Ontario Health Team
Self-Assessment Form

Overview of the Process to Become an Ontario Health Team:

- The Self-Assessment is the first of a multi-stage Readiness Assessment process to become an Ontario Health Team Candidate.

    1. **Self-Assessment (open call):** Interested groups of providers and organizations are invited to submit a Self-Assessment. Submissions will be evaluated to determine the likelihood that groups would be able to submit a comprehensive Full Application and adhere to the readiness criteria for Ontario Health Team Candidates set out in the *Ontario Health Teams: Guidance Document for Health Care Providers and Organizations.*

    2. **Full Application (invitational):** Based on Self-Assessment evaluations, selected groups will be invited to complete a Full Application.

    3. **In-Person Visits (invitational):** Based on Full Application scoring, a short list of groups will be selected for in-person visits in order to identify those most ready to begin implementation of the Ontario Health Team model.

- This process will be run on a regular basis, with further application dates to be communicated at a later date. All groups of providers and organizations who participate in the assessment process will receive access to supports that will help improve readiness for eventual implementation of the Ontario Health Team model.

Guidance for Completing the Self-Assessment:

- Please refer to *Ontario Health Teams: Guidance for Health Care Providers and Organizations* document to complete this form.
- This form should be endorsed and signed-off by leadership from all participating providers/organizations. While Board approval is not required due to the short timeframes of the Self-Assessment, participants are expected to confirm the highest level of commitment possible.
- Answers to relevant questions should be clear and concise. Supporting documentation may be supplied.
- Submit the Self-Assessment form to OntarioHealthTeams@ontario.ca.
- Where appropriate, the Ministry of Health and Long-Term Care (the Ministry) may suggest that groups that submit separate Self-Assessments collaborate to re-submit a joint assessment.
- Please contact OntarioHealthTeams@ontario.ca for any inquiries regarding this Self-Assessment form.

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Please note:

- The costs of preparing and submitting a Self-Assessment and a Full Application or otherwise participating in this Ontario Health Team Readiness Assessment process (the "Application Process") are solely the responsibility of the applicant(s). The Ministry will not be responsible for any expenses or liabilities related to the Application Process.

- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.

- All applications submitted to the Ministry are subject to the public access provisions of the *Freedom of Information and Protection of Privacy Act* (FIPPA). If you believe that any of the information you submit in connection with your application reveals any trade secret or scientific, technical, commercial, financial or labour relations information belonging to you, and you wish that this information be treated confidentially (subject to applicable law) by the Ministry, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA.

- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.

- In addition, the Ministry may disclose the names of the successful applicants and any other material that is subject to the public access provisions of FIPPA.

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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.

All (LHIN) funded organizations within the existing Algoma Sub-Region in northeastern Ontario were invited to collaborate in the development of this self-assessment. Out of this initial discussion the organizations listed below have indicated that they are prepared to join together now to expand on their vision of care coordination, improved patient outcomes and experience for their common patient population.

We see this process as an opportunity to accelerate integration and improve care by capitalizing on our strong history of collaborative and innovative partnerships. We believe that the residents of Sault Ste. Marie (population 75,503), and Algoma (total population 100,653) can be better served and enjoy better health outcomes and experience of care when we are able to work in a 'seamless' delivery system that revolves around their needs as individuals.

We have many successful collaborations to move froward from as a local system, two of which are:
- Walk-in Single Session Counselling Service: a collaboration of five MH&A service providers offering staff to support a one day a week service to provide counselling services without appointments. This has reduced wait lists and provided the 'right care in the right place' when people need it most.
- Integrated Care Nursing (evolved from the former Health Link): a collaboration of primary care, acute care, mental health and addictions providers and palliative care providers to support the most complex patients with personalized care coordination, self management and clinical services to allow them to achieve their own goals and optimal outcomes. This program continues to achieve these goals while reducing the need for ED and in-patient admissions and allowing patients to receive appropriate care in the right setting.

With the initial team composition we will be able to deliver care across the continuum.
Algoma District Medical Group (Primary Care)
Algoma Family Services (MH&A Programs)
Algoma Nurse Practitioner Led Clinic (Primary Care)
Algoma Public Health (MH&A Programs)
ARCH Hospice (Palliative)
Cedarwood Lodge (LTC)
Group Health Centre (Integrated Care Delivery System)
Home and Community Care, NE LHIN (Home Care)
Sault Area Hospital (Acute, MH&A, LTC)

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 Team Model.*

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.

The Group Health Centre (GHC) provides a range of primary and specialty health care, health promotion, diagnostic and outpatient services to approximately 80,000 patients. As a participant of our OHT the GHC currently offers patients on-line access to information via their patient portal called myCARE. MyCARE allows patients to view lab results, schedule appointments, message their providers and refill prescriptions. Data from 2015 showed that initial enrollment was around 4,000 with average growth of 158 patients per week. (Research paper attached)

The success of myCARE locally will be built upon as we start health system improvement with our year 1 target population (complex patient population). Utilizing the Integrated Care Nurses that are already in place across the community and embedded in several organizations we will support patients in improving their health literacy and ability to self-manage through collaborative care planning. This process puts the patient at the centre of care and wraps the necessary services around them thus ensuring all needs are identified and addressed.

Having already connected existing care plans into the hospital digital platform the next step for our patients will be to provide 24/7 care coordination. Currently, this service is only available to specific patient populations (i.e. palliative).

The Neighbourhood Resource Centre was established in 2014 in response to the high number of police calls for service within a 1000 meter radius of the intersection of Gore and Albert Streets in Sault Ste. Marie. In a truly patient centred approach, this has evolved to deliver accessible social and health services with front line care workers on site weekly to improve access, care coordination, transitions and system navigation.

With our OHT having a shared focus on metrics that are tied to improved patient outcomes (i.e. patient experience, hospital readmissions, repeat ED visits, ALC, etc.) and a strong history of innovative success across all team members we feel confident that we will can leverage our existing capacity to deliver improved care and experience to our target population.

Each participant of the OHT will continue to measure patient experience and engagement through the existing mechanisms that are in place. Commitments to improve patient experience through internal improvement projects and Quality Improvement Plans will be carried out.

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.

As an OHT we will leverage the success of existing patient engagement and advisory bodies. Patient and Family Advisory Councils, Resident Councils, Patient Advisors already exist within the structure of many of the participant organizations. Resources pools of patients, caregivers and those with lived experience support our work in multiple ways from working as part of improvement teams to sharing their first hand experience with providers to empower change.

With 5.6% of our population identifying as Francophone and 12.9% Indigenous we are aware of the need to be inclusive of all and ensure that our system is culturally safe. We are mindful that as we move forward in the development of an OHT we will need to engage individual First Nation communities and secure endorsements from their respective Chiefs. As a system, we realize that we serve a population in a designated area, we will ensure equitable access to services in French and will respect existing designations.

We will engage with patient, families, caregivers and our communities in a meaningful fashion to ensure that opportunities in co-design and leadership are fully operationalized to the betterment of the team.

Both Maamwesying North Shore Community Health Services Inc. and Reseau (French Language Planning Entity) have indicated they will support this work. Please note that a letters of support are attached to this assessment as an appendix.

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.*

Currently we understand that the area north of Sault Ste. Marie (North Algoma) as well as the area east of Sault Ste. Marie (East Algoma) will be undertaking their own self-assessment process. We are supportive of their desire to represent the unique patient population that each serves and we look forward to continued collaboration with both areas. Our OHT will service the population of Sault Ste. Marie and area and we would welcome an expansion to this catchment area as the OHT model moves toward maturity.

We know that the population we serve has the highest incidence of asthma and COPD in the region. Our population experiences higher rates of smoking and alcohol consumption and poorer health outcomes. We have an aging demographic resulting in those 65 years and older making up 22.2% of the population.

In Year 1 our OHT will focus on providing supports to the patients who are the most complex and vulnerable. We will capitalize on the success of care planning and coordination by utilizing a hybrid of the Integrated Care Nursing model (based on the former Health Link) to target a percentage the most complex patients from each partner's patient/client/resident population as the 'target population'. Patients with multiple co-morbid conditions and/or multiple mental health and addictions conditions will be offered

It is anticipated that this would include approximately 500 individuals (or 10% of the patient population that meets this definition) in Year 1. This population segment is often required to utilize the hospital to receive care through ED and inpatient settings that could be better delivered in community in conjunction with primary care. Providing better coordination, navigation and self management supports will not only deliver better outcomes to the patients served, it will also reduce the practice of 'hallway medicine' by reducing the number of patients seeking care in hospital.

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.

As an OHT we are confident in the ability of the group to provide at least three sectors of care to successfully support the Year 1 target population.

Like many other northern communities we struggle with capacity issues that may pose challenges to delivery of 'full and coordinated continuum of care' at maturity. Items like Primary Care Capacity will need to be addressed as part of our plan to phase into the mature state. We will need to innovative and support all providers in working at full scope in an integrated system to address some of the gaps we experience.

Over time, the OHT model will result in people getting appropriate care from the right providers at the right time which should reduce the demand on individual providers. With work underway to embed Care coordinators into primary care we will have improved capacity to ensure smooth transitions for patients from one care setting to another.

As a group we will work to establish a plan to phase in to providing the full continuum of care to our patient population at maturity. We will look beyond our team to identify and engage additional partners like the District Social Service Administration Boards with whom we have a strong working relationship locally and in the region

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 services
☒ 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 (please provide more details below):

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.

In our area we have a demonstrated history of successful collaboration where local providers have come together to advance integrated care and provide better patient experience and outcomes. Some recent examples include:
- Sault Ste. Marie Integrated Care Nursing (based on former Health Link) where Home and Community Care seconded an employee to the GHC to take on the role of an Integrated Care Nurse
- Memory Clinic co-located with the Family Health Team and staffed in collaboration with the team from the Alzheimer Society
- Walk-in Single Session Counseling Service resourced by five organizations delivery mental health and addictions services in the community
- Neighbourhood Resource Centre - supported by primary care as well as multiple social service and healthcare organizations working together to reach some of our communities most vulnerable residents in their own neighbourhood

The partners completing this self-assessment are committed to delivering an integrated continuum of care that is patient focused and in pursuit of the quadruple aim. As an OHT we will develop collaborative leadership and governance approaches to enable shared performance measurement and accountability and support pursuit of the quadruple aim. We are committed to the OHT vision and goals and will work together with clinicians and physicians to develop a strategic plan for our team. We recognize the fundamental role clinicians, physicians, and primary care providers will play in leadership and governance models. We will look to existing successful models such as the one at Sault Area Hospital where two executive roles are filled by physicians (Chief of Staff, VP Medical Affairs) to move us forward in governance.

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.

We are committed to the principals of the quadruple aim. We have strong histories of performance measurement, quality improvement, and within some member organizations there are dedicated resources to support this work. We will share our resources and develop a quality improvement framework that is tied to key metrics of integration, transitions and patient and provider experience to inform us in regards to our systems performance.

There are some existing common indicators include ALC rates, ED readmission rates, utilization rates and experiences of care used across members of our team to inform improvement opportunities. We can demonstrate examples of collective standardization for clinical standards, best practice and evidence-based care. For example, SAH has adopted standard approaches to quality-based procedures, quality standards and now will be implementing bundled care. Implementation of these standard approaches has resulted in reduced variation and improved clinical and financial outcomes.

In implementing the ICNs and their care of the 'medically complex' patient population all partners (approx. 15) agreed to a standard set of metrics focused on patient and provider experience, patient interactions as well as a number of utilization based indicators. A standard reporting cycle was established where results were shared with all supporting agencies and used to inform the 'next steps' as the program evolved.

Additional examples of our experience in focusing on measurement, improvement and continuous learning include:
- Existing annual Quality Improvement Plans (QIP) (required in LTC, Acute, HHC, FHT) with alignment focused on 'transitions' in the 2019-20 cycle across all sectors.
- Decision support resourcing in multiple organizations or shared among several (i.e. FHTs) allowing for custom and real time access to data. The Data to Decisions (D2D) work of the FHTs has allowed some primary care organizations to benchmark their own performance against their peers.
- Existing Process Improvement/Quality Improvement programs (Lean in acute, E-QIP in MH&A sector, IDEAS Program).
- SAH has made spots available in it's quarterly Leadership Development Institute (LDI) for partner organizations such as Algoma Public Health and the GHC to participate. Continuous learning at SAH includes regular clinical skills fairs, use of Lean and weekly leader report out sessions.
- SAH has a strategic plan with measures, annual goals and an aligned QIP.

We are committed to the opportunity to continue to work jointly to improve quality, engage in continuous learning and provide more intgrated care to the patients we all serve.

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.

Our team has a strong track record of responsible fiscal management and were willing to work towards an integrated funding envelope and single fund holder at maturity.

Examples of this model include bundled care for joint replacement or operating as 'paymaster' for multiple projects. Recently across the region the ONE initiative that has had all 24 hospitals coming together voluntarily on a significant multi year financial matter - to establish a common EMR in all hospitals.

We believe that these funding mechanisms will allow us to better allocate and target funds to where they have the greatest impact and allow for savings that we can invest back into care.
We understand the clinical and financial impacts of delivering the right care at the right place at the right time. The opportunity to take a proactive approach to care by facilitating earlier primary care and intervention on exacerbation of illness to prevent hospital stays; or how early attention to the social determinants of health can prevent or delay disease progression and reduce health system costs.

These new funding mechanisms are a significant shift and will require ongoing and evolving conversations within our OHT and the broader system. We have already started this dialogue across our OHT partners about the practicalities of joining and will be discussing the required challenging topics (i.e. reinvestment).

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 digital health capabilities that are already being used for virtual care, record sharing **and** decision support	☒	☐	☐
• 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 and services	☒	☐	☐
• Your team can identify a **senior-level** single point of contact for digital health	☒	☐	☐

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.

As an OHT most partners have digital health capabilities, opportunities for virtual care, record sharing and decision support. Technology examples that were touched on included:
- Provincial Viewers
- the existing myCare Patient Portal (GHC)
- Telemedicine Network (or similar platform)
- ONE Initiative (Meditech 6.1x) regional EMR for all 24 acute care hospitals in the region
- within FHTs information from ICES and from EMRs are used to guide care as well D2D
- Most Long Term Care Homes have point click care for capturing of clinical and financial data.

As an emerging OHT the chance to build upon the current implementation of a single Hospital Information System in the NE. The ONE Initiative has a vision and plan to establish and coordinate a sustainable, scalable, change-ready integrated set of digital health services across all health sectors. We can leverage the opportunity that currently exists between the ONE Initiative and the existing systems throughout acute, primary and the community care allowing us to deliver better, more integrated care to the people we serve.

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?*

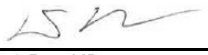
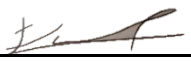
To implement our OHT model we would plan to carry out two somewhat parallel work streams.
The first would focus on the delivery of service to our Year 1 target population of 'complex' patients. The target for this population would be approximately 10% of the total number of individuals connected to any team member who are currently seeking care or treatment. This is currently estimated to be 5,000 individuals so our initial target would be 500 individuals (10%).
With the commitment of all team members, and the existing care planning tools and resources created to support complex patients we would be able to wrap services around this population; including care coordination, navigation support, online access to some records (in Year 1), self-management support and health coaching.
In the former model utilized (Health Link) this approach was proven to improve patient experience, engagement and outcomes, reduce cost (through reduced utilization of acute care and diagnostics testing) while it improved provider experience. This is well aligned with the quadruple aim.

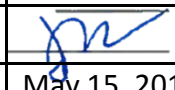
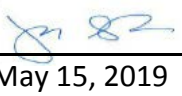
The second stream would be focused on the development of the OHT itself. A number of tasks would need to be carried out in rapid succession to ensure that the Year 1 patient population is appropriately served and that we are able to leverage the lessons learned to apply to planning for out years. We will plan to carry out the following tasks in support of the OHT development:
1. Engage the broader community in the OHT conversation
2. Strategic planning (change management):
a. Governance set-up and decision-making framework
3. Patient, Caregiver and Family Engagement:
a. Including roles in governance and/or leadership
b. In supporting co-design of structure and service delivery
4. Technology and Tools Inventory (who has/uses what)
The key risks to meeting Year 1 expectations would include:
1. Reduced Engagement/OHT Instability/Governance Challenges – to mitigate this risk we will need to ensure that members are committed to the future vision of the OHTs at the outset. Clear and honest conversations need to be ongoing in conjunction with a robust change management strategy where everyone is seen to have an appropriate degree of autonomy within the team.
2. Insufficient Capacity to Care for Year 1 Population – to mitigate this risk we will ensure that all team members understand the return value in serving our Year 1 target population and are therefore willing to provide financial or human resources to ensure we are on track to achieving this target.
3. Degradation of Care for Other Patient Populations – to mitigate this risk we must ensure that we establish 'standard work' that can be successfully embedded into all team members' structures. This will allow us to be nimble and spread and scale innovation quickly without the risk of creating 'speciality' teams at the expense of other services which are still required.

Part IV: Sign Off

Proposed name of the Ontario Health Team	Ontario Health Team Algoma	
Primary contact for this application	Name:	Ila Watson
	Title:	Interim President & CEO
	Organization:	Sault Area Hospital
	Email:	watsoni@sah.on.ca
	Phone:	705-759-3644

Please have **every provider or organization listed in Part I sign this form**. While Board approval is not required due to the short timeframe of the Assessment process, participants are expected to confirm the highest level of commitment possible.

Endorsed by	
Name	Dr. David J. Fera
Position	Chief Executive Officer
Organization	Algoma District Medical Group
Signature	
Date	May 15, 2019
Endorsed by	
Name	Ali Juma
Position	President and CEO
Organization	Algoma Family Services
Signature	
Date	May 15, 2019
Endorsed by	
Name	Dominic Noel
Position	Clinic Director
Organization	Algoma Nurse Practitioner Led Clinic
Signature	
Date	May 15, 2019

Endorsed by	
Name	Dr. Marlene Spruyt
Position	Medical Officer of Health
Organization	Algoma Public Health
Signature	
Date	May 15, 2019
Endorsed by	
Name	Theresa Mudge
Position	Executive Director
Organization	Algoma Residential Community Hospice
Signature	
Date	May 15, 2019
Endorsed by	
Name	Joe Dipietro
Position	President and CEO
Organization	Autumnwood Group Inc.
Signature	
Date	May 15, 2019
Endorsed by	
Name	Alex Lambert
Position	President and CEO
Organization	Group Health Centre
Signature	
Date	May 15, 2019
Endorsed by	
Name	Jeremy Stevenson
Position	President and CEO
Organization	NELHIN Home and Community Care
Signature	
Date	May 15, 2019

Endorsed by	
Name	Ila Watson
Position	Interim President and CEO
Organization	Sault Area Hospital
Signature	
Date	May 15, 2019

Please repeat signature lines as necessary