OXFORD
ONTARIO HEALTH TEAM

Oxford and Area Ontario Health Team

Progress Report

Together in Coordinated Care

In Development Ontario Health Teams
Progress Report

Proposed name of the Ontario Health Team	Oxford and Area Ontario Health Team

Part I: Defined Patient Population and Priority Year 1 Population(s)

Reflecting on your team's self-assessment response for Model Component 3: Defined Patient Population, please provide the following additional information.

What did the attributed population data reveal about the population accessing care from partners in your team? Please note that while the attribution data may be used to identify potential partners, it is not prescriptive. Teams are encouraged to partner with individuals and organizations they deem appropriate.

Response *(750 words maximum)*

The attribution data provided by the Ministry of Health validated our previous assumptions about our proposed Ontario Health Team (OHT), and the people accessing care in our geographical area.

The attributed population for our proposed OHT is 103,072. This attributed population is made up predominantly by residents of Oxford County, accounting for approximately 72% of the total. Geographies surrounding Oxford County contributing significantly to the attributed population include Norfolk County residents (8.6% of total) London/Middlesex residents (4.4%) and Elgin County residents (4% of total). This geographical distribution is consistent with our primary care and hospitals' experience, and has led us to re-brand ourselves to "Oxford and Area" our initial self-assessment target population which was focused on Oxford County.

Our assumptions about the demographic of patient accessing services in our proposed OHT were validated, indicating an "older" population. Our attributed population over the age of 65 accounts for 20.3% of the population compared to a provincial average of 17.6%. In our initial self-assessment, we highlighted the economic burden of chronic disease and aligned our Year 1 Target Population accordingly, opting to focus on people within our geography experiencing readmission to hospital as a result of chronic disease. It is well established that the incidence of chronic disease increases with age. We are confident that the attribution data validates this portion of our Target Population. As highlighted later in this report, we are proposing an expansion to our Year 1 Population, which will also support our older demographic.

There are a variety of primary care models in Oxford County including Family Health Organizations, a Family Health Team, a Nurse Practitioner Led Clinic (NPLC) and a Community Health Centre (CHC). We have confirmed that all primary care providers (physicians and nurse practitioners) within Oxford County are organized into one of these three models, and that there are no "solo" physicians. Of note, there are 4600 patients registered to either the NPLC or the CHC who may not have been captured in the attribution data, as they have not accessed OHIP covered diagnostic or lab tests, or hospital care. It is our assumption that these unaccounted for individuals are in fact part of our attributed population, bringing our total attributed population closer to 107,700.

The Primary Care Patient Enrollment Model (PEM) data provided validates our prior assumptions about primary care providers and their patients for our proposed OHT. According to the data, none of the patients in the listed PEMs are in different Ontario Health Team Networks, which is consistent with our understanding of how the primary care and acute care partners in our proposed OHT support their patients. The primary care physicians in Oxford County work very closely with the hospitals in our region, and, in fact, many of them have hospital privileges and work as hospitalists in one or more of the three acute care sites. This close affiliation between primary care physicians and acute care leads to a strong sense of community and the ability to work collaboratively within the Oxford and Area Health Team.

Based on the geographical distribution and demographics of our attributed population, the pattern of patients accessing services in our area, and the close relationships between the primary care and acute care sector, we are confident in our proposed Oxford and Area OHT. We feel the data provided has reinforced our desire to further strengthen the existing partnerships and enhance the patient experience in our Ontario Health Team.

How has or how might these data be used to inform your planning to achieve quadruple-aim metrics related to your patient population?

Response *(750 words maximum)*

We were pleased to receive the full data package from the Ministry of Health for our attributed population, and were reassured that the information aligned with the data our team was able to gather over the past several months.

As part of our strategy to educate our team about all aspects of our healthcare system, we have received sector specific presentations and associated data from our OHT partners. The presentations and ongoing participation of our partners has further enhanced our understanding of patient volumes and access patterns, current challenges meeting demand, and barriers to providing optimal care.

Our partners consistently highlight themes including lack of Long Term Care (LTC) beds, shortages of community based Personal Support Workers and nursing and long wait lists for Assisted Living, Supportive Housing and Adult Day Programs. 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 (ED). 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 more appropriately managed in the community and/or the patient's residence.

In addition to the impact to patients and their families, we heard that the strain related to the lack of community resources significantly impacts providers and leads to burnout and abandonment of their chosen profession.

To round out the stories we heard from our partners and prior to receiving the provincial data, we recognized that robust data was required to inform our plan and strategy. We worked closely with our Local Health Integration Network (LHIN) partners to gather current data from sectors including Home and Community Care, Community Support Services, Long Term Care, Mental Health and Addictions, Acute Care, Palliative Care and Primary Care. We engaged Public Health to further expand our knowledge of the social determinants of health for the residents in our region. The South West LHIN provided a full, updated data package outlining patient volume and utilization, service provider contract layout, patient population breakdown and access patterns, acute care metrics, and current funding for all LHIN funded organizations across our OHT geography.

From the Ministry data, several key areas stand out where our local performance does not align with that of the province, pointing to improvement opportunities. (2017/18 data)

- Rate of avoidable ED visits is significantly higher than the provincial rate with an average of 12.9 visits per 1,000 attributed populations age 1-74 compared to 4.2 visits per 1000 provincially.
- Rate of hospitalizations for ambulatory care sensitive conditions is also significantly higher than the provincial rate with an average of 117 per 100,000 attributed population age 0-74 for our network, compared to 84 per 100,000 provincially.
- Percentage of the population with no ED visits in a year is significantly lower in our network at 65% compared to 76% provincially.
- Percentage of CTAS IV and V patients is significant higher in our network at44% compared to the province at 33%, with a corresponding lower rate of CTAS I, II, and III compared to the province.
- Rate of CTAS IV and V Emergency Department visits per 1,000 enrolled patients is significantly higher at 297.4 for our network compared to 140.2 for the province.

A lack of access to team-based primary care in many regions of our geography, poor alignment of existing team-based care resources, limited primary care after-hours access, high patient panel size and a significant number of unattached patients (approximately 9,300 individuals) demonstrates that current primary care resources are not well aligned with the needs of the attributed population. This results in using EDs for health issues best managed elsewhere, as demonstrated by the data provided by the LHIN and the Ministry.

In Development Ontario Health Teams
Progress Report

The new Ontario Health Team model presents opportunities to better meet the needs of our population through a realignment of resources and to work collaboratively to support primary care and community providers. This will lead to improved quality of care, patient and provider experience, and value for money. We feel that this coordinated approach to care, focused on shoring up primary care and community resources and planning for care as a team, is essential. It is with this mindset that we have envisioned a health system transformation for the patients and families of the Oxford and Area OHT.

Proposed Priority Year 1 Population(s):

Please identify the priority Year 1 population(s) proposed in your Self-Assessment and note any changes that are based on a greater understanding of demographics, cost drivers, referral & utilization patterns, and barriers to equitable care. (1000 words maximum)

In our self-assessment, our proposed Year 1 Target Population included people who experience a readmission to hospital within 30 days of discharge as a result of a chronic disease. In the response letter from the Ministry, we were encouraged to work to more clearly identify our immediate implementation priorities, objectives and/or plans for Year 1 Population.

We have reviewed all material and available data related to the people accessing health care in our area. Detailed data and information was provided by the Ministry, our LHIN, Public Health, and specific health sectors. We heard from acute care, community providers, primary care providers, patients, and caregivers to provide context and validate the data. We incorporated this full breadth and depth of perspective into our planning tables and working groups, to provide a robust understanding of the current state of health care in our region, including barriers and opportunities.

In addition to a large and inclusive OHT coordinating committee, multiple working groups or "Action Teams" have been established to focus on detailed aspects of our 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 Population. The Action Teams have representation from patients and caregivers from across our geography. The Year 1 Population Action Team has membership representing all health sectors, and has created a proposal for identified Year 1 Populations.

Through the co-design process, and in recognition of current best practices within our OHT geography, the Year 1 Population Action Team has recommended an expansion of our previous identified Year 1 Population to include the following three populations:

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.

In Development Ontario Health Teams
Progress Report

Chronic Disease and Palliative Care

- 5.4% of our OHT residents have four or more chronic diseases (5600 patients).
- 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.
- Approximately 2,400 patients per year receive Home Care in our OHT 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”.
    - “Chronic” population definition:
        - May have one or more health/chronic conditions with complicating factors or requires assistance to continue with age-related concerns. Direct care needs are stable and predictable. Chronic patients tend to be self-reliant and/or can achieve stability with the right support network in place. Chronic conditions include Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Renal Failure, Dementia, Chronic Wounds, Age-related Morbidities, Diabetes.
    - “Complex” population definition:
        - May have one or more health/chronic conditions with complicating factors. Direct care needs are unstable and unpredictable. The individual or support network is not self-reliant, with high risks in more than one area. Complex patients tend to have multiple care partners across sectors; overall poor coping (significant caregiver distress), multiple complex and/or psychosocial issues. Complex conditions include all metastatic cancers and neuro-degenerative disease, end-stage CHF, COPD, Renal Failure and end-stage Dementia.
- The number of Year 1 Home Care patients in our OHT, numbers of visits or hours, and average cost per patient, per year:
    - 1,698 Chronic patients = 146,338 visits or hours ($3,555/patient)
    - 674 Complex patients = 73,058 visits or hours ($5,466/patient)
- 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 1 or more ED visit each month.

Mental Health and Addictions

- Schedule 1 Psychiatric Facility with 16 adult care beds and three Psychiatric Intensive Care Units
- Approximately 650 mental health admissions per year, average length of stay (LOS) per admission is 10 days
- 20-30% repeat unscheduled ED visits within 30 days for substance abuse across all acute care sites
- Mental Health Case Management wait times highest in Oxford County compared to all other areas in the South West LHIN at 189 days
- Primary Care Providers are often the first point of contact for those experiencing mental health problems, yet only 1 in 4 Ontarians has access to team based primary care such as FHT, CHC and NPLC.

Mental Health and Addiction issues are compounded by the rurality of our geography. It has been well established that there are significant barriers to seeking care for mental health related issues such as privacy and anonymity, stigmatism, lack of resources and transportation. There is a significant portion of the population that is agriculture dependent for their livelihood. These farmers grapple with daily stressors including market volatility, long work days, isolation and weather fluctuations.

Persons living with Mental Health and Addictions face significant stigma when having to access care and treatment at stand-alone Mental Health and Addictions agencies. When individuals are able to address these issues within the primary care environment there is early identification, improved outcomes, collaboration between primary care and Mental Health and Addictions providers, and better patient experience.

Based on the challenges patients and caregivers experience navigating transitions in and out of hospital, and working with multiple community providers, the need for care coordination and system navigation for this population was evident, and it was identified that these populations would benefit from an integrated care team approach.

The “Year 1 Population” Action Team explored examples of integrated care that were currently in use for small pockets of our geography to support Chronic Disease, Palliative Care needs and Mental Health and Addictions. The Action Team felt there was tremendous opportunity to further expand these examples to the broader Year 1 Target Population, strengthened by digital health supports and a standardized approach.

Part II: In-Scope Services That Can be Provided by Team Members

Reflecting on your team's self-assessment response for Model Component 4: In-Scope Services, please provide the following additional information.

Who are the members of your team and describe the breadth of services they can provide (e.g., in home and community care, primary care, and hospital care)?

Please note any changes from your self-assessment – if there are no changes to your team members, please indicate this here. (1500 words maximum)

The breadth of services provided by our proposed OHT spans the full spectrum of comprehensive health and human services. To accommodate the expanded membership we have experienced since submission of our self-assessment, we have organized in accordance to the RISE framework. This structure includes a Coordinating Committee, a Steering Committee, six Action Teams including Collaborative Governance, Communications and Community Engagement, Digital Health, Patient Engagement, Year 1 Population and Primary Care Engagement.

Across these various planning and steering tables, we are confident that we represent the full continuum of care providers in our region. Additions to our OHT tables since our self-assessment includes 100% of the current contracted Home Care Service providers, Board of Director representation, multiple primary care physicians and front line nurse practitioners, expanded Community Support Sector leaders, patient advisors from across our region, and caregivers of patients.

Please see Appendix 1: Oxford and Area OHT Organizational Chart

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 primary care for all primary care providers will be a focus and priority, supported by centralized intake, 24/7 navigators, and a commitment to community based care.

Our Year 1 Population has been further refined since our self-assessment, and we are working together to create Integrated Care models to support our Year 1 Target Population. In year 1, one model we are strongly considering is an integrated care team with "Nurse Navigators" aligned and embedded with primary care providers to support individuals with chronic disease and palliative care needs. This team will work across the acute care, home care and primary care sectors as a single team to support patients where they are, and to ensure seamless communication across sectors, along with wraparound patient support.

Our integrated care team concept will be focused on maintaining people in the community setting with the support of primary care, existing home care providers, and other community based supports. Although still conceptual, the structure of this team is evolved. Working to full scope and in conjunction with primary care, our Year 1 Proposal will blur the lines between "Care Coordinator", "System Navigator" and "Visiting Nurse" by blending responsibilities. This in turn will build capacity within the system, where a traditional care coordination role will be expanded to include clinical intervention under the direction of primary care. In collaboration with the primary care provider our Nurse Navigators will

develop individualized care plans based on patient need, and coordinate service from home and community care, community support services, mental health and addictions, specialized geriatrics, palliative care, housing stability, etc. Each patient care team will be supported by Coordinated Care Planning, with the individual's goals a priority.

We are proposing that our potential integrated care model will be enabled by digital health solutions anchored in current provincial assets (CHRIS, E-Notification, Clinical Connect, e-consult), working with existing local acute and primary care electronic medical records. The ability to support patients in the community to access their own health records will be enabled through the patient facing portal MyChart, already available in all acute care settings in our proposed OHT.

To address the Mental Health and Addictions population, we will leverage existing structures within Oxford County and area including the Oxford Mental Health & Addictions Network, Oxford Situation Table, Oxford County Community Drug and Alcohol Strategy Steering Committee, and the Oxford Health Link /Coordinated Care Planning Steering Committee. Several Mental Health and Addictions agencies and partnerships currently exist to support our attributed population, and these organizations will come together under the guidance of recommendations of the Ministry to support the development of a Mental Health and Addictions sector anchored in Primary Care. As this work evolves, further refinement of this population will ensue, based on data and local need.

How have primary-care providers been involved as members or leaders in your team?

Please note any changes from your self-assessment. (750 words maximum)

The Oxford and Area OHT Coordinating Committee recognized from the outset that primary care engagement and leadership will be an essential building block for the success of the OHT, particularly in an underserviced, rural context.

To that end, since submitting our self-assessment, four (4) family physicians, two (2) nurse practitioners, and a primary care administrative representative have joined forces to form a Primary Care Engagement Action Team. One of the family physicians, a hospitalist and President of Medical Staff at a local hospital, is taking a lead role to champion our next steps across the physician community. The aforementioned team members represent a diversity of primary care models, including FHT, FHO, Nurse Practitioner-Led Clinic, and Community Health Centre. Additionally, several of these team members have been actively participating in the Oxford Health Link/Coordinated Care Planning Steering Committee, with a firm belief in the value of team-based, connected care.

The work plan for the Action Team encompasses the following key elements:

1. *Continuing to Understand the OHT landscape (short term and long term vision) while supporting primary care to become leaders & shape their OHT:*

   a. Utilizing the full scope of resources and modelling provided by the Rapid-Improvement Support and Exchange, particularly Brief 4: Primary-care leadership and engagement / family- physician engagement mechanisms
   b. Active primary care participation on Oxford and Area OHT Steering and Coordinating Committees

c. Continuous learning from Ministry of Health Connected Care updates, and bulletins/sessions offered by respective provincial associations

2. Mentorship and Experience-based Advice

a. Seeking experiences and best advice for moving forward from primary care colleagues in jurisdictions that have been given official OHT status.

3. Building Trusting Relationships

a. A matter of utmost importance is building trusting relations and understanding amongst primary care providers, particularly family physicians, in the Oxford community. This will be accomplished by meeting with small groups of physicians across the community, in their space and comfort level, and respecting their time availability.
b. The long-term plan is a strong and connected primary care OHT network, and emerging leaders therein.

4. Communications

a. Brief, electronic communications, drawing from a larger comprehensive Oxford and Area OHT Newsletter, will be regularly distributed to primary care providers, with a consistent focus on e.g. *"what do your patients need?"* and *"how can we support you?",* within a framework of achieving collective accountability for Quadruple Aim.

5. Remuneration

a. The physicians on the Action Team will be recommending a model and related policies for remuneration to recognize the involvement of primary care providers in leadership roles who would be taken away from direct patient care for which they are paid.

Steps leading to the aforementioned Oxford and Area OHT primary care milestones include, for example:

1. The Ingersoll Nurse Practitioner-Led Clinic (INPLC), Thames Valley Family Health Team (TVFHT), Oxford County Community Health Centre (OCCHC), and Regional Clinical Co-Lead for the South West Hospice Palliative Care Network, & Lead Physician for Oxford/Elgin Palliative Outreach Team (former Oxford Chair, South West Primary Care Alliance), were part of the original members of the Oxford and Area OHT and Area Development Team before expanding to a much broader cross-sector Coordinating Committee which exits today. The INPLC/TVFHT/OCCHC provides care to approximately 23,900 patients, or 23% of the Oxford & Area attributed population.

2. The aforementioned members were heavily engaged in the Oxford and Area OHT Self-Assessment scoring, written content, and submission in May 2019, serving as signatories.

3. A professionally facilitated Primary Care Engagement Session was held September 11th, 2019. An invitation was extended to primary care providers across Oxford County for the purpose of Creating and Co-Designing what primary care looks like in an Ontario Health Team. The feedback obtained during this session is being used to inform our current Action Teams, and full OHT application. Specifically, the agenda and roundtable group

work focused on:

a. An overview and update on OHTs and context for Oxford County
b. Feedback regarding barriers and needs of primary care as well as what would make the greatest difference for primary care providers within an OHT model
c. Discuss the potential of a primary care network/ways of organizing primary care within Oxford
d. Discuss the potential of a primary care network/ways of organizing primary care within Oxford

4. Primary Care is currently represented on the *Oxford and Area OHT Digital Health Action Team, and Year One Target Population Action Team*

In summary, primary care in the Oxford and Area OHT is well-leveraged to achieve readiness in the next stages of our development.

Part III: Other OHT Building Blocks

Reflecting on your team's self-assessment responses for each of the Model Components, please provide the following additional information.

Which of the following areas of the Ontario Health Team model have you focused your efforts on since receiving the results of your self-assessment? For each area you have chosen to focus on, please describe how these efforts have prepared you to complete the full application in the text field below:

- **Patient partnership and community engagement (e.g., engagement of Francophone populations and Indigenous communities)** *(Self-Assessment Response to Model Component 1: Patient Partnership and Engagement)*
- **Patient care and experience (e.g., setting the stage to use population-health management to improve key metrics related to patient care and experience among groups of patients for whom quadruple-aim metrics are particularly poor)** *(Self-Assessment Response to Model Component 2: Patient Care and Experience)*
- **Digital health (e.g., steps that have been taken to support a current state assessment of each team member's digital health capabilities and the identification of any gaps)** *(Self-Assessment Response to Model Component 8: Digital Health)*
- **Leadership, accountability and governance (e.g., shared decision-making approaches and steps towards building the trusted relationships needed for collaborative governance)** *(Self-Assessment Response to Model Component 5: Leadership, Accountability and Governance)*
- **Performance measurement, quality improvement, and continuous learning (***Self-Assessment Response to Model Component 6: Performance measurement, quality improvement, and continuous learning)*
- **Other components of the OHT model**

In your response, please comment on how you have utilized resources and supports available through the OHT Central Program of Supports.

Response *(1500 words maximum)*

Patient Partnership and Community Engagement

A key area we sought to advance from our self-assessment was patient partnership and community engagement. Since that time we have integrated the perspective of patients, caregivers and family members in purposeful and meaningful ways to support the development of our OHT application.

First, we developed a Patient Engagement Action Team, recruiting six patient partners from across our geography, all with a variety of experiences as personal users of the health care system and also as caregivers.

This group has developed a Patient Engagement Framework to plan out the various ways that patient input will drive navigation, quality improvement, patient relations, patient experience, and leadership roles (including governance). Communication materials have been shaped by the input of this action team, and we are in the process of developing a local Patient Declaration of Values aligned with the provincial version. Further, we are committed to advancing the creation of a Patient and Family Advisory Council drawn from patient advisors from across member organizations that will guide the Oxford and Area OHT in its operations.

Oxford and Area OHT Patient Engagement Framework

Purpose:
To guide the Oxford and Area OHT in its efforts to engage patients in the integrated model of care being developed by partners. Engaged patients are crucial partners in the design and delivery of care, helping make services more navigable and in line with patient's experiences and values. This in turn reduces readmission rates, leads to greater adherence to treatment, and promotes self-care.

Audiences:
A variety of patient audiences exist in the Oxford County community, all who have a different interest and stake in the proposed Oxford Ontario Health Team. Each audience is unique in terms of becoming informed or participating in the development of an Oxford and Area OHT. A brief description of each and how they may be impacted is listed below:

- *Patients/families/caregivers*
  - *People who use the variety of health services across the full continuum of care.*
- *Patient/lived experience advisors*
  - *These are patients, families, and caregivers who are volunteering their efforts to partner with organizations to help make them patient-centered in their focus.*
- *General public*
  - *These are all individuals whom the Oxford and Area OHT would be responsible for providing care to across the healthcare continuum. While the majority of these individuals live the Oxford County area, because these are part of the attributed population to the Oxford and Area OHT, these individuals may or may not live in Oxford County. They also may be taxpayers and voters.*

Areas of Focus:
The perspective of patients can inform the following areas, both in terms of their development or implementation:

- *Access to services*
- *Navigation of services*
- *Direct care experiences with a health care provider*
- *Sharing feedback (patient experience)*
- *Sharing concerns (patient relations) and patient safety*
- *Quality improvement*
- *Human Resources, including hiring and training*
- *Leadership roles, including governance*

Approaches Towards Engaging:
A variety of approaches can be taken to engage different audiences for varying purposes.

Engagement spectrum	Audience	Engagement approach
Inform	General Public	Newsletter
		Website
		Social media
		Email
Consult	Patients/families/caregivers	Patient feedback survey
		Patient relations process
Involve	Patients/families/caregivers	Direct care experience
Collaborate	Patient/Lived Experience Advisors	Quality committee
		HR hiring panel
		Training & Orientation design and delivery
Empower	Patient/Lived Experience Advisors	Leadership role
		Governance role

**The engagement spectrum is attributed to the International Association for Public Participation*

Engagement in OHT Application:
The Oxford and Area OHT development consists of engaging patient advisors in the Coordinating Committee and Patient Engagement Action Team to support the work of the Coordinating Committee. Patients/families/caregivers have also been active in the development of the Year 1 model for the OHT application. A key deliverable for the Patient Engagement Action Team is to develop a Patient Engagement Framework (this document) that will guide the OHT partners in delivering care through an integrated manner.

Patient Declaration of Values:
As stipulated by the Ontario Health Team model requirements, each organization within an OHT shall base a Declaration of Values on the Provincial Patient Declaration of Values. The Oxford and Area OHT will look at an Oxford specific version of this work that may also touch on the responsibilities that patients have to being active and informed participants in their care.

Second, patient members have now joined our Coordinating Committee to help advance the overall OHT application. These members have been on-boarded and are supported throughout the meetings to help enable their participation. This includes touching base with them before meetings to ensure they have sufficient knowledge and context of issues being discussed, as well as communicating with

them in between meetings to find other ways for input to be gathered and to find ways to continually adjust out engagement approach. Ongoing patient participation on all OHT committees and action teams is a priority for our OHT.

Community engagement is ongoing, and is supported by our Communications and Community Engagement Action Team. This action team has developed a Communications and Community Engagement Framework and Communications Plan to guide how we can reach and engage over ten different audiences in our region, from the general public, to community service providers, to municipal leaders and elected officials, to front-line staff across various health and social service organizations.

Standardized presentation materials and branding have been developed and used to present OHT information and updates to a wide variety of audiences, including community partners, municipal leaders, patients and volunteers. Most recently, the team has produced a public website (www.oxfordandareaoht.com), and a quarterly newsletter that has been distributed widely to community partners and public. Our website offers an opportunity to sign up for ongoing updates and newsletters, and invites ongoing dialogue with our community through feedback and commentary options.

Patient Care and Experience

In addition to the individuals on the Patient Engagement Action Team, we have actively engaged four caregivers in the co-design of our Year 1 Population pathway including mapping current state and co-design of our proposed solution. Patient experience, both positive and negative, has informed our proposed Year 1 model, and we will be working with these individuals and others as we continue to refine our strategy and plan utilizing principles of rapid cycle improvement. Patient experience measures will be designed with patient partners, and evaluation of meaningful, experiential evaluation will be a priority in this initiative.

Digital Health

We have created a Digital Health Action Team and are nearing completion of the current digital health asset inventory required for the full OHT application. This action team has members from primary care, acute care, Home and Community care, and includes the South West LHIN e-health lead and a primary care physician. Recognizing that a strong digital health strategy is essential to achieving our goals, this team has membership sitting on the Year 1 Population Action Team as well. In this way, we will ensure our digital health strategy is supporting the clinical design of our integrated care solution, rather than driving it. This team is extremely knowledgeable of many of the current provincial assets, and is developing a proposed solution that will be anchored in these assets (CHRIS, E-Notification, Clinical Connect, e-consult), working with existing local acute and primary care electronic medical records.

In Development Ontario Health Teams
Progress Report

Leadership, Accountability and Governance

To provide additional leadership and direction, our initial Coordinating Committee has expanded to include a Steering Committee of decision makers from all OHT sectors. Formalized Terms of Reference have been developed for the Steering Committee and Coordinating Committee, with attention paid to decision making mechanisms including consensus definition and description of voting rights. A Collaborative Governance Action Team, led by members of the Steering Committee, is in development. An inaugural meeting of the Governance action team was held in early November engaging Board members from all OHT partners. Through a facilitated discussion, this group was further educated on the system transformation associated with integrated care models and OHTs and explored different models of collaborative governance that may be considered as we go forward.

Please see Appendix B: Coordinating Committee Terms of Reference

Please see Appendix C: Steering Committee Terms of Reference

Performance Measurement, Quality Improvement and Continuous Learning

Understanding our current performance across sectors as reported by the South West LHIN and the Ministry of Health attribution data has been very valuable, and has assisted the Year 1 Population Action Team on which population to focus on. The co-creation of patient reported experience measures (PREMS) and patient reported outcome measures (PROMS) will further enhance key performance indicators as we evaluate the success of our model.

In your Response, please comment on how you have utilized resources and supports through the OHT Central Program of Supports.

Through the RISE program of supports, RISE briefs have been valuable in establishing many of our action teams, and leads of action teams have been in attendance at RISE webinars outlining the various materials. Patient Engagement and Collaborative Governance and Population Health were particularly valuable for the development of these teams.

Part IV: Preparing for and Completing the Full Application

Reflecting on your team's self-assessment response for Part III: Implementation Snapshot, please provide the following additional information.

What challenges/barriers do you foresee in completing the full application and how do you propose to address these?

Response *(750 words maximum)*

Our most significant challenge is the engagement of primary care physicians. Although organized into Family Health Organizations (FHOs), many of the physicians in our region practice essentially as solo physicians and this has led to a lack of any sort of unified or organized primary care sector. The lack of a physician compensation model to support participation, and an ongoing challenge with engaging physicians at times that do not limit them from their patient care responsibilities, remain a barrier for fulsome engagement across all providers.

We have made strides in the past several months with primary care engagement, and are achieving early physician engagement and leadership, but this remains a challenge that we will continue to focus on.

Ongoing governance engagement will continue to be a challenge for organizations within the OHT with Boards of Directors, and also those organizations that are not governed by a Board of Directors. A unified and standardized communication strategy with key messages and consistent presentation materials will continue to be critical. The introduction of our website with public facing materials and a private members page, our newsletter, our brand/Logo and our Communications Action Team will assist with this.

Currently the OHT model does not have a single source of data or metrics/dashboard. The development of a dashboard to track key indicators of performance across multiple sectors will be a vital component of our rapid cycle improvement. It would also be valuable to see a provincial set of indicators, so that we are able to benchmark against our peers and the province. At this time, we are relying on LHIN and Public health data to inform our understanding of performance, and determine if we are focusing on the right areas for improvement.

It has been repeatedly stated that we are embarking on the most significant health system transformation since the introduction of the Canada Health Act. A transformation of this magnitude requires massive people power to coordinate, collaborate, plan and drive change as we recreate healthcare. Although Ontario Health is still in its infancy, consistent messaging and education from the province that supports the ongoing work of Ontario Health Teams is needed. Through our Communications and Engagement Framework, we are diligently working to inform and engage the public, but we feel it would be beneficial to have our messaging underscored by provincial communication materials. Furthermore, the work of creating an Oxford and Area OHT cannot be done off the side of one's desk. Some members of our OHT have put resources forward to provide dedicated support to this critical work. Our OHT is well resourced with close to 3 full time equivalents (FTE) of new resources including a Chief of Program Development and System Transformation, a Director of Strategic Planning, and an OHT Coordinator, each with a significant proportion of their time or dedicated full time resourcing the work required by the OHT. Additionally we have utilized the expertise of health system planners, epidemiologists, e-health leads, and seasoned leaders from across over thirty organizations.

What supports from the OHT Central Program of Supports would you find particularly helpful in completing the full application?

Response *(500 words maximum)*

- It would be helpful to see a summary/ tracking/trending of the various successful OHT candidates as they move forward, and a theming of successful integrated care strategies, as well as information about those teams that have faced challenges
- RISE may be in an ideal position to support a broad public education campaign to the citizens of Ontario to support education to help people understand what an OHT is, and how it will impact health care
- There is an unknown of how OHTs will evolve over time, and how Home Care, Ontario Health, and the Regional Offices will continue to evolve concurrently. Information about this would be valuable, perhaps in a framework for how we can successfully connect with these organizations/services
- Support for change leadership would be helpful, as the scope of this work is so significant
- Assistance to understand the future Integrated Funding envelopes
- We believe that the unknown aspect of the OHT model, and what a successful Integrated Care Model will look like, is an overarching challenge for all teams. We believe that every geography presents its own unique challenges, and expect there to be multiple versions of a successful model. It will be valuable to see how teams in similar geographies to ours (i.e. small rural) evolve over the next several years, and hope this information is available publicly in an ongoing way through RISE.

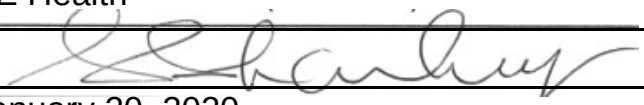
Part V: Sign Off

Proposed name of the Ontario Health Team	**Oxford and Area Ontario Health Team**
Primary contact for this Progress Report	**Name: Sandy Jansen**
	Title: President and Chief Executive Officer
	Organization: Alexandra Hospital Ingersoll/Tillsonburg District Memorial Hospital
	Email: sandy.jansen@tdmh.on.ca
	Phone: 519-642-3611 x5301
	Signature: 

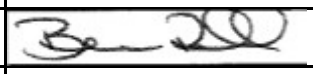
Please describe how you have confirmed the contents of this Progress Report with the members of your team.
Response *(250 words maximum)* The progress report submission for the Oxford and Area OHT has been an exceptionally collaborative effort. The report has allowed us to confidently detail the continued efforts on the development of our proposed OHT since our original self-assessment. The authorship of the report has been shared by many, and has truly been a co-creation. Iterative reviews and engagement has occurred across each action team and with patient advisors. • All Action Teams were participated in the development of sections of this Progress Report. The Primary Care Engagement, Year 1 Population, Patient Engagement, Digital Health, and Communications Action Teams have all been heavily engaged to develop the sections aligned to them, and verify content. • Multiple versions of the full Progress Report have been reviewed, revised and signed off by the full Coordinating Committee and Steering Committee over the past several weeks. • An additional eleven signatories have been added to our application since our Self-Assessment submission. This includes six physicians; four primary care physicians, and two hospital Chiefs of Staff, two patient Advisors, and three Home Care Service Provider Organizations. Individuals and organizations that have joined more recently have been engaged and educated about the full evolution of the OHT application. In doing a final review with our large and inclusive Coordinating Committee and posing this question to them, we were reassured to hear comments that they felt engaged, that their feedback had been heard, and were very pleased to be signatories on the report.

In Development Ontario Health Teams
Progress Report

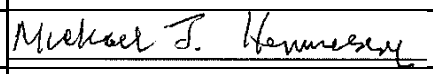
Please have **only** those **new individuals or organizations (i.e., those who were <u>not</u> signatories to the initial Self-Assessment Form) sign below.** While Board approval is not required, participants are expected to confirm the highest level of commitment possible.

Endorsed by	
Name	Shirlee Sharkey
Position	Director
Organization	SE Health
Signature	
Date	January 20, 2020

Endorsed by	
Name	Linda Knight
Position	Chief Executive Officer
Organization	Care Partners
Signature	
Date	January 16, 2020

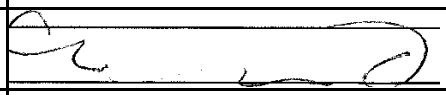
Endorsed by	
Name	Bernie Rilling
Position	VP Finance
Organization	CBI Home Health
Signature	
Date	January 15, 2020

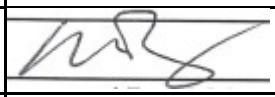
Endorsed by	
Name	Justin DeWaard
Position	Regional Manager
Organization	Indwell
Signature	
Date	January 15, 2020

Endorsed by	
Name	Mike Hennessy
Position	Patient Advisor
Organization	
Signature	
Date	January 15, 2020

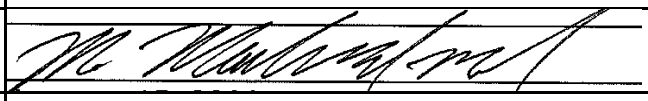
Endorsed by	
Name	Dr. Ian Hons
Position	Physician, Hospitalist
Organization	
Signature	
Date	January 14, 2020

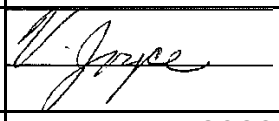
Endorsed by	
Name	Dr. Rachel Orchard
Position	Physician, Primary Care
Organization	
Signature	
Date	January 15, 2020

Endorsed by	
Name	Dr. Shameena Tamachi
Position	Physician, Primary Care
Organization	
Signature	
Date	January 15, 2020

Endorsed by	
Name	Dr. Kim Baker
Position	Physician, Primary Care/Hospitalist
Organization	
Signature	
Date	January 15, 2020

Endorsed by	
Name	Dr. Joel Wohlgemut
Position	Chief of Staff
Organization	Alexandra Hospital
Signature	
Date	January 15, 2020

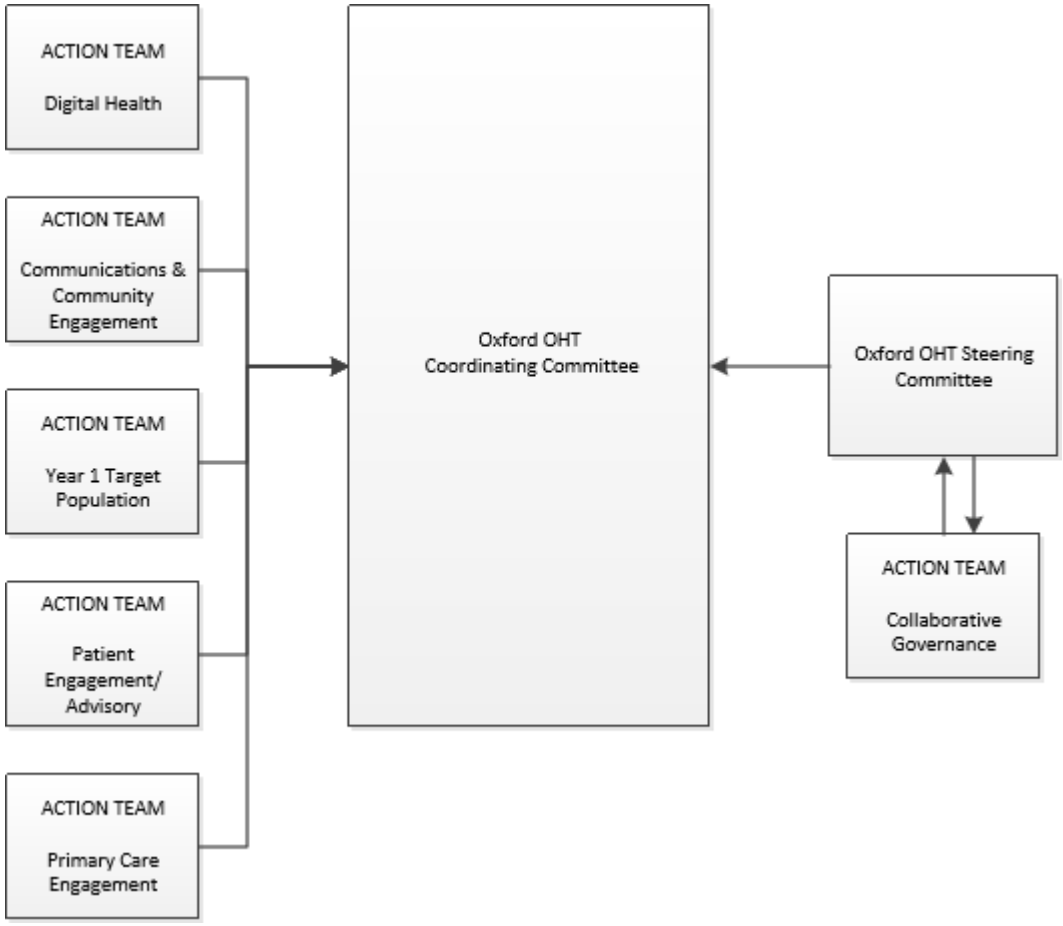
Endorsed by	
Name	Dr. Malcolm MacLeod
Position	Chief of Staff
Organization	Woodstock Hospital
Signature	
Date	January 15, 2020

Endorsed by	
Name	Valerie Joyce
Position	Patient Advisor
Organization	
Signature	
Date	January 15, 2020

OXFORD & AREA ONTARIO HEALTH TEAMS (OHT)

APPENDIX A

Organizational Structure



Oxford & Area OHT Steering Committee							
PRIMARY CARE		**ACUTE CARE**		**HOME AND COMMUNITY CARE**		**COMMUNITY SUPPORT SERVICES**	
Organization	**Member**	**Organization**	**Member**	**Organization**	**Member**	**Organization**	**Member**
Community Health Centre (CHC) Nurse Practitioner Led Clinic (NPLC) Primary Care Physician, Hospitalist	*Randy Peltz* *Sue Tobin* *Dr. Ian Hons*	Alexandra Hospital Ingersoll (AHI) Tillsonburg District Memorial Hospital (TDMH) Woodstock Hospital (WH)	*Sandy Jansen, Jennifer Row* *Sandy Jansen, Jennifer Row* *Perry Lang, Mark Weir*	South West Local Health Integration Network (LHIN) LHIN Contracted Home Care Service Provider	*Daryl Nancekivell* *Omar Aboelela*	Community Support Services (CSS)	*Julie Johnston, Leanne Turner*

Oxford & Area OHT Coordinating Committee

Organization	Member	Organization	Member
Addiction Services Thames Valley	*Linda Sibley*	Physician, Palliative Care and Hospitalist	*Dr. Jitin Sondhi*
Alexandra Hospital Ingersoll/Tillsonburg	*Sandy Jansen, Jennifer Row*	Physician, Primary Care	*Dr. Rachel Orchard*
District Memorial Hospital		Physician, Primary Care	*Dr. Shameena Tamachi*
Alzheimer Society	*Leanne Turner*	Physician, Primary Care and Hospitalist	*Dr. Kim Baker*
Alzheimer Society	*Shelley Green*	SE Health	*Alan Morrow*
Canadian Mental Health Association, Oxford	*Lynn Wardell*	South West LHIN	*Craig Hennessy*
Care Partners	*Beth Byrnes*	South West LHIN	*Daryl Nancekivell*
CBI Home Health	*Omar Aboelela*	South West LHIN	*Rachael Griffin*
Indwell	*Justin DeWaard*	South West Public Health	*Cynthia St. John*
Ingersoll Nurse Practitioner Lead Clinic	*Sue Tobin*	Thames Valley Family Health Team (TVFHT)	*Alisha Van Gorp*
Oxford Community Health Centre	*Randy Peltz*	Thames Valley Family Health Team (TVFHT)	*Mike McMahon*
Oxford County	*Lisa Lanthier*	Victoria Order of Nurses (CSS)	*Julie Johnston*
Oxford County Emergency Medical Service	*Ben Addley*	Wellkin Child and Youth Mental Wellness	*Mamta Chail*
Patient Advisor	*Mike Hennessy*	Woodstock Hospital (WH)	*Perry Lang*
People Care Long Term Care	*Megan Allen-Lamb*	Woodstock Hospital (WH)	*Mark Weir*
Physician, Hospitalist	*Dr. Ian Hons*	Woodingford Lodge Long Term Care (LTC)	*Mark Dager*
ACTION TEAM: Collaborative Governance		**ACTION TEAM: Digital Health**	
Steering Committee to Lead - quarterly meetings	*Representation from Hospital, NPLC, CHC, CSS Boards of Directors*	Alexandra Hospital Ingersoll/Tillsonburg District Memorial Hospital	*Dan Carney, Jennifer Row, Jodi Edwards*
		Clinical Advisor	*Dr. Joel Hamilton (CHC Physician)*
		Community Health Centre	*Mike Page*
		Nurse Practitioner Lead Clinic	*Kathryn Nicholson*
		Patient Engagement/Advisory Team *(as needed)*	
		South West LHIN	*Craig Hennessy (lead)*
		Woodstock Hospital	*Kevin Somerville*
ACTION TEAM: Communications & Community Engagement		**ACTION TEAM: Year 1 Pathway Development**	
Alexandra Hospital Ingersoll/Tillsonburg District Memorial Hospital	*Jennifer Row, Josh Crann*	Alexandra Hospital Ingersoll/Tillsonburg District Memorial Hospital	*Jennifer Row (lead)*
Executive Assistant	*TBD*	Community Health Centre	*Tina Arthur, Abbie Boesterd*
Nurse Practitioner Lead Clinic	*Stephanie Nevins*	Community Support Services	*Julie Johnston, Diana Handsaeme, Leanne Turner*
Patient Advisor	*Valerie Joyce*	Family Health Organization	*Scott Gould*
Woodstock Hospital	*Mark Weir (lead), Chelsea Vella*	Home Care Service Provider	*Omar Aboelela (CBI), Alan Morrow (SE Health), Beth Byrons (Care Partners)*
		Nurse Practitioner Lead Clinic	*Sue Tobin*
		Patient Advisors	*Heather, Ron, Murray*
		South West LHIN	*Rebecca Sutcliffe*
		Woodstock Hospital	*Mark Weir, Cindy Smart, Heidi Dantes*
ACTION TEAM: Patient Engagement Advisory		**ACTION TEAM: Primary Care Engagement**	
Alexandra Hospital Ingersoll/Tillsonburg District Memorial Hospital	*Jennifer Row*	Community Health Centre	*Randy Peltz (lead)*
		Family Health Organization	*Dr. Ian Hons, Dr. Kim Baker, Dr. Rachel Orchard, Dr. Shameena Tamachi*
Ingersoll Residents	*Mike Hennessy, Heather Wilson-Boast*		
Tillsonburg Resident	*Karen Devolin*		
Woodstock Resident	*Valerie Joyce, Maureen Ross*	Nurse Practitioner Lead Clinic	*Sue Tobin*
Woodstock Hospital	*Mark Weir (lead)*	Thames Valley Family Health Team	*Alisha VanGorp*

Oxford Ontario Health Team - Coordinating Committee
TERMS OF REFERENCE

Objective of the Oxford Ontario Health Team (O-OHT)
At maturity, as an Ontario Health Team (OHT), we will hold ourselves and each other clinically and fiscally accountable for delivering a full and coordinated continuum of care to the defined geographic population currently referred to as Oxford Region. In a highly collaborative way, we will actively shape how local health care services are delivered and managed, working towards a common goal of improved health outcomes, patient and provider experience, and value across the geography – also referred to as "The Quadruple Aim".

Role of O-OHT Coordinating Committee (O-OHT-CC)
The O-OHT–CC oversees, with a strategic lens, all steps of the O-OHT design and implementation and evaluation according to the deliverables set out by the Ministry of Health (MOH). The committee and it's associated "Action Teams" will be responsible to establish work plans, draft and revise the OHT Self Assessment and Full Application and engage broader representation from all sectors, patients and families and front line staff.
The role of the O-OHT-CC will change as the team progresses through the OHT application and designation process. These Terms of Reference will be reviewed upon movement to the each stage of development. The O-OHT-CC will report to the O-OHT Steering Committee (O-OHT-SC) for matters related to service prioritization and resource allocation (see O-OHT-SC Terms of Reference).

Guiding Principles
Aligned with the Quadruple AIM we will be guided by the following principles:

- Patients, families and caregivers are at the centre of everything we do,
- All members are treated with dignity and respect supporting an environment of openness, transparency and candor,
- Decisions are based on the good of the healthcare system and the health of the population of Oxford county and area, and not to serve the needs of individuals or organizations,
- Leverage the strengths of our existing relationships and nurture new ones
- All sectors have joint and equal accountability for attainment of results

Deliverables – Year 1

1. Completion of the OHT Self-Assessment
2. Completion of OHT Full Application
3. The selection of **a Defined Year 1 Target Patient Population** aligned with the O-OHT attributed population to begin implementation of changes and improve integrated patient care and experience.
4. The development of a OHT **Communication and Engagement Strategy** to ensure timely and relevant information sharing with all stakeholders, partners, the community, caregivers, patients and families.
5. The creation of a **Patient Engagement Framework** with support from the communities we serve. Patient representation will be established and included in governance structure(s) and system co-design. A Patient Declaration of Values will be in place. A patient relations process and community engagement plan will be put in place.
6. The development of an Integrated **Quality Improvement Plan** reflective of our Year 1 population which includes data collection, complete and accurate reporting on required indicators, and joint quality improvement activities to reduce variation and implement clinical standards and best practices.

7. The development of a **Strategic Plan** for the OHT Leadership, Accountability, and Governance which includes a central brand, appropriate financial and management controls, and a physician and clinical engagement plan. Future development will include funding through an integrated funding envelope based on the needs of attributed patient populations.

Note: The O-OHT-CC should not duplicate or supersede current organizational governance or operational decision making paths. The purpose of a Coordinating Committee is to provide guidance and enable strategic decisions in order to move nimbly and achieve results in a streamlined and efficient manner.

The O-OHT-CC will establish **Action Teams** for the purpose of accomplishing the specific deliverable listed above.

Membership

The O-OHT-CC will be composed of the following individuals who were a part of the original self-assessment submission. If an individual or an organization listed below elects to vacate their role on the Committee, the O-OHT-CC will agree by consensus on a replacement, if warranted. Membership and role of the o-OHT-CC will be re-evaluated throughout of the development process:

Sector	Organization	Representative
Primary Care	Oxford Community Health Centre Ingersoll Nurse Practitioner Led Clinic Thames Valley Family Health Team	Randy Peltz Sue Tobin & Stephanie Nevins Mike McMahon Dr. Ian Hons Dr. Kim Baker Dr. Rachel Orchard Dr. Shameena Tamachi
Acute Care	Alexandra Hospital Ingersoll & Tillsonburg District Memorial Hospital Woodstock Hospital	Sandy Jansen & Jennifer Row Perry Lang & Mark Weir
Hospice Palliative Care	Southwest Hospice Palliative Care	Dr. Jitin Sondhi (also Primary Care)
Home and Community Care	South West LHIN CBI Health Group Care Partners SE Health	Daryl Nancekivell Omar Aboelela Beth Byrnes Morrow, Alan
Community Support Services	Victorian Order of Nurses for Canada Alzheimer Society Oxford	Julie Johnston Leanne Turner
Mental Health & Addictions	Addiction Services of Thames Valley Canadian Mental Health Association, Oxford Wellkin Child & Youth Mental Health	Linda Sibley Lynn Wardell Mamta Chail
Long Term Care	People Care Communities Oxford County-Woodingford Lodge	Megan Allen-Lamb Mark Dager
Public Health	Southwestern Public Health	Cynthia St. John
Paramedic Services	Oxford County Paramedic Services	Ben Addley
Human Services	Oxford Human Services	Lisa Lanthier
eHealth	South West LHIN	Craig Hennessy
Indwell	Indwell	Natasha Thuemler
Patient/Family Advisor		Mike Hennessy Valerie Joyce

Communication
Highlights of meetings including any decisions will be drafted and available to members as soon as possible after each meeting.
Innovative communication strategies with the communities will be utilized including regular meetings with municipal and community leaders, broad distribution of newsletters, and utilization of sector leads to communicate among specific groups.
Organizational leaders will be responsible for communicating to their respective organizations and Boards.

Decision Making
When decisions are required, the preferred option will be to do so by consensus. Consensus is a process for group decision-making where an entire group of people come to an agreement to move forward. The input and ideas of all participants are heard, gathered and synthesized to arrive at a final decision that can be supported by everyone in the group.

The levels of consensus are:

1. Agree Strongly - I fully support the decision.
2. Agree - The decision is acceptable to me.
3. Agree with some reservation - I can support the decision or action, but I have concerns.
4. Disagree but willing to go along with the group - I am not thrilled with the decision but I can live with it and will not block it.
5. Disagree but will not block the decision - I need more information or more discussion.
6. I cannot support or accept the decision – I completely disagree and will work to block the decision.

The goal is that every member of the group is at level 1 through 4. If someone is at level 5 they are required to explain what information or discussion they require from the group. If someone is at level 6, it is important for them to try to offer a solution that could accommodate their needs and the needs of the group.

Should members be unable to come to consensus the matter will be referred to the Steering Committee.

Conflict of Interest
O-OHT-CC members are required to fulfill the duties of their appointment in a professional, ethical, and competent manner and avoid any real or perceived conflict of interest. Committee members have an obligation to declare a personal or pecuniary interest that could raise a conflict of interest concern at the earliest opportunity to the Chair. Each member has an ongoing obligation to disclose any actual, potential or perceived conflict of interest arising at any point during a member's term of appointment in regard to any matter under discussion by the Committee or related to the Committee's mandate.

Quorum
To constitute a formal meeting and conduct business, two-thirds of the Committee members including one Co-Chair must be present. Decisions or actions taken in the absence of a quorum are not binding on the Committee.

Meetings
Meetings will be scheduled at least monthly. Participants are encouraged to attend in person; however teleconference/videoconference options will be available. Members may elect to send a delegate if they are unable to attend. Voting privileges will not be extended to delegates unless specifically communicated by the member to the O-OHT-CC.

APPENDIX C

Oxford and Area Ontario Health Team - Steering Committee
TERMS OF REFERENCE

Objective of the Oxford and Area Ontario Health Team (O-OHT)
At maturity, as an approved Ontario Health Team (OHT), we will hold ourselves and each other clinically and fiscally accountable for delivering a full and coordinated continuum of care to the defined geographic population currently referred to as Oxford and area. In a highly collaborative way, we will actively shape how local health care services are delivered and managed, working towards a common goal of improved health outcomes, patient and provider experience, and value across the geography – also referred to as "The Quadruple Aim".

Role of O-OHT Steering Committee (O-OHT-SC)
The O-OHT–SC is responsible for clinical and fiscal oversight of all matters related to the O-OHT design, implementation and evaluation according to the deliverables set out by the Ministry of Health (MOH). The O-OHT Coordinating Committee (O-OHT-CC), informed by Action Teams, will make recommendations to the Steering Committee for matters related to service provision and resource allocation for decisional purposes. Additionally, the O-OHT-CC will refer matters where they are unable to come to consensus for final direction and decision. The Steering Committee will not duplicate or supersede current organizational governance or operational decision making paths.
The Steering Committee shall:

- Approve an overall strategic plan for the OHT, develop an annual work plan, and share it with all Partners including patients and families, and others as appropriate;
- Identify, implement, and oversee collaborations, ensuring ongoing and effective engagement;
- Develop guidelines for the allocation of resources to the OHT, including MOH funding earmarked for the Community and as well as human resources, capital, and facilities;
- Develop a decision-making framework that identifies types of decisions where a majority vote is sufficient to bind all Steering Committee
- Review and collaborate on quality and financial performance, resource allocation and use, best practice, innovation, and quality improvement, risk allocation and mitigation and corrective actions in respect of OHT activities;
- Develop and implement clinical and financial accountability standards;
- Review and set standards for cyber security risk:
- Approve communications strategy, including communication to stakeholders and the Community;
- Evaluate and identify areas of improvement in the integrated leadership and governance structure of the OHT on an ongoing basis;
- Discuss compliance with, and recommend amendments to these Terms of Reference;
- Once designated as an OHT, ensure compliance with all required reporting obligations.

Guiding Principles
Aligned with the Quadruple AIM we will be guided by the following principles:

- Patients, families and caregivers are at the centre of everything we do,
- All members are treated with dignity and respect supporting an environment of openness, transparency and candor
- Decisions are based on the good of the healthcare system and the health of the population of Oxford county and area, and not to serve the needs of individuals or organizations,
- Leverage the strengths of our existing relationships and nurture new ones
- All sectors have joint and equal accountability for attainment of results

Membership
The voting members of the O-OHT-SC provide comprehensive cross-sectoral representation, knowledge and insight. Voting privileges will be extended to individuals who represent distinct models and resources within a sector. As a part of their role on the Steering Committee they will be responsible for ongoing communication with their sectorial peers. If an individual or an organization listed below elects to vacate their role on the Committee, the O-OHT-SC will agree by consensus on a replacement, if warranted. Membership and role of the O-OHT-SC will be re-evaluated throughout the OHT development process.

Sector	Organization	Representative
Primary Care	Oxford Community Health Centre Ingersoll Nurse Practitioner Led Clinic Primary Care Physicians	Randy Peltz* Sue Tobin* Dr. Ian Hons*
Acute Care	Alexandra Hospital Ingersoll and Tillsonburg District Memorial Hospital Woodstock Hospital	Sandy Jansen* & Jennifer Row Perry Lang* & Mark Weir
Home and Community Care	South West LHIN LHIN Contracted Home Care Service Provider	Daryl Nancekivell* Omar Aboelela*
Community Support Services (CSS)	Victoria Order of Nurses Alzheimer Society	Julie Johnston* Leanne Turner

(*) indicates individual with voting privileges

Communication
Highlights of meetings, including any decisions are made available to Steering Committee as soon as possible after each meeting. Minutes will be circulated with the Agenda of the next schedule Coordinating Committee meeting. Organizational leaders will be responsible for communicating to their respective organizations and Boards.

Decision making
When decisions are required, the Steering Committee will be to do so by consensus. Consensus is a process for group decision-making where an entire group of people come to an agreement to move forward. The input and ideas of all participants are heard, gathered and synthesized to arrive at a final decision that can be supported by everyone in the group.

The levels of consensus are (See Appendix A):

1. Agree Strongly - I fully support the decision.
2. Agree - The decision is acceptable to me.
3. Agree with some reservation - I can support the decision or action, but I have concerns.
4. Disagree but willing to go along with the group - I am not thrilled with the decision but I can live with it and will not block.
5. Disagree but will not block the decision - I need more information or more discussion.
6. I cannot support or accept the decision – I completely disagree and will work to block the decision.

The goal is that every member of the group is at level 1 through 4. If someone is at level 5 they are required to explain what information or discussion they require from the group. If someone is at level 6, it is important for them to try to offer a solution that could accommodate their needs and the needs of the group.

Members will come to the Steering Committee with clear authority vested in them by their Board and/or their sector. That clear authority will identify which decisions must be brought back to the Board or their sector for approval. Members will be given mutually agreed upon time to consult with their Board and/or Sectors prior to the vote.

Conflict of Interest
O-OHT-SC members are required to fulfill the duties of their appointment in a professional, ethical, and competent manner and avoid any real or perceived conflict of interest. Committee members have an obligation to declare a personal or pecuniary interest that could raise a conflict of interest concern at the earliest opportunity to the Chair. Each member has an ongoing obligation to disclose any actual, potential or perceived conflict of interest arising at any point during a member's term of appointment in regard to any matter under discussion by the Committee or related to the Committee's mandate.

Quorum
To constitute a formal meeting and conduct business, two-thirds of the Committee members including the Chair must be present (in person or electronically). Decisions or actions taken in the absence of a quorum are not binding on the Committee.

Meetings
Meetings will be scheduled at least monthly. Participants are encouraged to attend in person; however teleconference/videoconference options will be available. Members may elect to send a delegate if they are unable to attend. Voting privileges will not be extended to delegates unless specifically communicated by the member to the O-OHT-SC.