and trusted partners, we unanimously embrace change with similar forethought and commitment – we are prepared to serve as an early adopter rural OHT to engage in redesign and share lessons.

The Oxford Ontario Health Team is comprised of 20 cross-sectoral partners with a strong history of collaboration and integration of services. By leveraging existing relationships, we are confident in our ability to deliver quickly on the vision of the OHT. Organizations include:

Primary Care: Ingersoll Nurse-Practitioner Led Clinic; Thames Valley Family Health Team; Oxford County Community Health Centre
Acute Care: Alexandra Hospital Ingersoll; Tillsonburg District Memorial Hospital; Woodstock Hospital
Home and Community Care: Oxford Palliative Care Outreach Team; South West LHIN Home and Community Care; VON Community Support Services and Sakura House Residential Hospice; Alzheimer Society of Oxford
Long Term Care: PeopleCare Communities; Woodingford Lodge
Mental Health and Addictions: Canadian Mental Health Association Oxford; Wellkin Child and Youth Mental Wellness; Addiction Services Thames Valley
Public Health: Southwestern Public Health
Housing and Social Services: Oxford County Human Services
eHealth: South West eHealth Lead
Paramedic Services: Oxford County Paramedic Services
Coordinated Care Planning: Oxford Health Link

Why Partner?

In addition to the above, we face similar circumstances in service delivery attributed to a rural population e.g. access, health equity, transportation, housing, etc. – the social determinants of health highly correlated with health status. The Oxford Region has a population of approximately 113,000, 40% of whom live within two qualifying urban areas (Woodstock & Tillsonburg) *(Appendix 1)*.

In order to provide a more modernized suite of services across our region and address the aforementioned challenges, providers have developed, for example, voluntary service *"hubs"* where residents can access a range of health and wellness services. We share e.g. physical space, resources, programs, responsibility for patient care, back office support services, and join together on a variety of collaborative network tables. We clearly see neighborhood "hubs" growing stronger within an OHT framework, as ***one element*** of our design. The OHT mandate is a "natural fit".

Commitment to collaborate with others

☒ *Please confirm that you are willing to work and engage with other interested groups in your geographic area to collaborate towards becoming an Ontario Health Team, if recommended by the Ministry.*

Commitment to the Ontario Health Team vision

☒ *Please confirm that all proposed partners have read the Ontario Health Teams: Guidance for Health Care Providers and Organizations in full and are committed to working towards implementation of the Ontario Health TeamModel.*

Part II: Self-Assessment Scoring

Model Component 1: Patient Care and Experience

At maturity, Ontario Health Teams will offer patients, families and caregivers the highest quality care and best experience possible. Patients will be able to access care when and where they need it and will have digital choices for care. Patients will experience seamless care from providers who work together as a team. They can access their health information digitally, and their providers ensure they know what to expect in each step of their care journeys. Patients can access coordination and system navigation services whenever they need to.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• You can identify opportunities and targets and can propose a plan for improving access, transitions and coordination of care, and key measures of integration	☒	☐	☐
• You are able to propose a plan for enhancing patient self-management and/or health literacy for at least a specifically defined segment of your Year 1 population	☒	☐	N/A
• You have the ability and existing capacity to coordinate care across multiple providers/settings for Year 1 patients and you will be able to quantify this capacity (e.g., FTE count)	☒	☐	N/A
• Your team is committed to			
➢ Measuring and reporting patient experience according to standardized metrics and improving care based on findings	☒	☐	N/A
➢ Putting in place 24/7 coordination of care and system navigation services, available to Year 1 patients who require or want these services	☒	☐	N/A
➢ Offering one or more virtual care services to patients	☒	☐	N/A
• You are able to propose a plan to provide patients with some digital access to their health information	☒	☐	☐

Self-Assessment Scale for Patient Care and Experience

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

KEY MESSAGE: Performance improvements are clearly understood, with a strong belief in system navigation.

Based on "Oxford Sub Region at a Glance" *(Appendix 2)*, as well as "Access to Primary Care in the South West LHIN 2016", key performance opportunities are identified, which clearly align with OHT objectives. Year 1 population is focused on preventing 30-dayreadmissions for people with chronic diseases.

To reach maturity, our readiness is evidenced by the following:

- A strong clinical presence in community care including robust team-based primary care; community based palliative care services *(Appendix 3)*; solid home care sectors with strong relationships to hospitals and primary care; and Coordinated Care Planning *(Appendix 4).*
- 58 active family physicians and 16 nurse practitioners. In 2011, 96% of the population reported they had access to primary care.
- A network of community support services comprised of staff and volunteers that wrap around patients and families with shared common intake and central access to services *(Appendix 5).*
- A 24/7 care coordination and system navigation process will be strengthened with our Year 1 population through existing home and community care sector availability.
- Oxford Situation Table – highly successful inter-agency interventions for those at acutely elevated risk *(Appendix 6).*
- Partners measure patient experience and actively utilize these results to improve care.
- Virtual care is offered to patients in the acute, primary care, and community setting. The expansion of digital health records will result in more efficient services.
- *See Appendix 7 – Integration – Case Examples*

Model Component 2: *Patient Partnership & Community Engagement*

At maturity, Ontario Health Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers, and the communities they serve.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Each partner in the team can demonstrate a track record of meaningful patient, family, and caregiver engagement and partnership activities[1]	☒	☐	☐
• You are able to propose a plan for how you would include patients, families, and/or caregivers in the governance structure(s) for your team and put in place patient leadership	☒	☐	N/A
• Your team is committed to			
➢ The Ontario Patient Declaration of Values	☒	☐	N/A
➢ Developing a patient engagement framework for the team	☒	☐	N/A
➢ Developing a team-wide, transparent, and accessible patient relations process for addressing patient feedback and complaints and a mechanism for using this feedback for continuous quality improvement	☒	☐	N/A
• If you intend to involve patients, families, and caregivers in the design and planning of a subsequent Full Application (if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	☒	☐	N/A
• If you intend to engage your community in the design and planning of a subsequent Full Application (if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	☒	☐	N/A
• Your team adheres to the requirements of the *French Language Services Act,* as applicable, in serving Ontario's French language communities	☒	☐	N/A

[1] *Examples include presence of a Patient and Family Advisory Council within each partner organization, reporting to senior leadership (CEO or Board) to provide direction on strategic issues; inclusion of patient partners on key committees, including hiring committees; patient experience is a key focus for each partner organization with defined targets for meeting/exceeding patient experience metrics. This list is provided for example only and is not exhaustive.*

• If your team is proposing to be responsible for geography that includes one or more First Nation[2] communities you will be able to demonstrate support or permission of those communities	☐	☐	N/A

Self-Assessment Scale for Patient Partnership & Community Engagement

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☒

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

[2] For a map of First Nations communities and reserves, please refer to the following link: https://www.ontario.ca/page/ontario-first-nations-maps

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

KEY MESSAGE: A shared commitment to (1) standardized patient, family, caregiver, & community engagement processes, and (2) an integrated measurement framework.

The majority of the 20 participating agencies are Accredited, and meaningfully engage patients, families and persons with lived experience (PLE) in e.g. designing programs and services; program evaluation; improvements in care delivery; Advisory and Governance Committees; Working Committees (e.g. Health Link; Drug & Alcohol Strategy); Hiring Committees; and Strategic Planning teams, to name a few.

- Annual Quality Improvement Plans submitted by our OHT members to Health Quality Ontario include targets for measuring patient experience.
- The Ontario Perception of Care Tool is currently established in our Mental Health & Addictions agencies.
- Together in partnership, it is anticipated that Experience Based Co-Design or similar methodology will be utilized to enable staff and patients to redefine services and pathways.
- Patient Feedback policies (e.g. Satisfaction, complaint processes, ethics, mediation, safety, confidentiality) are in force across the Oxford OHT.

Less than 2% of our population report French as their Mother-Tongue. All organizations adhere to the French Language Service Act. A French Language system navigator in place at Addiction Services of Thames Valley, which serves our region.

There is no First Nations Community within the proposed geography, and less than 2% identify as Indigenous *(Appendix 2).*

Oxford County has noticeable concentrations of Amish, Mennonite and Low German populations, many of whom are uninsured by OHIP. The Oxford OHT will endeavor to engage and build pathways to healthcare for these populations.

Model Component 3: Defined Patient Population

At maturity, Ontario Health Teams will be responsible for meeting all health care needs of a population within a geographic area that is defined based on local factors and how patients typically access care.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team is able to identify the population it proposes to be accountable for at maturity	☒	☐	N/A
• Your team is able to identify the target population it proposes to focus on in Year 1	☒	☐	N/A
• Your team is able to define a geographic catchment that is based on existing patient access patterns	☒	☐	N/A
• You know how you will track (e.g., register/roster/enrol) the patients who receive services from your team in Year 1	☒	☐	N/A
• Of your Year 1 target population, you are confident that you will be able to deliver integrated care to a high proportion of this population and can set an achievable service delivery volume target accordingly	☒	☐	N/A

Self-Assessment Scale for Defined Patient Population

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

Rationale (300 words maximum)

Please provide a rationale for your self assessment response.
In addition, please include in your response:

- *Who you would be accountable for at Maturity – describe the proposed population and geographic service area that your team would be responsible for at Maturity. Include any known data or estimates regarding the characteristics of this population, such as size and demographics, 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.*
- *Who you would focus on in Year 1 – describe the proposed target population and geographic service area that your team would focus on in Year 1. Include any known data or estimates regarding the characteristics of this population and explain why you have elected to focus on this population first.*
- *Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap and transitions between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 target populations and populations at maturity.*

KEY MESSSAGE: We are acutely aware of the impact of Social Determinants of Health specific to a rural setting, and the related implications for Year 1 targets, as well as at Maturity.

Accountability at Maturity

At maturity our OHT will deliver full and coordinated care to the population currently defined as Oxford Region. *(Appendix 11 – Oxford Region Demographics).*

The social determinants of health are best understood through a recent Oxford County Community Index of Wellbeing Survey *(Appendix 8).*

Furthermore, the "Access to Primary Care Report" cited earlier found that in Oxford:

- The impact of the social determinants of health and primary care need is lower than the South West LHIN as a whole. There are some areas of very high need in Woodstock and Tillsonburg.
- High roster size combined with high risk of potential retirement could lead to a significant decrease in primary care accessibility in the future
- The geographic areas of greatest need in Oxford have good primary care accessibility, but "poor timely access".

Year 1 Focus

In Ontario, the economic burden of chronic disease is estimated to be 55% of the total direct and indirect health costs. Chronic diseases are long term diseases that develop slowly over time, often progressing in severity - controlled but rarely cured. Further, it is estimated that 70% of Ontarians with chronic conditions over the age of 45 have more than one condition.

In Oxford, approximately 5.4% of residents have 4 or more chronic conditions and are therefore considered complex.

Accordingly, our Year 1 Target population includes people within our geography who experience a readmission to hospital within 30 days of discharge as a result of a chronic disease *(see Appendix 9)*

Noticeable 30-day readmission rates for selected Case Mix Groups include Acute MI, CHF, Stroke, and COPD.

Model Component 4: In Scope Services

At maturity, Ontario Health Teams will provide a **full and coordinated continuum of care** for all but the most highly-specialized conditions to achieve better patient and population health outcomes as needed by the population.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team is able to deliver coordinated services across at least three sectors of care[3] and you have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., your team includes enough primary care physicians to care for all Year 1 patients)	☒	☐	☐
• You are able to propose a plan for phasing in the full continuum of care over time, including explicit identification of further partners for inclusion	☒	☐	☐
• As part of that plan, you can specifically propose an approach for expanding your team's primary care services to meet population need at maturity	☒	☐	N/A

Self-Assessment Scale for In Scope Services

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

[3] *Prioritization will be given to submissions that include a minimum of hospital, home care, community care, and primary care (including physicians and inter-professional primary care models, such as family health teams, community health centres, and other models that feature a range of inter-disciplinary providers)*

Rationale (300 words maximum)
Please provide a rationale for your self assessment response.

KEY MESSAGE: The breadth of services provided by our proposed team goes far beyond the requirement of 3 sectors at this stage. Reaching Maturity is an early goal of the Team. Cross-sectoral Coordinated Care and leadership will be an expectation of proposed Oxford OHT partners. Expanding Access to Team-based Care for solo practitioners, or practices with limited resources, is a priority.

Recognizing the importance of holistic health and human services, we have engaged at this early stage Public Health, Mental Health and Addictions, Community Support Services, Long Term Care, Residential Hospice, Palliative Care Outreach, and e-health. This large multi-sectoral team, supported by centralized intake and 24/7 navigators, will work together to improve access, care coordination, transitions and system navigation, with the goal of ensuring warm transfers.

- Within this proposed OHT we have three groups of primary care delivery, including CHC, NPLC and FHT. Each of these three groups stand together and, in collaboration with FHO colleagues, are openly prepared to organize primary care around our patient population.

- This target population is estimated to be approximately 113,000. In Oxford County, we have 74 primary care providers; a robust home and community care system; and a well-established centralized community support services sector.

- Oxford County is experiencing shortages of PSW's and Nurses. Furthermore:
    - 20% of Physicians are 60+ years of age
    - Changes in practice styles suggest a 2:1, or greater, replacement ratio to cover existing roasters, plus unattached individuals.

Recruitment of new primary care providers to our Region will be leveraged by our active affiliations with Medical Schools and Nurse Practitioner Institutes. New providers look for engaged teams, which we can offer. Further, to offset the pressure created by real and potential resource constraints, we will optimize the scope of practice in health disciplines.

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In addition to your scoring rationale, please identify the services you propose to provide to your Year 1 population. For each checked service, you must have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., to check off 'primary care physicians' your team must include enough primary care physicians to care for your Year 1 population). Where relevant, provide additional detail about each service (e.g., which member of your team would provide the service).

primary care

- ☒ interprofessional primary care
- ☒ physicians

☒ secondary care (e.g., in-patient and ambulatory medical and surgical services includes specialist services)

☒ home care and community support

☒ mental health and addictions

☒ health promotion and disease prevention

☒ rehabilitation and complex care

☒ palliative care (e.g. hospice)

☒ residential care and short-term transitional care (e.g., in supportive housing, long-term care homes, retirement homes)

☒ emergency health services

☒ laboratory and diagnostic services

☐ midwifery services; and

☒ other social and community services and other services, as needed by the population: *(OCCHC Housing Stability Team and Oxford County Human Services)*

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Model Component 5: Leadership, Accountability and Governance

At maturity, Ontario Health Teams will be self-governed, operating under a shared vision and working towards common goals. Each Team will operate through a single clinical and fiscal accountability framework.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• You have identified your partners and at least some partners on your team are able to demonstrate a history of formally working with one another to advance integrated care	☒	☐	☐
• You are able to propose a plan for physician and clinical engagement and ensuring inclusion of physician and clinical leadership as part of the team's leadership and/or governance structure(s)	☒	☐	☐
• Your team is committed to:			
➢ The vision and goals of the Ontario Health Team model	☒	☐	N/A
➢ Putting in place a strategic plan or direction for the team, consistent with the Ontario Health Team vision	☒	☐	N/A
➢ Reflecting a central brand	☒	☐	N/A
➢ Working together towards a single clinical and fiscal accountability framework	☒	☐	N/A
➢ Entering into formal agreements with one another	☒	☐	N/A

Self-Assessment Scale for Leadership, Accountability and Governance

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

KEY MESSAGE: Boards of Directors and Senior Leadership are well informed of the OHT goals with information to-date. We are committed to designing a highly functional clinical & fiscal accountability framework, and shared self-governance model.

The group of individuals that have come together to form this proposed OHT have an extensive track record of success as it relates to formal and informal collaboration to improve care for patients.

- Some of the most successful to-date include the Oxford Addiction Treatment Strategy (OATS); Situation Table; Coordinated Care Planning (Health Link); Oxford Palliative Care Outreach Team; & CSS Central Intake.
- Two hospitals within the geography served have integrated at the governance and leadership team level.
- All 20 partners, including physicians and a variety of health care providers at the planning table, have indicated they are committed to this OHT.

The Leadership Team for this proposed OHT includes the original members of the self-assessment team. This exceptional group of leaders has set the unifying vision and strategy aligned with the vision and goals of the OHT model, as together we re-think how care is delivered in our geography.

Leadership and Governance will evolve over time as the OHT reaches maturity along a continuum from operational coordination to shared management to joint board governance, and finally to a single OHT corporate entity as one possibility. Our model will be organized to best serve our patients and our communities.

Model Component 6: *Performance Measurement, Quality Improvement, and Continuous Learning*

At maturity, Ontario Health Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be publicly reported.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team can demonstrate that it has a basic understanding[4] of its collective performance on key integration metrics	☒	☐	☐
• Each member of your team has a demonstrated history of quality and performance improvement	☒	☐	☐
• Your team has identified opportunities for reducing inappropriate variation and implementing clinical standards and best available evidence	☒	☐	N/A
• Your team is committed to:			
➢ Collecting, sharing, and reporting data as required	☒	☐	N/A
➢ Working to pursue shared quality improvement initiatives that integrate care and improve performance	☒	☐	N/A
➢ Engaging in continuous learning and improvement, including participating in learning collaboratives	☒	☐	N/A
➢ Championing integrated care at a system-wide level and mentoring other provider groups that are working towards Ontario Health Team implementation	☒	☐	N/A

Self-Assessment Scale for Performance Measurement, Quality Improvement, and Continuous Learning

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

[4] *Each partner collects/reports data for and knows its own performance on at least some of the given metrics (or other similar metrics)*

Rationale (250 words maximum)

Please provide a rationale for your self assessment response. Identify any shared indicators that are currently being measured or monitored across the members in your team.

KEY MESSSAGE: The proposed Oxford OHT is fully committed to providing the highest quality and safest care possible, informed by quality standards and evidence-based guidelines. We welcome an integrated set of indicators, benchmarks, and public reporting.

We are experienced with performance metrics & comprehensive reporting to funders.

- Quality Improvement Plans (QIPs), Patient Experience Surveys, and key system performance indicators such as e.g. Emergency Visits Best Managed Elsewhere, Alternative Level of Care (ALC) rates, hospital readmission rates, consistently shape decision-making and practice changes.
- Data drives our selection of Year 1 population - 30 day readmissions due to chronic conditions – as clearly there is opportunity to reduce variation and implement a higher quality of care.
- The proposed OHT team will have access to local expertise in decision support and business intelligence for purposes of making informed decisions in developing meaningful and relevant performance measures. These indicators will be aligned with provincial standards for OHT's and will track achievement of the desired outcomes of the Quadruple Aim as well as reducing inappropriate variation in care provision.

In addition, in Year 1 data from various disparate sources will be brought together to give a holistic view of our entire patient population. Data sources will include primary care, community care, acute care, mental health and addictions, demographic characteristics, housing, and data capturing the social determinants of health.

Together this will form a complete picture of the patient's health care utilization and total cost incurred.

Model Component 7: Funding and Incentive Structure

At maturity, Ontario Health Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations. Teams that exceed performance targets will be able to keep a portion of shared savings. Teams will gain-share among members.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Each partner in the team is able to demonstrate a strong track record of responsible financial management[5] (this may include successful involvement in bundled care and management of cross-provider funding)	☒	☐	☐
• Your team can demonstrate that it has a basic understanding of the costs and associated cost drivers for your Year 1 population and/or proposed population at maturity	☐	☐	☒
• Your team is committed to:			
➢ Working towards an integrated funding envelope and identifying a single fund holder	☒	☐	N/A
➢ Investing shared savings to improve care	☒	☐	N/A

Self-Assessment Scale for Funding and Incentive Structure

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

[5] *Examples of evidence that may suggest poor or declining financial management include: For hospitals - Balanced budget waivers due to deficit, operating pressures request history, cash advance request history, deteriorating working funds position, demonstrated difficulty in managing cross-provider funding as part of bundled care. For primary care (physician and non-physician models) - Non-compliance with their current contract, service accountability agreement and applicable public service procurement practices*

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

KEY MESSAGE: The Oxford OHT stands prepared to be held accountable for an integrated funding model, focused on reinvestment in front line services. To achieve success, we commit to support processes which will change existing legislative and policy boundaries to facilitate this provincial goal. We step up as an early adopter to implement innovative funding management in a rural setting, relying on best evidence across national and international jurisdictions.

All partners participating in this proposed OHT have a track record of responsible fiscal management, reporting balanced financial positions, and compliance with Service Accountability Agreements. This is evident by our positive operating income and accumulated working capital if applicable (cash reserves). Throughout the planning stage the team will develop a robust costing model for the care required by the population and determine the drivers of cost including variation and duplication.

- Investing shared savings to improve care will be examined. Incentive parameters will be defined and effective incentives will be introduced to ensure that the team assumes responsibility for the population's health.
- Incentives that may be considered include e.g. Incentives for population-based outcomes, preventative care, shared savings contracts, bundled care, and quality rewards.
- Through the integration of services, shared digital health records and a comprehensive quality of life assessment of each patient, expedited and appropriate referral processes should result, leading to financial efficiencies and savings.

Model Component 8: Digital Health

At maturity, Ontario Health Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Most partners in the team have existing digitalhealth capabilities that are already being used for virtual care, record sharing **and** decisionsupport	☐	☐	☒
• Your team is able to propose a **comprehensive**plan to improve information sharing and resolve any remaining digital health gaps, consistent with provincial guidance regarding standards andservices	☒	☐	☐
• Your team can identify a **senior-level** single pointof contact for digitalhealth	☒	☐	☐

Self-Assessment Scale for Digital Health

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.

Your team is able to meet fewer than 2 of the requirements above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self assessment response. Identify any common digital tools currently in use by the members of your team.

KEY MESSAGE: Our proposed connected care model will leverage pre-existing electronic services integrating Hospital, Primary, Community, Emergency and Virtual Care to patients inclusive of their families and supports.

Patient centered system navigation and electronic access to health information for all members of the circle of care is the foundation of our proposed connected care strategy. Connected Care equates to better access to information, data standards, and real time communication.

- Each member of this OHT is utilizing a digital record and has the ability to share information in a limited manner.
- Existing integrated technologies in our region include CHRIS, Clinical Connect, eConsult, Telemedicine, eShift *(Appendix 10)*, My Chart, eNotification, Hospital Report Manager, SPIRE, Ontario Lab Information System, and the Community Support Services Central Intake.
- Taking into consideration legal agreement frameworks, policy, work flows, partnerships, existing supports, privacy and security compliance, our goal is to build on this existing technology, and better share patient information locally and provincially. This goal includes user friendly application sign on strategies, patient and provider portals, and access gateways currently available and proposed by eHealth Ontario.

Future state, patients will transparently review their personal health information, and connect to qualified clinicians in near real time. Patients will be able to share their personal health information as they see fit, communicate with health care providers, and access to their full patient record through a Patient Portal or a container.

Part III: Implementation Snapshot

Please provide a high-level overview (maximum 500 words) of how you plan to implement the Ontario Health Team model and change care for your proposed Year 1 target population.
Include in your response:

- ☐ *Considering the quadruple aim, standard performance measurement indicators, and Year 1 Expectations for Early Adopters set out in the Ontario Health Teams Guidance for Health Care Providers and Organizations, what are your immediate implementation priorities?*
- ☐ *What would you anticipate as key risks to successfully meeting Year 1 Expectations and how would you address them?*

KEY MESSAGE: The challenging Year 1 expectations are well within our reach. Optimizing digital health tools is a priority in Year 1, including the expansion of virtual care and patient-facing portals.

The partners who form the proposed Oxford Ontario Health Team are committed to the modernization of health care for the residents of Oxford County. In Year 1, we intend to work hard toward transforming care experiences, quality of life, and outcomes for our target population.

Advancing the Quadruple Aim as our implementation scorecard, we will improve the health of this population through a personalized and targeted approach to optimizing wellness by:

- Coordinating chronic disease management that reflects bestpractices
- Empowering patients and families through teaching, health literacy and self-management strategies - knowing what to expect
- Providing access to 24x7 care coordination andsystemnavigation
- Broadening access to team-basedcare
- Wrapping services around patients and families and ensuring zero cold hand-offs
- Implementing Quality Standards underpinning successful discharge from hospital to home
- Strengthening home care and community supportservices

With this laser focus we will reduce re-admissions to hospital within 30 days of discharge due to chronic disease. Our patients will experience timely access to care in the community supporting a better quality of life, improving outcomes, and reducing cost to the system.

The positive engagement of front line providers, reduced administrative burden, and minimizing barriers to care is of paramount importance in achieving success of the OHT.

- Cost savings associated with system efficiencies will be reinvested into front line care.
- We will measure our success through meaningful indicators such as patient experience, provider engagement and financial metrics.
- Our multi-sector QIP will embed joint accountability and measure cost reduction, standardization and implementation of bestpractices.

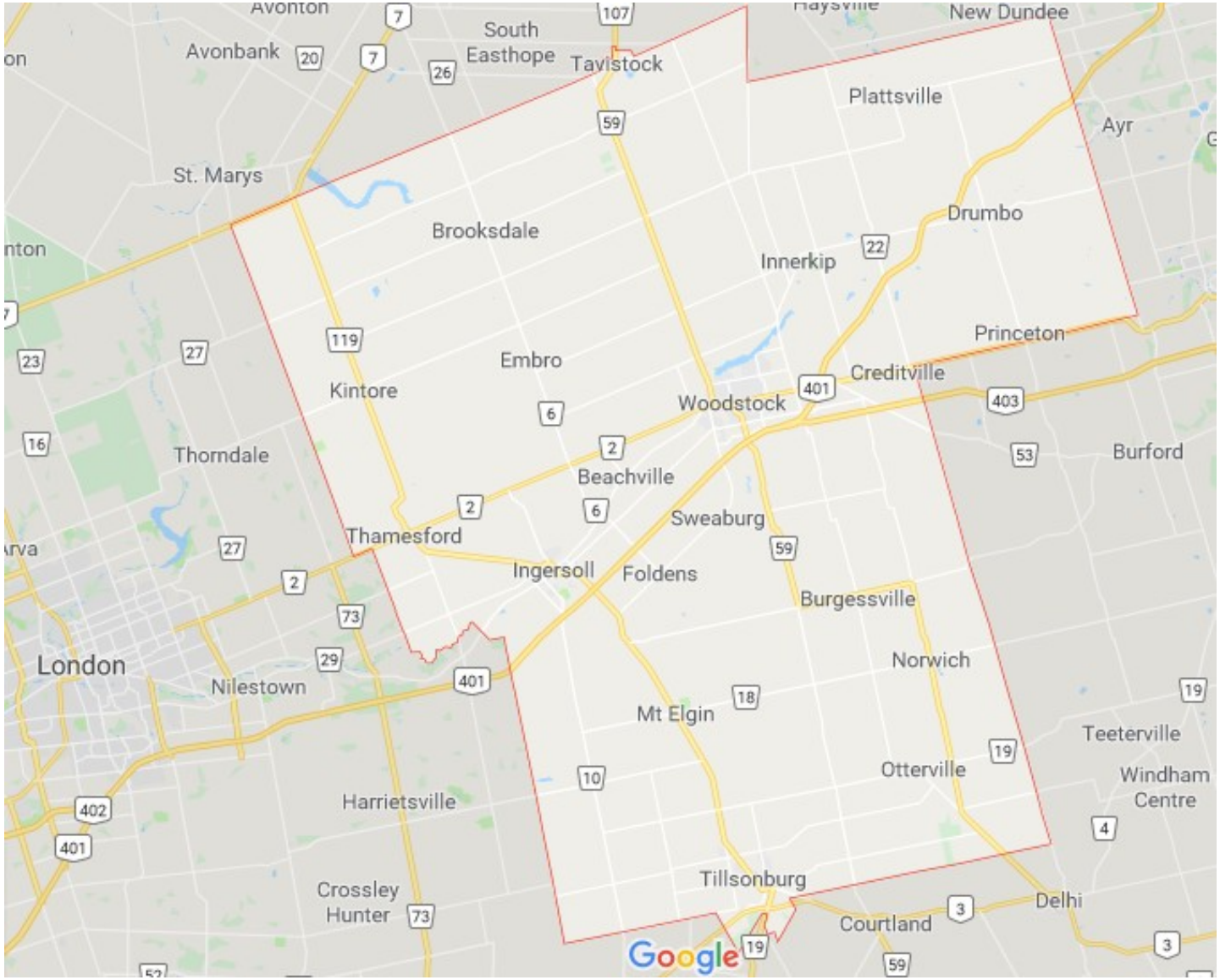
A system change as large and complex as that of creating an Ontario Health Teams presents a number of risks e.g.:

- Lack of receptiveness, adoption, or capacity among all system partners will challenge our ability to meet year 1 objectives.
- Potential system fragmentation until OHT maturity is reached may create risks including continuity of patient care, health human resource challenges, and confusion among the public and providers.

To address these risks, existing trusting relationships will be leveraged, as well as relentless communication of the "why" behind what we are trying to achieve. Oxford County residents, health care and community support services providers, will be empowered as they co-design care processes and strategies. Our OHT Patient Declaration of Values will be co-designed in year 1 by the communities we serve to align with Provincial and local accountabilities. Community engagement will capitalize on existing resources to embed local dialogue in our work to maturity.

The learning in Year 1 will serve as the road road-map towards expanding care to the full population of Oxford County. Back office integration, streamlining of care processes, efficient utilization of systems, and all providers working to full scope will be prioritized such that expansion of services can and will occur.

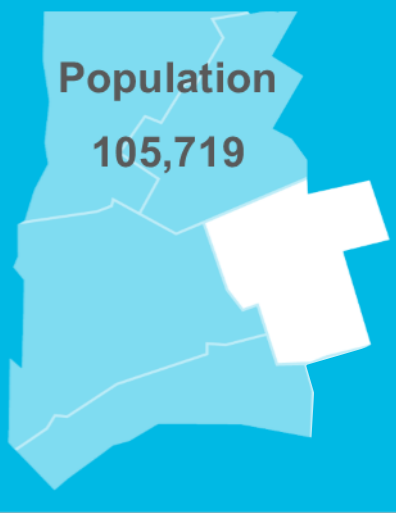
Oxford Region Map



Sub Region At A Glance

- 2.5% of people self-identify as visible minorities
- 1.3% of people self-identify as Indigenous
- 1.2% of people have French as mother tongue
- 16.6% of people are 65 years and older
- 12.0% of people live below the low income cut-off

Oxford

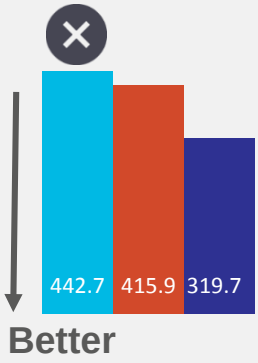


In the South West LHIN,

42.5%

of Acute Care Patients Had a Follow-up with a Physician Within 7 Days of Hospital Discharge

Hospitalization Rate for Ambulatory Care Sensitive Conditions (per 100 000)

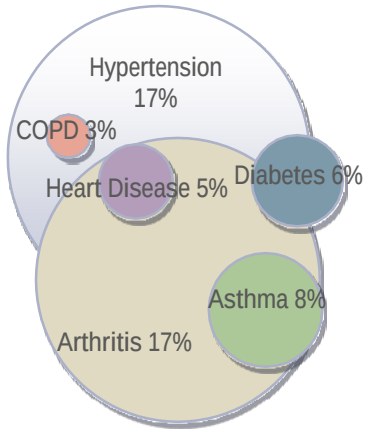


In the South West LHIN,

33.3%

of People had Same Day or Next Day Access to Physician

Chronic Disease Prevalence (Self-Reported)

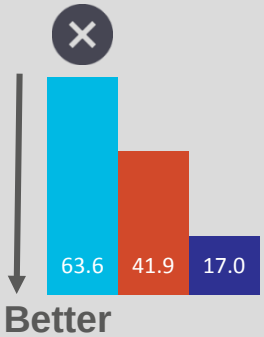


***COPD*: 2% lower than South West average**

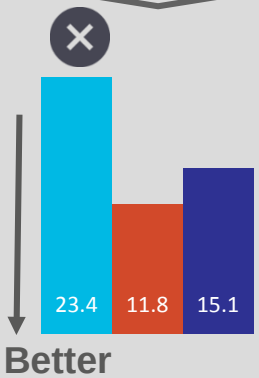
***Arthritis*: 4% lower than South West average**

5.5% of health care users are *Complex Patients* with 4 or more conditions

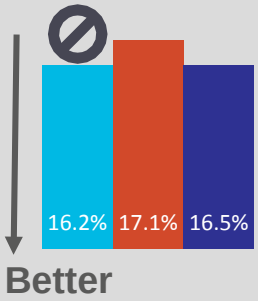
Emergency Visits Best Managed in an Alternate Primary Care Setting (per 1 000)



Hospital Beds Occupied by Patients Who Could Receive Care Elsewhere (ALC)



Readmission to Hospital Within 30 Days of Discharge (Chronic Conditions)

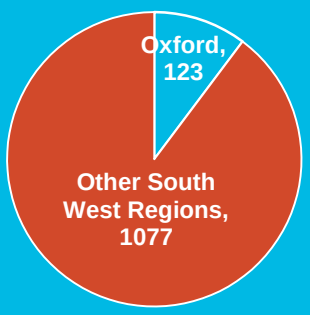


An average of 22 Patients Wait in Hospital for Long Term Care (ALC-LTC).

Oxford Performance	South West LHIN Performance	Provincial Performance

- Exceeding Target
- Close to Target Not
- Meeting Target

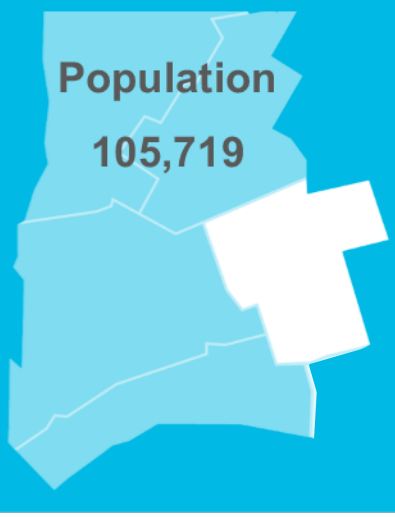
Health Links - Total Number of People Supported by Coordinated Care Plans in the Last Year



October 2017

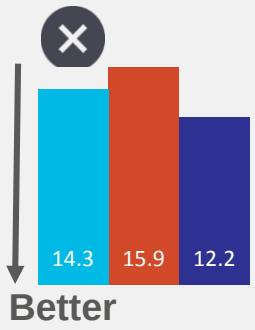
Sub Region At A Glance

Oxford

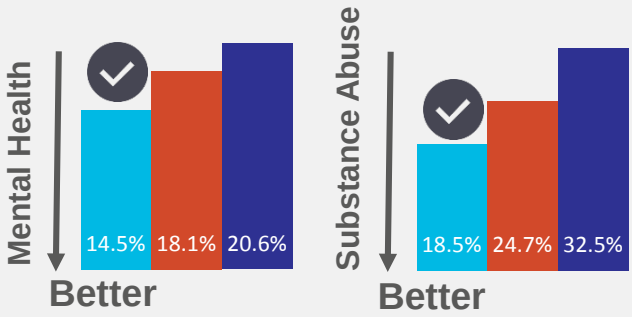


15.3% of the Population have been diagnosed with a Mental Health Illness.

Hospitalization Rate for Mental Health or Substance Abuse (per 10,000)

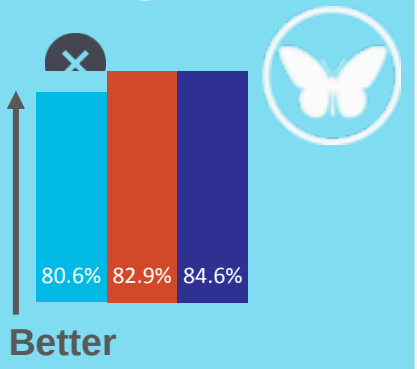


Repeat Visits to Emergency Within 30 days of Visit:



Average Time Waited for Mental Health Case Management in the Community 110 days

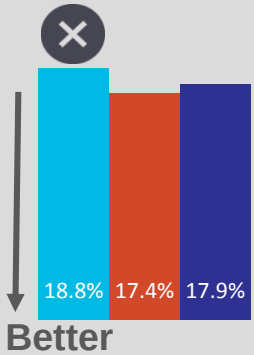
Percentage of Palliative Patients Discharged from Hospital with Home Support



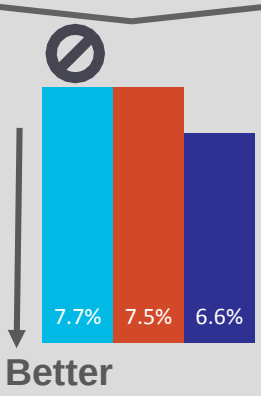
Wait time for Long Term Care Admission: 9 of 10 people waited 517 days or less

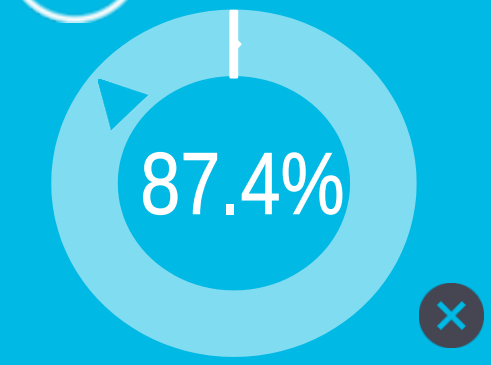
65.8% of People in the South West LHIN, Died in Their Location of Choice

Home Care Patients Who are Readmitted Within 30 Days of Discharge



Home Care Patients Returning to Emergency Within 30 Days of Visit





People Satisfied with Health Care in their Community

Oxford Performance | South West LHIN Performance | Provincial Performance

- Exceeding Target
- Close to Target
- Not Meeting Target

How Hospices Help End Hallway Medicine

Appendix 3

Acute Care Hospital

$1,100/day

People who do not need hospitalization

Hospice Residences
(in-patient beds)

$470/day

For people who can't stay at home

Hospice at Home

$80/day

Continuum of Community Based Hospice Services

Coordination & Navigation of Care

Hospice Beds

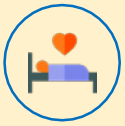
Education

Bereavement Support

Caregiver and Family Support

Psychosocial & Spiritual Care

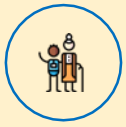
Pain Clinics



Respite & Symptom Management

Wellness Programs

Chronic Disease Management

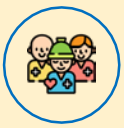


Community Volunteers

Pain & Symptom Management Consultation

Interdisciplinary Teams

Complementary Therapies



Day Programs

Practical Assistance

Hospice programs and services vary based on the local community's needs

Larger hospices with in-patient beds typically offer the full spectrum of services. They may act as regional hubs, with the highest concentration of community based palliative care services

Hospice at Home, brings services to the patient's home through volunteers and shared care clinical teams

Hospices provide a wide range of supports for caregivers, including respite, grief and bereavement care, practical assistance, spiritual care, and children's programs

Hospices build compassionate communities that enable neighbours to support neighbours with social programs available to people who need some extra help and social interaction at home

Ontario's Hospices have over 16,000 active volunteers

Hospice is not just a place; it is a service that comes to patient and caregiver

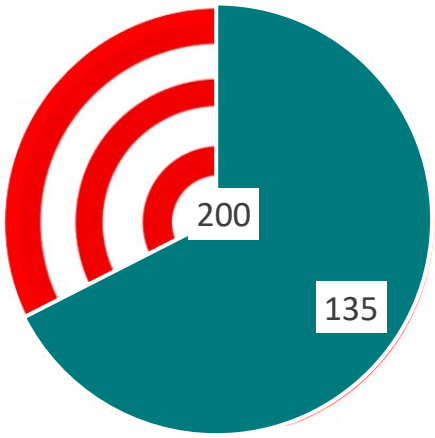
76% of hospice patients receive hospice services in their own home

96% of clients say hospice has positive impact on quality of life
97% of clients have high satisfaction with their hospice experience

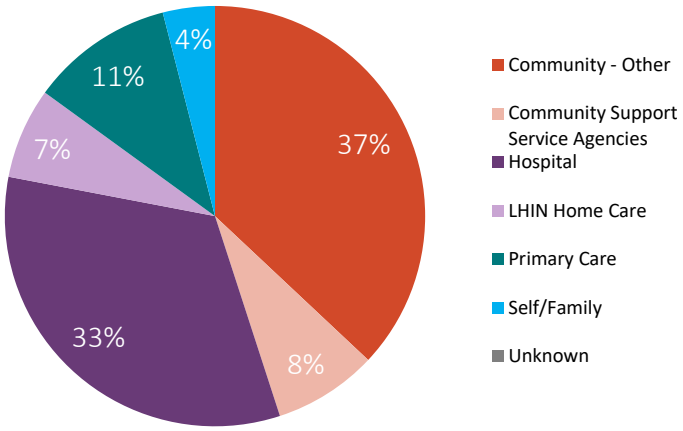
Source: HPCO Hospice Outcome Data, 2017-2019
5,142 clients surveyed while receiving hospice care

Oxford - Q4 2018/19 Health Links Coordinated Care Planning Summary

369 people in Oxford supported by Coordinated Care Planning since 2015
3,611 people supported in the South West LHIN since 2014



Progress compared to annual target (200 CCPs), 2018/19

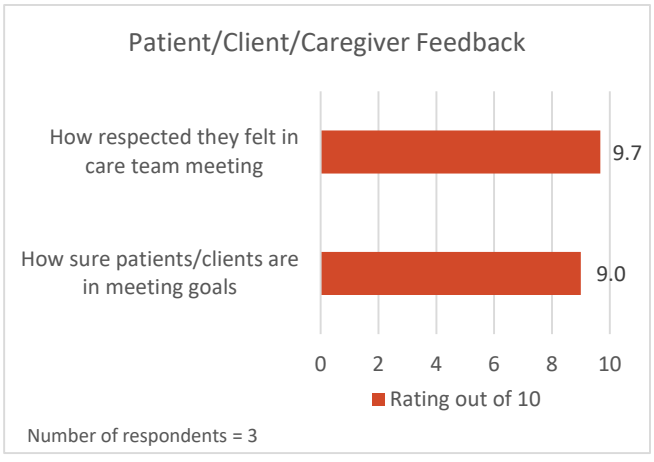


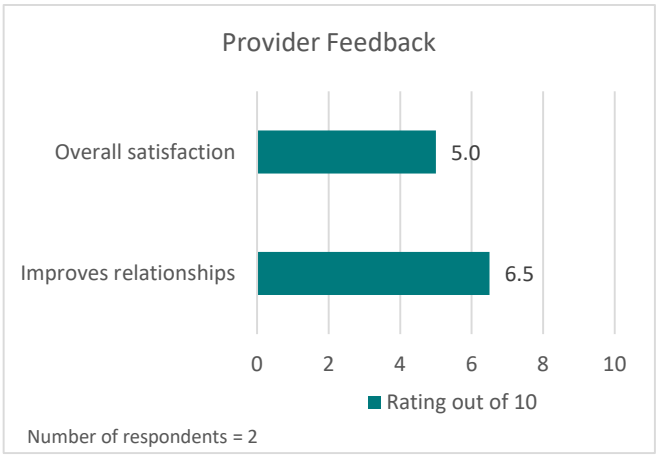
Referral source by sector, Q4 2018/19

Coordinated Care Planning (CCP) is making a difference…

	EMERGENCY Visits (rate per 100 patients)		Admissions (rate per 100 patients)		Average Length of Stay (rate per 100 patients)	
	Oxford	South West	Oxford	South West	Oxford	South West
3 months post CCP	42% ↓	36% ↓	31% ↓	41% ↓	6.2 days ↓	5.1 days ↓
6 months post CCP	46% ↓	30% ↓	41% ↓	39% ↓	8.0 days ↓	6.9 days ↓

**Percentage change is the difference in rate of utilization 3 and 6 months prior to CCP date and 3 and 6 months post CCP date. Data is cumulative (2014-present). Source: CHRIS; NACRS; DAD.*





"Keep promoting this service!"
~Provider~

"Getting everyone on the same page and having the information available for everyone."
~Family/Caregiver~

"Everyone coming together -- I had no idea of the different services that are available to me."
~Patient/Client~

HealthLink / Maillon santé

Oxford Health Link

Q4 2018-2019

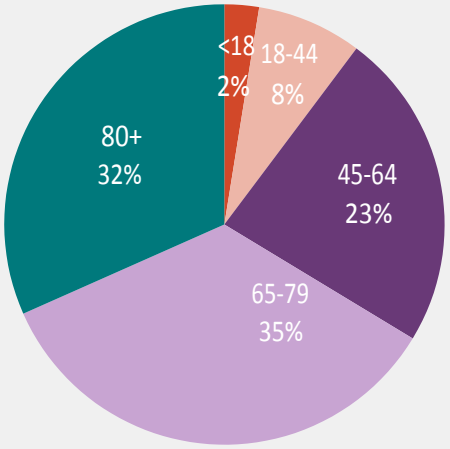
Demographic

Health Link Target Population (Number of Individuals with 4+ Chronic Conditions)

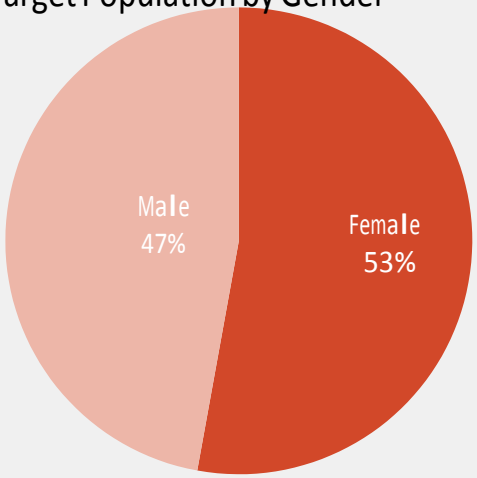
Oxford

5180

Target Population by Age



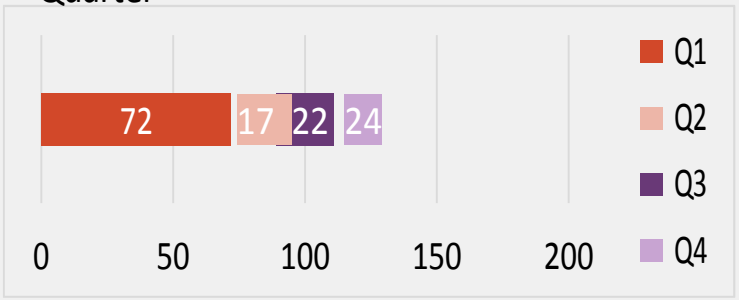
Target Population by Gender



ource: Health Links Target Population, MOHLTC 2014/2015

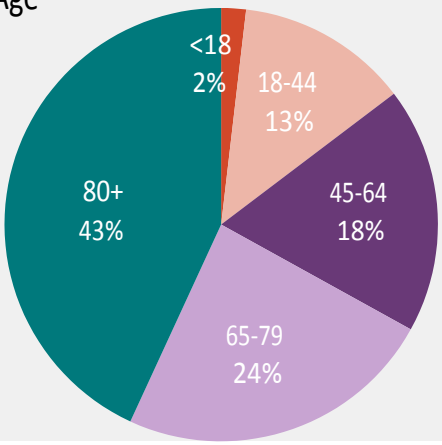
Number of Completed Coordinated Care Plans (CCPS) by:

Quarter

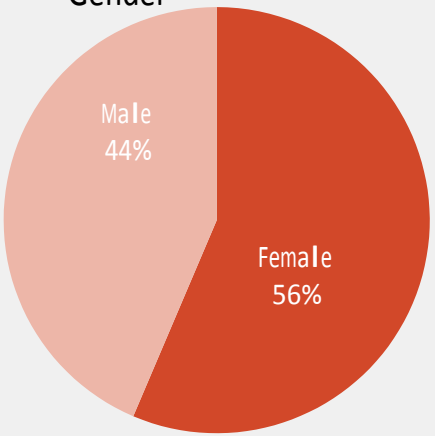


Total: 135
Target: 200

Age



Gender

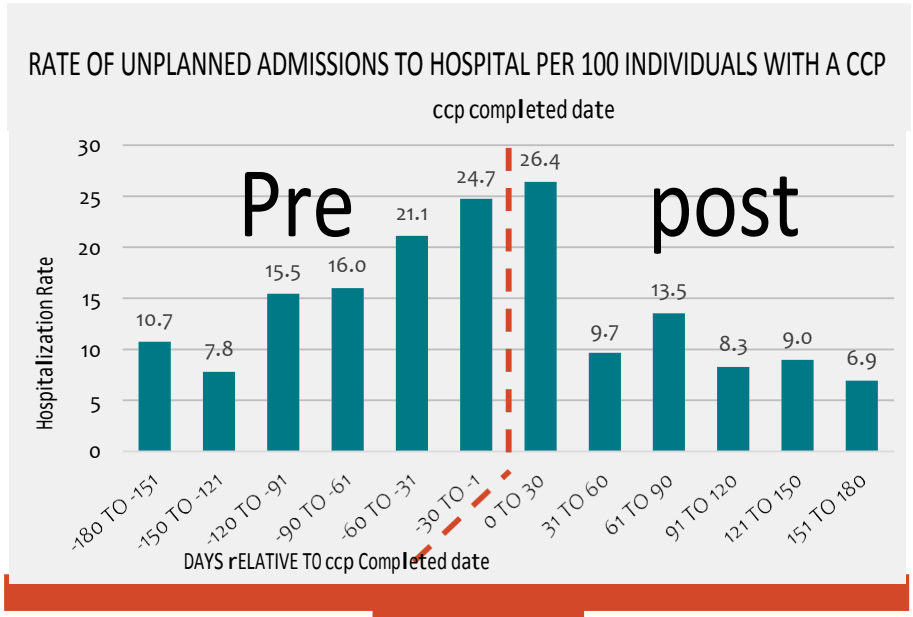


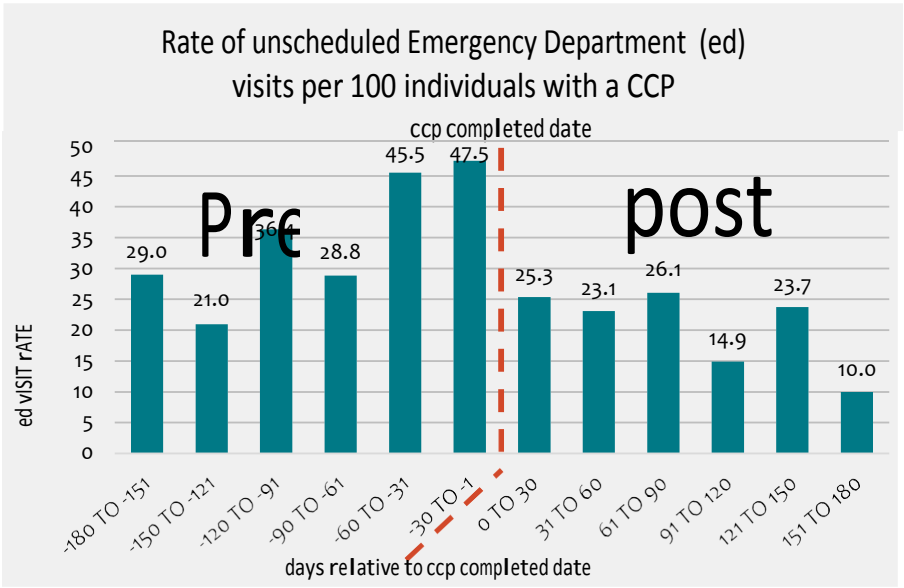
ource: CHRIS (Q4, 18/19)

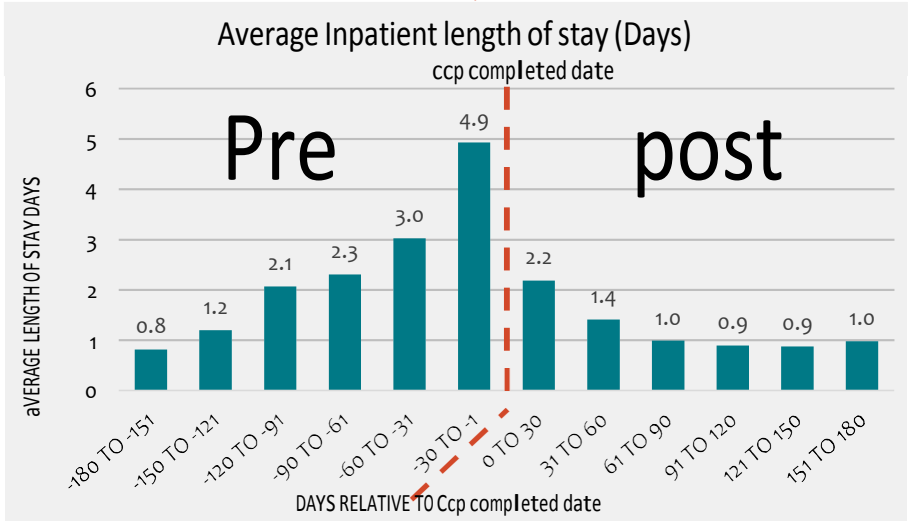
Oxford Health Link

Q4 2018-2019

Outcome Measure







Source: CHRIS, DAD, NACRS (Nov 30, 2018)

COMMUNITY SUPPORT SERVICES

OXFORD • 1.888.866.7518

One call, one go-to person, a team approach, to provide supports and services for you to live at home

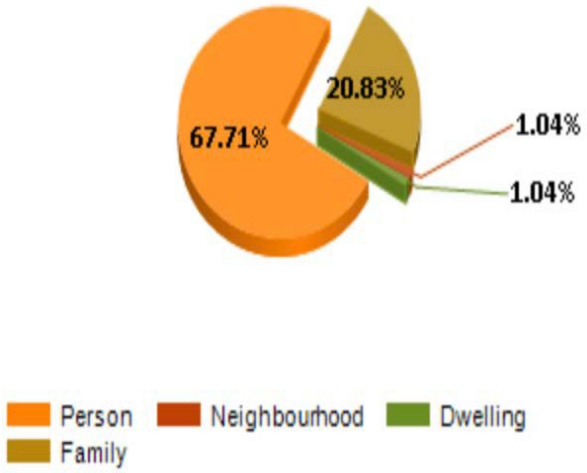
Community Support Services focus on promoting independent living through prevention, early intervention, self-management, health & well-being services such as nutrition, health & wellness, personal and social supports for older adults, persons with disabilities, brain injury, or dementia.

OXFORD SITUATION TABLE

From November 14, 2014 to December 31, 2018, 19 agencies participated at the Oxford Situation Table. 288 situations were reviewed, and 261 situations were deemed as "acutely elevated risk".

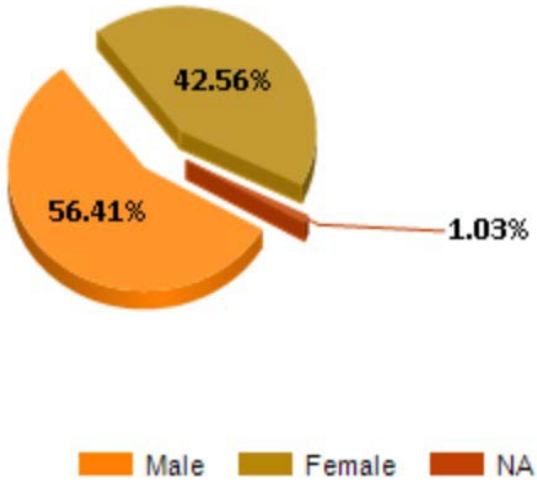
DISCUSSION TYPE

The majority of the situations (67.71%) involved individuals.



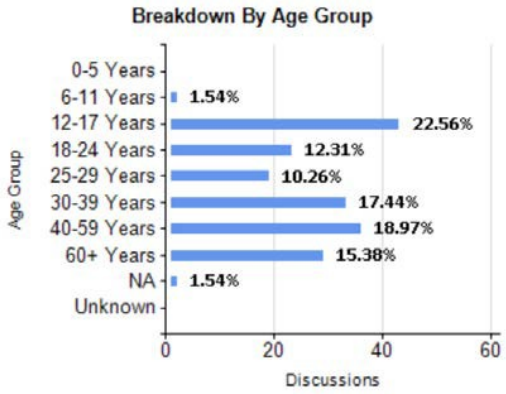
GENDER

Situations involving individuals were split by gender with 56.41% of the situations involving males and 42.56% were female. A narrow 1% identified as "X" gender.



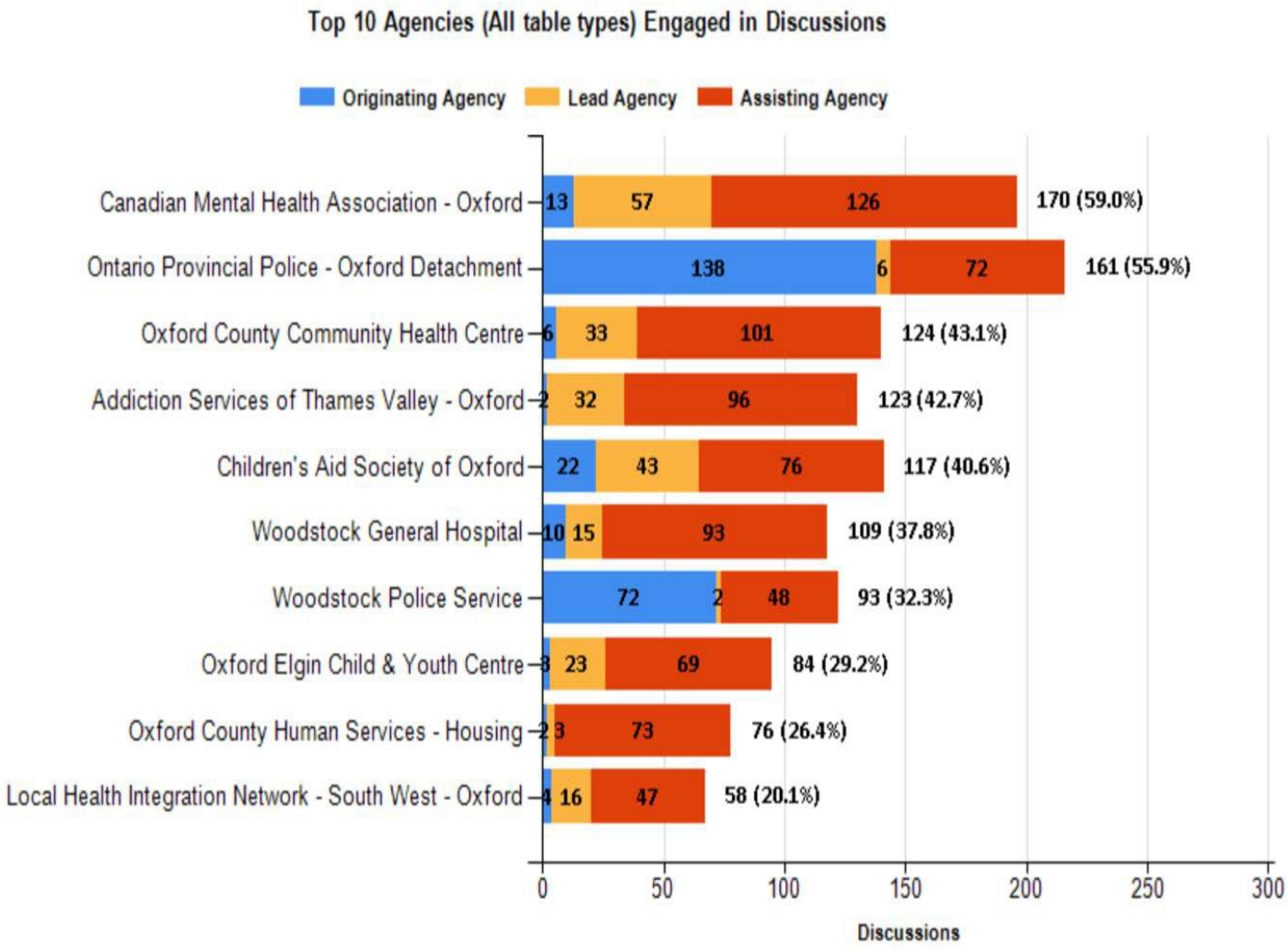
CLIENT AGE IN YEARS

The most common age group for "person" was the 12-17 year old (22.56%).



Appendix 6

SITUATION TABLE COLLABORATING AGENCIES



Note: Integrated Activities are Examples Only – Not an Exhaustive List			
Integrated Activity	**Oxford County Community Health Centre (OCCHC)**	**Ingersoll Nurse Practitioner-Led Clinic (INPLC)**	**CMHA Oxford**
Co-Located Space / Hubs / Shared Resources	**OCCHC** o Share primary building site with Pharmacy, ODSP Oxford, and Assertive Community Treatment (ACT) Team o Co-located County of Oxford Client Services Worker at the CHC – supporting Housing Stability & shared clients o Co-located ADSTV staff – 2 offices at CHC and integration of specialized addictions counselling o Co-located at INPLC – Community Outreach and Oxford Health Link staff o Co-located at the Livingston Centre Tillsonburg for FT Addictions and Mental Health Counsellor, and CHC Community Outreach – staff integration at the hub is comprised of Multi-Service Centre services; ADSTV; Domestic Abuse Services Oxford; Big Brothers/Sisters; Community Options for Justice; Credit Counselling; Legal Clinic; Fanshawe College; MCCSS; Public Health; Ontario Works; & Service Canada o Activate Oxford Coordinator – Child & Youth Planner, Co-located at CHC **INPLC** o Share primary building site with Pharmacy & Multi-purpose Community Room o Co-located Oxford Health Link staff & OCCHC Community Outreach o Co-located CMHA case managers o INPLC provides counselling space and Reception services for Oxford Walk-In Counselling and Addictions Support **CMHA** o Co-located CMHA case managers at INPLC o Co-located CMHA case managers at Tillsonburg District Memorial Hospital (TDMH) o TDMH & Star Family Health Team (Tavistock) provide Counselling space for Oxford Walk-In Counselling and Addiction Support		
In-Kind / Community Space	**OCCHC** o Teaching Kitchen & Multipurpose program rooms used by a variety of community groups at no cost **INPLC** o Counselling rooms & Multi-purpose Community Room used by e.g. ADSTV, CAS Oxford, and other community groups at no cost o OPP – use gym for training **CMHA** o Oxford Self Help Network integrated with CMHA Oxford in 2017 – CMHA now hosts programs, groups, and drop-in services, as well as Self Help Transitional Discharge support.		
Joint Programming & Service Delivery / Community Outreach	**OCCHC** o Multi-Agency Mental Health & Addictions Walk-In Counselling o CHC Dietitian – Group Education Sessions – Blossom Park, Harvey Woods, VON Day Program, Alzheimer Society, Woodstock & District Developmental Services, Women's Employment Resource Centre, Community Employment Services o Situation Table – 19 agencies weekly meeting to assess and intervene on acutely elevated risk situations o Partnered with Thames Valley District School Board & Fanshawe College to provide SWAC – *School Within a College* o Psychiatry (Dr. Chahal) – on-site at CHC once weekly - reimbursed through CMHA Sessional Fees o CHC Rapid Access Addiction Medicine (RAAM) Clinic – opening July 2019 – multi-partner coordinating strategy o CHC Dental Clinic Low Income – opening August 2019 – multi-partner coordinating strategy – particularly with Oxford Dental Society & discussions with Schulich School of Medicine and Dentistry o Concurrent Disorders - shared programming with CMHA in Tillsonburg & Woodstock o Resource Networks – Tillsonburg and Ingersoll – 20+ agency front line staff sharing programs, referrals, education, new developments on a monthly basis o Shared Groups with CMHA – cooking groups, weight management, peer-led		

	o Partner with CMHA to facilitate ASIST (Applied Suicide Intervention Skills Training) for community o Partner with "Prescription to Get Active" – ways to promote physical activity through partnerships with local recreational facilities (Goodlife, YMCA, rec centres, yoga classes etc.) o Public Health - Naloxone administration, kit distribution (including INPLC & CMHA) o Weekly Outreach to the Adelaide Soup Bowl o Large trailer stationed in Tillsonburg with "gently used" furniture, household items, & medical equipment for distribution to residents in need – organized by volunteers **INPLC** o SW Self Management Program -groups provided in collaboration with SWSMP to engage persons living with chronic disease to positively contribute to their health status o Chronic Disease Management Programs – Craving Change, Diabetes Conversations, Hypertension Management Program - offered to registered and non-registered patients from other primary care providers o Mental Health Programs - CMHA Walk In Counselling, Happiness 101 (Thames Valley Family Health Team) o Southwestern Public Health /Area Pharmacies – smoking cessation program o OTN site- facilitate virtual specialists appointments for non-registered patients & provide in-kind nursing support **CMHA** o Joint Family Education groups with PEPP -Woodstock Hospital and ACT Team o OTER (Oxford Tragic Events Response) – joint agency response protocols o MHEART with Woodstock Police Services and Oxford OPP (CMHA Counsellor joins police to attend to calls) o Coordinated and joint Emergency responses with Victim Assistance Services Oxford County
Patient Flow / Coordination	**OCCHC** o Oxford Addictions Treatment Strategy (OATS) – coordinated access via open calendars for booking clients & shared counselling resources between OCCHC, INPLC, CMHA Oxford, ADSTV o Coordinated Care Planning – Oxford Health Link o Referrals to Physiotherapy via VON Smart Exercise and Falls prevention classes o Family Health Team in Woodstock- shared learning/groups and referring clients seamlessly o Shared Dietitian / Diabetes education with Woodstock Hospital – cross referrals, eating disorders, mental health o Cross-referrals between CHC Tillsonburg Addictions Counsellor and Social Worker at the TDMH – intakes and discharge planning support. o Cross-referrals between Ontario Addiction Treatment Centres (OATC Methadone Clinic) Tillsonburg **INPLC** o OATS o working on partnership with TMHI/ and AGH for non urgent ER future partnership o RAAM – will provide primary care for patients/clients who do not have a primary care provider **CMHA** o OATS o Coordinated Wait list management/referrals monthly with Woodstock Hospital and ACT Team o Provide Crisis Assessment and Support services at Woodstock Hospital Emergency Departments from 7am to 11am - 7 days a week and cover for staff illness/shortages o Provide Crisis Assessment and Support services at Alexandra and TDMH Emergency Departments 7am to 11pm - 7 days a week o Peer Support Transitional Discharge program at Woodstock Hospital Inpatient Unit o Shared Calendar between Wellkin and CMHA for scheduling of next day Urgent/Crisis appointments o Joint quality improvement initiative with Woodstock Hospital trialing *Patient Oriented Discharge Summary* (PODS)
Case Management / Rounds	**OCCHC** o Case Management Review (shared clients) once monthly with LHIN Home Care, Indwell, Prevention & Early Intervention Program for Psychoses (PEPP – Woodstock Hospital), and Assertive Community Treatment (ACT) Team **CMHA**

	o Weekly Psychogeriatric BSO meetings with Alzheimer's Society, Woodstock Hospital, and CMHA
Transportation	**OCCHC & CMHA** o Shared transportation calendar & exchange / coordination of vehicles with CMHA depending on size of group & destination
Housing	**OCCHC** o Housing Stability Team at the INN (homeless shelter) regularly o Exploration around Transitional Housing with private / public sector partners in Oxford o Housing Stability Worker Youth (16 & 17 year old) – core action response team created with CAS Oxford to address needs of this specific population – case consultation, support, and coordinated access to services **CMHA** o Partnership with Indwell for a set number of subsidized housing units as well as Office space at Harvey Woods
Back Office Support	**OCCHC** o South West LHIN provides back-office support for Financial Management, Payroll, AP, AR, and Reporting **INPLC** o QIIMS – data and quality improvement support to 7 NPLCs in South Central Ontario

OXFORD Community Wellbeing SURVEY

In 2016, just over 11,000 randomly selected households in Oxford County-- representing 25% of all households-- were invited to take part in the Oxford Community Wellbeing Survey. Administered by the Canadian Index of Wellbeing (CIW) at the University of Waterloo, the final survey report offers a snapshot of the wellbeing of our citizens based on factors like educational opportunities, job satisfaction, health behaviours, community involvement, the environment, and more.

The survey results are being used to set baseline targets in the Future Oxford Community Sustainability Plan, directly mapping wellbeing themes—like quality of work and environmental concerns—to the Plan's community, environmental and economic goals.

WHAT IS COMMUNITY WELLBEING?

Wellbeing encompasses an individual's health, wealth, life satisfaction and more, as well as one's sense of belonging to a community.

The CIW defines wellbeing as "the presence of the highest possible quality of life in its full breadth of expression focused on but not necessarily exclusive to: good living standards, robust health, a sustainable environment, vital communities, an educated populace, balanced time use, high levels of democratic participation, and access to and participation in leisure and culture."

Why measure wellbeing?

Measuring wellbeing consistently and comprehensively over time gives us information about our quality of life that helps us make decisions, invest our resources, and monitor progress on the Future Oxford Community Sustainability Plan.

Wellbeing domains

Oxford themes

derived from CIW domains

- **Community Engagement** (civic engagement, sense of belonging)
- **Accessibility** (health services, recreation, culture)
- **Quality of Work** (flexibility, work-life balance)
- **Health Behaviours & Perceptions** (health status, healthy behaviours)
- **Environmental Concerns** (conservation, stewardship)

Sustainability plan pillars

- COMMUNITY
- ENVIRONMENT

Overall wellbeing

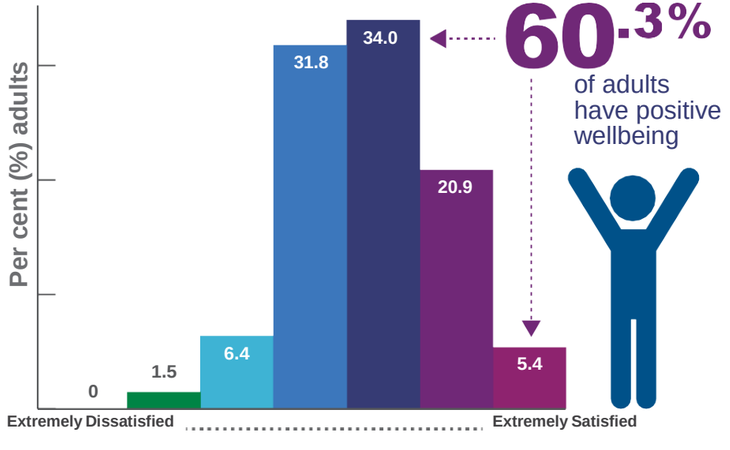
WELLBEING

- 60.3% of adults in Oxford County reported positive wellbeing (score of 5 or higher on a scale of 1 to 7)
- Overall wellbeing score for all adults in Oxford County was 4.81. Adults 65+ report the highest levels of wellbeing (5.36) compared with those less than 35 years old (4.61)

LIFE SATISFACTION

- 78% of adults in Oxford County are satisfied with life, although this varies with other factors:
  - o age group (<35 yrs 76.4%, 65+ 87.4%)
  - o household income (less than $40,000 67.9%, $100,000 or more 86.0%)
  - o living arrangements (living alone 64.2%, living with another adult 83.5%)
  - o length of residency (new residents 72.0%, established residents 80.9%)
  - o location of residence (Tillsonburg 69.1%, Woodstock 76.1%, Ingersoll 76.4%, rural 84.5%)

Overall wellbeing of adults in Oxford County



HEALTHY POPULATIONS

Self-rated physical health
- 45.8% of adults rated their physical health as very good or excellent

Self-rated mental health
- 64.2% of adults rated their mental health as very good or excellent

Health behaviours
- 21.6% of residents disagree that they get good quality exercise (and an additional 16.8% are neutral)
- 9.7% of adults disagree that they regularly eat healthy meals (and an additional 11.2% are neutral)

Quality of health care services
- Over a quarter of adults (29.0%) rated the overall quality of health care services as poor/ fair (39.7% rated the overall quality of health care services as very good/ excellent and an additional 31.3% rated it as good)

Access to health care
- Over a third of adults (38.3%) rated overall accessibility of health care services as poor or fair (30.1% good, 31.5% very good/ excellent)

COMMUNITY VITALITY

Community belonging
- 55.0% of adults in Oxford County have a strong sense of belonging to their community (19% weak, 26% neutral)

Volunteering
- 52.9% of adults volunteered in the 12 months prior to the survey

DEMOCRATIC ENGAGEMENT

Local government services
- Just under half of adults (44.5%) are satisfied with the way local government responds to community needs (20.9% are dissatisfied and 33.9% are neutral)
- 12.8% of adults feel programs and services of local government have not made them better off and an additional 48.4% indicated that they have not made a difference (38.8% indicated that programs and services have made them better off)

CommunityOxford

MORE

LIVING STANDARDS

Work-life conflict

What is it? When people experience that the demands and expectations of their work and personal life create conditions where it is difficult to function effectively in either.

- Adults in Oxford County rate their work interference with personal life on average as 3.76 on a scale of 1 to 7.
  - This is higher in Tillsonburg compared with other urban centres (Ingersoll 3.85 and Woodstock 3.70) and more rural areas 3.61

Work satisfaction

- 61.3% of employed adults were satisfied with their work situation
  - Higher in older workers (84.8%) than younger workers (60.6%)
  - Lowest in Tillsonburg (48.3%) compared with other urban centres (Ingersoll 53.1%, Woodstock 62%) and rural areas (69.5%)
- Just over half of adults agreed that considering all their efforts and achievements, their salary/ income is adequate (26.2% feel salary is not adequate, 15.2% are neutral)
- Over half of adults (58.8%) commute less than 15 minutes each day (22.1% 16-30 minutes, 13.6% 31-45 minutes, 4.2% 45-60 minutes, 1.3% more than one hour)

61.3%

of employed adults were satisfied with their work situation

EDUCATION

Opportunity for formal education

- Over a quarter (26.6%) of adults did not feel that there are plenty of opportunities to take formal courses in the community
- Almost a quarter of adults (22.4%) did not feel that their current occupational position adequately reflects their education and training

LEISURE AND CULTURE

Access to arts and culture

- Only about 4 in 10 (41.9%) of adults were satisfied with their access to arts and culture opportunities in the community (19.0% were dissatisfied and 39.2% were neutral)

Welcoming facilities

- About half (49.9%) of adults felt that the recreation and cultural facilities were very welcoming to them, while 44.6% were neutral and 5.5% disagreed

Cost of participation

- A quarter of adults indicated that the cost of public recreation and cultural programs prevents them from participating (30.3% were neutral and 45.5% did not find cost prevents their participation)

TIME USE

Access to child care

- Only a third of younger adults with children (38.3%) believe that access to childcare is adequate in the community

88.9%

of adults feel that they have a personal responsibility to help protect the natural environment

ENVIRONMENT

Personal responsibility to protect the environment

- 88.9% of adults feel that they have a personal responsibility to help protect the natural environment (1.7% disagree, 9.4% neutral)

Air quality

- 71.4% of adults reported that the air quality in our community is very good (10.2% disagree, 18.4% neutral)

Water quality

- 16.7% of adults did not feel that the water quality in our community is very good and an additional 17.1% were neutral as to whether it was very good (66.2% of adults reported that the water quality in our community is very good)

58.8%

of adults commute less than 15 minutes each day

READING THE REPORT

More than 1,300 adults responded to the survey. Because some groups responded in greater numbers than others (e.g., based on age), responses were weighted to match the make-up of Oxford's population. See pages 3-6 in the report for more information about research methods and reporting.

Comparison profile:

Rural vs. urban residents

Rural adults:

- reported the highest levels of life satisfaction and wellbeing
- more often provided unpaid help to others
- had the strongest sense of community belonging
- had the highest levels of self-rated physical and mental health
- more often felt they had a personal responsibility to protect the environment

Rural adults reported the highest levels of life satisfaction and wellbeing.

Opportunities for improvement

- Adults with children at home experienced higher levels of work-life conflict and longer commute times.
- New and recent residents (those who had lived in the community less than 10 years) had significantly longer commute times, less job security, and more work-life conflict. They were less likely than established residents to agree that the quality of the health care system was very good or excellent or that water quality in Oxford County was very good.
- In general, people living alone reported lower levels of wellbeing.
- Adults in the lowest income category reported poorer quality of life on almost every characteristic. For some indicators residents in the middle and upper income categories were similar. Being at or below the lower income threshold of $40,000 made a substantial difference to quality of life.
- Ingersoll residents reported the lowest levels of agreement that the air and water quality were very good; had the lowest per cent with a flexible work schedule; and expressed less job satisfaction than residents of other communities.
- People living in Tillsonburg reported the lowest level of life satisfaction. They less often agreed that their mental health was very good or excellent; expressed the highest level of work-life conflict; and more often experienced financial hardship in paying for food and other needs.

FutureOxford
OUR PATH TOWARDS SUSTAINABILITY

FutureOxford.ca | CommunityOxford.ca

Download the full Oxford County Community Wellbeing Survey report at www.communityoxford.ca.

ROI RURAL ONTARIO INSTITUTE

Woodstock and Area Community Health Centre

COMMUNITY EMPLOYMENT SERVICES
Embrace Possibilities.

United Way Oxford

OxfordCounty growing stronger...together

20170222

All Cause Readmissions Within 30 Days for Selected Case Mix Groups (CMGs)

Oxford County Hospitals

As of May 2, 2019(coding completed for all hospitals)

NOTE: Readmissions are for any condition

	2016/17			2017/18			2018/19		
		Any IDS Facility			Any IDS Facility			Any IDS Facility	
CMG Category Index	Index Cases	30 Day Readmits	Readmit Rate	Index Cases	30 Day Readmits	Readmit Rate	Index Cases	30 Day Readmits	Readmit Rate
Gastrointestinal	559	95	17.0%	610	113	18.5%	611	104	17.0%
COPD	310	52	16.8%	304	55	18.1%	317	61	19.2%
CHF	196	50	25.5%	212	47	22.2%	208	46	22.1%
Pneumonia	273	42	15.4%	261	39	14.9%	249	32	12.9%
Cardiac	312	36	11.5%	276	42	15.2%	278	28	10.1%
Acute MI	152	32	21.1%	135	29	21.5%	113	26	23.0%
Diabetes	92	19	20.7%	74	11	14.9%	82	12	14.6%
Stroke	91	12	13.2%	44	5	11.4%	57	11	19.3%
Total	**1985**	**338**	**17.0%**	**1916**	**341**	**17.8%**	**1915**	**320**	**16.7%**

Transformation
Passion
Collaboration

eShift®

TRANSFORMING PATIENT CARE

eShift helps keep families together during difficult times

The eShift® Technology platform allows health care systems to care for complex patients in a more cost-effective way while allowing improved patient outcomes at the same time. Complimentary to existing programs such as bundled care initiatives, the eShift platform is built to integrate and support existing service delivery and allow more complex care to be performed outside the hospital.

The eShift® platform is innovative and can be quickly integrated to existing systems with minimal associated costs. To date, deploying the eShift® platform has been seamless and easily integrates into our partners infrastructure. The eShift system has proven to deliver a positive return on investment within six (6) months of the date you decide to move forward. Training is key to any successful deployment, and Sensory technologies has tools that can enable even large scale adoptions to be completed in 60-90 days.

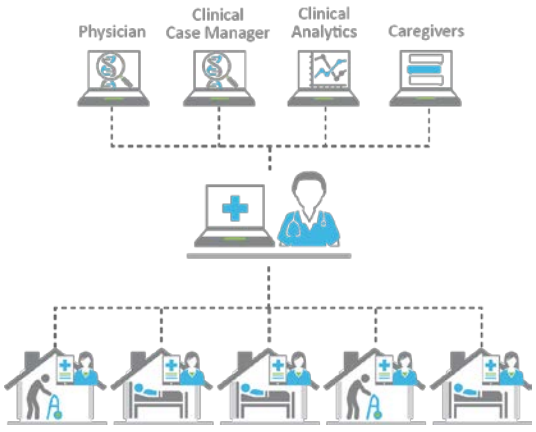
With over 14,820 patients who have successfully received eShift based care the technology platform and associated directed care model are proven to drive positive cost, readmission and hospital length of stay metrics.

9 years in Canada

5 years in the US

4 years in the UK

The eShift platform provides clear insight into patient care, status, updates, & larger regional aggregate data up the chain of command ensuring the right choices are being made from both Medically & fiscally.

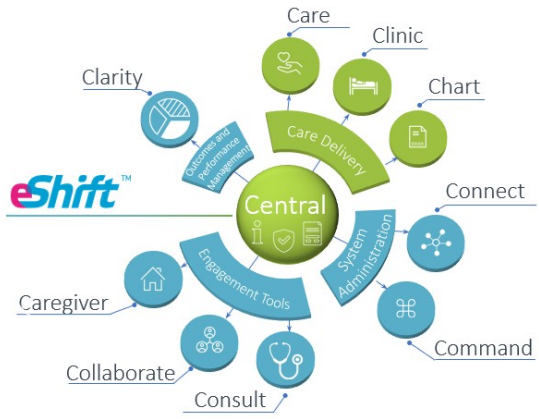


The Directed Care model leverages a single Clinician, Registered Nurse (RN) or similarly accredited healthcare professional who oversees multiple technicians providing care wherever the patient is. An eShift technician is a role best suited to a physician's aide, home support worker or potential informal caregivers, resulting in one Directing Clinician being able to provide care to 4, 6 or even up to 12 patients at a time. Leveraging readily available and cost-effective, unregulated clinicians in the field allows quick deployment and thereby shrinking the lag time to our client's Return on Investment realization. Today over 100,900 medications have been administered by bedside technicians.

Due to its unique HR model and data collections tools eShift captures a rich data set of "breadcrumbs." More than simply capturing points of decision by a senior clinician, this in turn allows us to work with our clients to drive ongoing quality improvements within each local install and provide comparative best practices from aggregated data across our international client base, all while allowing those senior clinicians the flexibility to cater each patient engagement as required to drive optimal patient care each and every time.

AND THE FUTURE OF ONTARIO HEALTHCARE

The eShift platform is well positioned to enable healthcare leaders to fulfil the MOHLTC vision of Ontario Health Teams.



Reinvest into front line care
eShift enables a unique model of care that expands the reach and scope of in-demand clinical resources

Operate within a single, clear accountability framework
The eShift Directed Care model provides a unique, accountable and transparent platform with real-time documentation of homecare activity

Improve access to secure digital tools, including online health records and virtual care options for patients – a 21st century approach to health care
The eShift Connect module enables the technology to integrate seamlessly and securely to other digital health systems and tools. Enabled by eShift, directed care in the patient's home is the first example of virtual care in Ontario

Provide a full and coordinated continuum of care for an attributed population within a geographic region
The engagement tools within the eShift product suite are designed for coordinated care planning and execution across care teams, ideally suited for wrap-around care within defined patient populations

Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey
The eShift patient portal allows patients 24/7 access to their eShift record, and the Connect module allows for rapid integration into other patient-directed digital tools

Be measured, report on and improve performance across a standardized framework linked to the 'Quadruple Aim'
The eShift Clarity module provides real-time, aggregated analytics for performance measurement supporting continuous quality improvement across populations or organizations

Be funded through an integrated funding envelope
The Connecting Care to Home (CC2H) program at LHSC & Southwest LHIN was a pioneer in the bundled funding model of care in Ontario and received the 3M Health Care Quality Team Award for Innovation.

Southwest LHIN Results

Performance Outcomes	Before eShift	eShift
Hospital Length of Stay	8.1 days	-59.3% ↓ 3.3 days
Community Length of Stay	150 days	-81.0% ↓ 28.5 days
30-day Readmission	22.5%	-41.7% ↓ 13%
Hospital Cost	$12,002	-57.9% ↓ $5,048
LHIN Care Path Cost	$3,275	-11.7% ↓ $2,901
Total Cost of Care	**$15,277**	**-47.9% ↓ $7,949**

In addition to meeting or exceeding the priorities of the Ministries new vision of healthcare, the eShift suite addresses all 8 components outlined as key factors in the successful implementation of an Ontario Health Team. For more information on how eShift could enable a collaborative, patient-focussed model of care for your team please contact your local account manager.

Oxford sub-region

Demographics

	Grey Bruce	Huron Perth	Oxford	London Middlesex	Elgin	South West LHIN
Total Population (2011)	148,178	145,794	113,943	444,509	88,849	956,468
% of the population that are Aboriginal	5.2%	0.5%	0.7%	3.8%	1.2%	2.8%

	Grey Bruce	Huron Perth	Oxford	London Middlesex	Elgin	South West LHIN
Total Population (2011)	148,178	145,794	113,943	444,509	88,849	956,468
% of the population that immigrated to Canada between 2006 and 2011	0.1%	0.3%	0.3%	2.3%	0.6%	1.2%
% of the population that are visible minority	1.2%	1.2%	2.0%	13.1%	2.0%	6.9%
% of the population that have Arabic as their Mother-Tongue	0.0%	0.0%	0.1%	1.8%	0.1%	0.8%
% of the population that have Spanish as their Mother-Tongue	0.1%	0.3%	0.2%	2.0%	0.3%	1.0%
% of the population that have French as their Mother-Tongue	0.9%	0.7%	1.0%	1.2%	1.0%	1.0%
% of the population who do not speak English or French	0.3%	0.7%	0.4%	1.1%	0.8%	0.8%

Demographics continued

	Grey Bruce	Huron Perth	Oxford	London Middlesex	Elgin	South West LHIN
Total Population (2011)	148,178	145,794	113,943	444,509	88,849	956,468
% of seniors 65 years and older	17.9%	15.1%	10.9%	8.6%	12.3%	11.9%
% of seniors 75 years and older	7.6%	7.1%	4.1%	3.7%	5.0%	5.2%

	Grey Bruce	Huron Perth	Oxford	London Middlesex	Elgin	South West LHIN
Total Population (2011)	148,178	145,794	113,943	444,509	88,849	956,468
Median Household Income	$52,770	$56,375	$61,042	$64,196	$59,392	$60,037
% of the population who live under the low income cut off	29.8%	23.7%	23.1%	33.5%	29.0%	30.0%
% of the population between 25 and 64 years old without a high school diploma	13.2%	16.5%	15.0%	9.3%	16.7%	12.6%
% of families who have lone parents	11.7%	11.2%	13.7%	17.1%	14.0%	14.5%

	Grey Bruce	Huron Perth	Oxford	London Middlesex	Elgin	South West LHIN
Prevalence of Chronic Conditions, Based on Self-Report (CCHS 2013/14)						
Arthritis	22.6%	20.9%	17.0%	16.4%	21.9%	20.6%
Asthma	8.0%	5.6%	7.2%	9.7%	9.0%	9.0%
COPD	4.4%	3.0%	3.1%	1.5%	3.3%	4.8%
Cancer	1.5%	1.1%	0.9%	1.2%	1.0%	1.0%
Diabetes	7.3%	8.0%	5.6%	6.5%	6.6%	7.0%
Hypertension	23.4%	22.4%	17.4%	16.5%	16.9%	17.5%
Ischemic Heart Disease	4.7%	5.3%	4.6%	4.1%	5.2%	4.7%
Stroke	1.6%	1.1%	0.9%	0.8%	1.7%	1.4%
Mortality Rate per 100,000 Population, for Select Chronic Conditions (Statistics Canada 2011)						
Arthritis	6.4	5.8	2.9	3.0	1.7	3.8
Asthma	0.7	0.7	< 0.5	0.4	0.6	0.5
COPD	44.6	48.0	31.9	27.9	40.0	34.8
Cancer	279.1	245.6	231.6	218.0	216.1	231.6
Diabetes	34.9	31.3	22.0	19.3	29.4	24.6
Hypertension	42.2	12.7	9.1	7.8	10.6	8.6
Ischemic Heart Disease	165.2	141.6	174.4	94.9	156.7	127.7
Stroke	45.9	45.9	37.7	29.0	36.7	35.7

Complex Patients 2013/14	Elgin	Oxford	Grey Bruce	Huron-Perth	London-Middlesex
Total patients (health care users)	75,222	92,547	116,212	109,169	379,098
Complex Patients (4+ conditions) #	4,265	5,005	7420	5,905	21,200
% of patients that are complex	5.7%	5.4%	6.3%	5.4%	5.6%
# of Complex patients NOT enrolled with a Patient Enrollment Model (PEM)	1,135	1,215	1,700	1,295	6,055
% of Complex patients NOT enrolled with a PEM	27%	24%	22.9%	22%	29%
Complex patients, by age group					
<18 yrs	80	115	130	150	515
18-44	340	420	635	455	2,225
45-64	1,130	1,185	1,810	1,385	5,735
65-79	1,650	1,845	2,770	2,050	6,965
80+	1,070	1,435	2,070	1,870	5,760
Complex patients, by sex					
Female	2,190	2,645	3,685	3,095	11,195
Male	2,075	2,360	3,735	2,815	10,005

This analysis is based on all patients who used health care services in 2013/14. Complex patients are those with 4 or more conditions (i.e.., the 'target population' for Health Links). Note that the number of patients (health service users) is not the same as the estimated population of an area.

Rural Population. The map showing the classification of urban and rural areas within the Oxford sub-LHIN area, finds that 40% of the population lives in urban areas, which are made up of the City of Woodstock and Town of Tillsonburg. The urban commute zones of these settlements capture an additional 47% of the Oxford sub-LHIN area population, leaving only 13.0% of the population living in rural areas (Table 7-4).

Table 7-4. Rural population

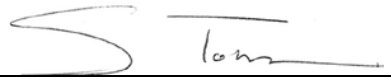
	Oxford	City of Woodstock	South West LHIN
Total Population (2011)	113,943	34,583	956,468
% of the population living in urban areas	40.0%	100.0%	50.0%
% of the population living in urban commute areas	47%	0.00%	19.8%
% of the population living in rural areas	13%	0.00%	30.2%

Ontario Health Team Self-Assessment Form

Part IV: Sign Off

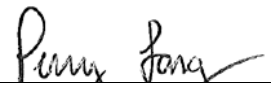
Proposed Name of Ontario Health Team	***Oxford Ontario Health Team***	
Primary Contact for this Application	Name:	Sandy Jansen
	Title:	President and Chief Executive Officer
	Organization:	Alexandra Hospital Ingersoll and Tillsonburg District Memorial Hospital
	Email:	Sandy.jansen@tdmh.on.ca
	Phone:	519-642-3611 x 5301

Endorsed By: Primary Care	
Name	Randy Peltz
Position	Executive Director
Organization	Oxford Community Health Centre
Signature	
Date	May 10, 2019

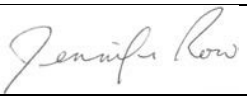
Endorsed By: Primary Care	
Name	Sue Tobin
Position	Nurse Practitioner and Clinical Director
Organization	Ingersoll Nurse Practitioner Led Clinic
Signature	
Date	May 10, 2019

Endorsed By: Primary Care	
Name	Mike McMahan
Position	Executive Director
Organization	Thames Valley Family Health Team
Signature	
Date	May 10, 2019

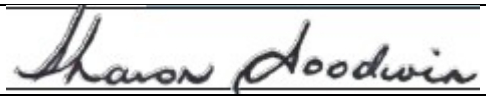
Endorsed By: Acute Care	
Name	Sandy Jansen
Position	President and Chief Executive Officer
Organization	Alexandra Hospital Ingersoll and Tillsonburg District Memorial Hospital
Signature	
Date	May 10, 2019

Endorsed By: Acute Care	
Name	Perry Lang
Position	President and Chief Executive Officer
Organization	Woodstock Hospital
Signature	
Date	May 10, 2019

Endorsed By: Primary Care; Hospice Palliative Care	
Name	Dr. Jitin Sondhi
Position	Regional Clinical Co-Lead for the South West Hospice Palliative Care Network Co-Chair for Primary Care Alliance Oxford
Organization	
Signature	
Date	May 10, 2019

Endorsed By: Home and Community, Palliative and Complex Care	
Name	Jennifer Row
Position	Director, Home and Community Care Director Nursing, Palliative, Complex
Organization	South West LHIN
Signature	
Date	May 10, 2019

Endorsed By: Home and Community Care	
Name	Daryl Nancekivell
Position	Vice President, Home and Community Care
Organization	South West LHIN
Signature	
Date	May 10, 2019

Endorsed By: Community Support Services	
Name	Sharon Goodwin
Position	Senior VP, Home & Community Care
Organization	Victorian Order of Nurses for Canada – Ontario Branch
Signature	
Date	May 14, 2019

Endorsed By: Health Links	
Name	Michelle Penfold
Position	Project Manager
Organization	Oxford Health Link
Signature	
Date	May 10, 2019

Endorsed By: Mental Health and Addictions	
Name	Linda Sibley
Position	Executive Director
Organization	Addiction Services of Thames Valley
Signature	*See Letter of Support*
Date	May 10, 2019

Endorsed By: Mental Health and Addictions	
Name	Lynn Wardell
Position	Interim Executive Director
Organization	Canadian Mental Health Association Oxford
Signature	*See Letter of Support*
Date	May 10, 2019

Endorsed By: Child and Youth Mental Health	
Name	Mamta Chail
Position	Executive Director
Organization	Wellkin Child & Youth Mental Wellness/Lead Agency, Woodstock
Signature	Mamta Chail
Date	May 10, 2019

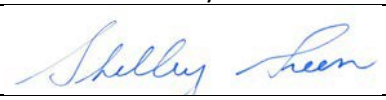
Endorsed By: Long Term Care	
Name	Megan Allen-Lamb
Position	President
Organization	People Care Communities
Signature	
Date	May 10, 2019

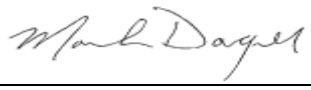
Endorsed By: Public Health	
Name	Cynthia St. John
Position	Chief Executive Officer
Organization	Southwestern Public Health
Signature	Cynthia St. John
Date	May 10, 2019

Endorsed By: Paramedic Services	
Name	Ben Addley
Position	Chief
Organization	Oxford County Paramedic Services
Signature	B Addley
Date	May 10, 2019

Endorsed By: Human Services	
Name	Lisa Lanthier
Position	Manager, Human Services
Organization	Oxford Human Services
Signature	Lisa Lanthier
Date	May 10, 2019

Endorsed By: eHealth	
Name	Craig Hennessy
Position	e-Health Lead
Organization	South West LHIN
Signature	
Date	May 10, 2019

Endorsed By: Alzheimer Society	
Name	Shelley Green
Position	Executive Director
Organization	Alzheimer Society Oxford
Signature	
Date	May 10, 2019

Endorsed By: Oxford County - Woodingford Lodge	
Name	Mark Dager
Position	Supervisor of Behavioral Supports Ontario (BSO)
Organization	Oxford County – Woodingford Lodge
Signature	
Date	May 10, 2019

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

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

Mayl4,2019

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 soencouraging to see mental health and addiction services included in such a prominent way in the essential elements of the OHT planning, There isno doubt that those we serve willbenefit greatly from this holistic approach to health care.

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

Best regards,

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

522 Peel Street,
Woodstock ON N4S 1K3
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40 Brock Street West
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C/o Ingersoll Nurse Practitioner-Led Clinic
19 King Street East, Ingersoll ON N5C 1G3
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