CND OHT Partners Meeting

REVIEW OF CO-DESIGN MEETINGS

SEPT 16, 2019

Agenda

Session led by Daniel Doane | MD+A Health Solutions

1:00 pm – 5:00 pm

	Topics	Time
1.	**Overview and Objectives** • Session structure overview • Goals of session	1:00 – 1:15 pm
2.	**Review of Governance Co-Design Session** • Review of full application questions • Co-design group decisions • Remaining questions	1:15 – 2:15 pm
3.	**Review of Services Co-Design Sessions** • Review of full application questions • Co-design group decisions • Remaining questions	2:15 – 3:30 pm
4.	**Review of Digital Health Co-Design Sessions** • Review of full application questions • Co-design group decisions • Remaining questions	3:30 – 4:30 pm
5.	**Next steps** • Full application completion and review process • Update on Partner contributions (Bill Davidson)	4:30 – 5:00 pm

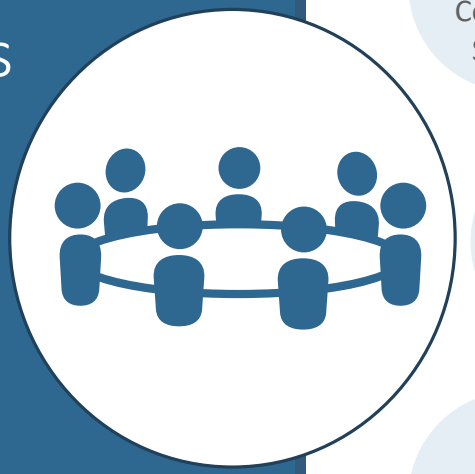
Goals of Today's Meeting

Review Full Application questions related to governance, services and service delivery, and digital health

Summarize and discuss of the findings from the co-design sessions

Discuss approach to review Full Application before submission

Review of Co-Design Meetings



1 Governance Co-Design Session

- August 14 – *Governance Co Design*

3 Services Co-Design Sessions

- August 28 – *Home and Community Care*
- Sept 4 – *Care Coordination and System Navigation*
- Sept 11 – *Year 1 Target Services*

1 Digital Health Co-Design Session

- Sept 6 – *Digital Health Co-Design Group*

Characteristics of CND OHT

Proposed features of CND's OHT

No organizational boundaries between providers

- *Co-location of services where possible*
- *Flexibility to move resources around the sector as needed*
- *Single brand identify*

Every patient has a dedicated and consistent care team

Common strategic and quality improvement planning amongst all providers

Population health focus

Standardized and aligned intake, assessment, care planning and service delivery

Expansion of supporting roles in Interprofessional teams

- *Health Concierge (one number to call)*
- *Primary Care Coordinators*

Coordinated after hours services (primary care and other as required) to minimize inappropriate ER visits

Accountability and efficiency

Governance

1. Overview of Full Application Requirements
2. Options Presented to Co-Design Group
3. Co-Design Group Decisions
4. Remaining Questions to be Answered

Governance: Full Application

The application consists of 7 Sections and 2 Appendices

1 About your population	2 About your team	3 How will you transform care?
4 How will your team work together?	5 How will you learn and improve?	6 Implementation planning & risk analysis
7 Membership Approval	Appendix A: H&CC	Appendix B: Digital Health

These sections cover Governance questions that must be answered in the Full Application

Governance: Application Questions

Section 2: About your team

2.1: Who are the members of your proposed OHT?

- Complete table 2.1.1 below – primary care physician or group members.
- Complete table 2.1.2. Indicate member organizations (not including physicians/physician groups.

Governance: Application Questions

Section 4: How will your team work together?

4.2: What are the proposed governance and leadership structures for your team? (1500 words)

How will your team be governed or make shared decisions?

- Describe the planned Year 1 governance structure(s) for your OHT are whether they are transitional
- If your team hasn't decided on a governance structure, please describe how the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing and resource allocation.
- To what extent will your governance arrangement or working relationships accommodate new team members?
- What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structures?

How will your team be managed?

- Please the planned operational leadership and management structure of your proposed OHT
- Include a description or roles and responsibilities, reporting relationships and FTE where applicable
- If your team hasn't decided on an operational leadership, please describe your plan for putting structures in place, including timelines.

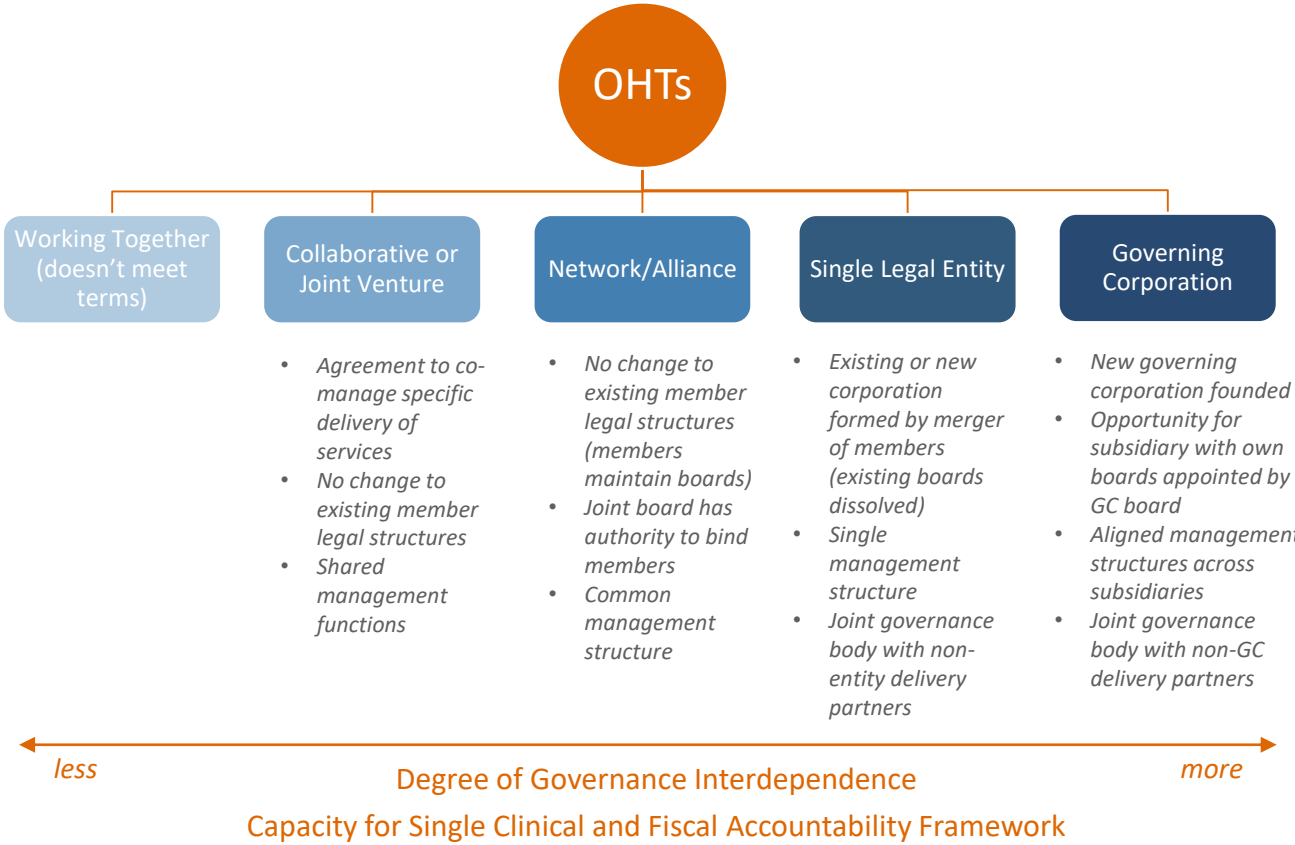
What is your plan for engaging physicians and clinicians/clinical leads across your team's membership for ensuring physician/provider leadership as part of the proposed leadership/governance structure?

- For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation?
- What approaches will your team use to engage community-based physicians and hospital-based physicians?

Governance: Continuum of Options

- BLG's proposed continuum of governance models was presented to the co-design group
- The co-design group proposed the Collaborate or Joint Venture model for Year 1 with plan to transition to Network/Alliance by end of Year 1
- These models used as a baseline and were customized for the specifics of the CND context

Continuum of Governance Options



There is currently no requirement from MOH to change legal structures

Governance: Proposed Evolution of Models

Implement during Year 1 → ***Ready for implementation by end of Year 1***

Collaborative/Joint Venture

Characteristics

- No new entity created: maintain separate corporate structures
- Agreement to co-manage specific delivery of services to enable integration
- A 'joint committee' or governance structure to oversee joint services
- Separate employers
- Expectation would be that arrangement is ongoing but with termination provisions

Implications

- Strategic planning, funding, and central branding would be achieved mainly through the basket of services which are integrated, but not to the individual organizations
- Relatively easy for providers to join OHT, but also leave)

Network/Alliance

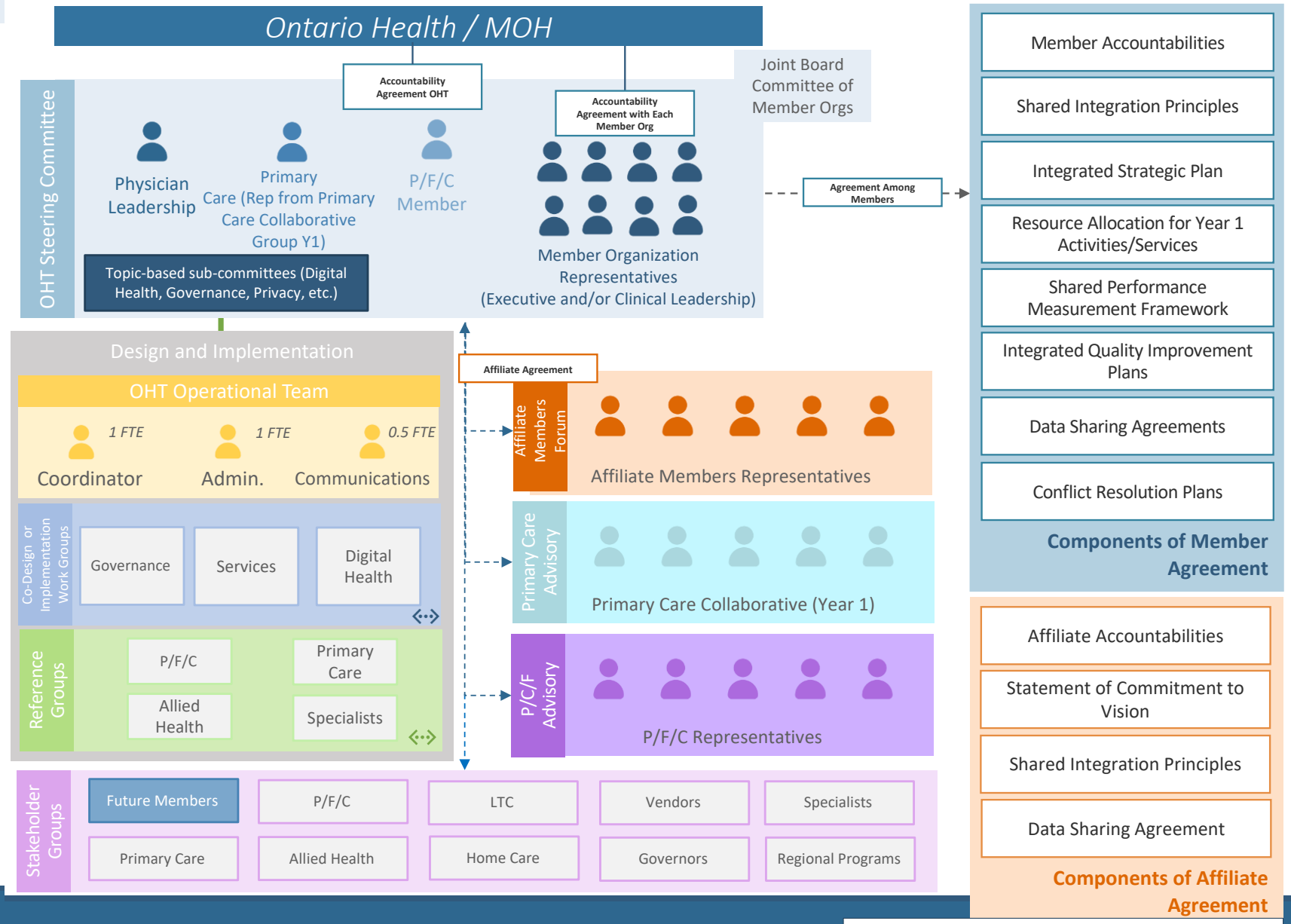
Characteristics

- No new entity created: maintain separate corporate structure
- *Broader* agreement to share and/or collaborate
- Agreement to formal governance arrangement: common board (mirror image), joint boards, joint executive committee with delegated power.
- Governance body members has the ability to bind their organizations; body has decision-making authority to manage shared resources
- *May* create common employer; *may* have one management team
- Allows for more significant operational integration
- "Escape clause" or process to unwind

Implications

- More easily enables one funding agreement
- More effectively enables common strategic planning and central brand
- More difficult to add new partners; governance model may require re-structuring; more difficult (but not impossible) for partners to leave

Governance: Proposed Year 1 Model



Governance: Members vs. Affiliates

What will the role of members and affiliates look like in year 1?

CND OHT Members

Which organizations should consider being a Member in Year 1?

- Primary Care organizations whose patients will form Year 1 target population base
- Organizations that will commit resources transforming services in Year 1

What is required of a member?

- Sign agreement with associated performance standards with the Ministry
- Sign agreement (see components) with other OHT members
- Members will need to commit organizational resources to OHT governance, planning, design and implementation activities
- Members should be prepared to move or receive financial and human resources
- Members should be prepared to integrate/transform services through service re-design, adopting standardized pathways/protocols/data; re-design workflow; adopting quality and performance targets, adopting and using digital health tools, etc.

What will it look like to be a member?

- Members will have representatives on governance body (Steering Committee for Year 1)
- Member agreement would include board commitment to joint board committee and associated mechanisms

Governance: Members vs. Affiliates

What will the role of members and affiliates look like in year 1?

CND OHT Affiliates

Which organizations should considering being an Affiliate Member?

- Organizations that will not directly be involved in service delivery transformation during Year 1
- Organizations that want to contribute to strategic direction, service transformation/integration design, but may not implement significant service changes in Year 1.

What is the role of an affiliate?

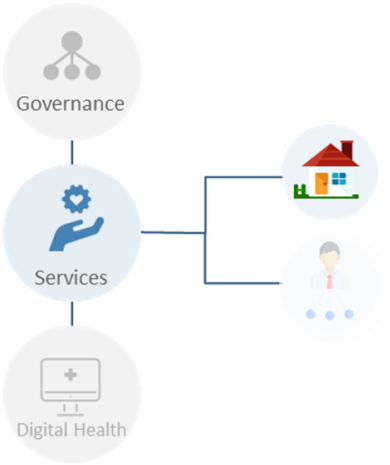
- Affiliates could be involved in achieving the Year 1 goals, but will not sign agreement with the Ministry
- Affiliates will sign an Affiliate Agreement (see components) committed to participating in Affiliate Member forum, contributing resources to co-design groups, agreeing to shared vision and integration principles, and agreeing to share data as required to support population health planning and ongoing OHT design and planning. Affiliates should also agree to work toward Collaborative QIP aims, although not necessary sign-off on C-QIP commitments.
- Affiliates should be preparing their organizations/sub-sectors for service integration/transformation in future years.

What will it look like to be an affiliate?

- Participation in affiliate forum to review strategic and technical directions and provide input
- Opportunity to participate in co-design groups
- Role of championing and communicating OHT strategies/goals with stakeholders
- Current Planning partners have options of being member or affiliate; Potentially future affiliates would need to apply for affiliate status (TBD)
- Affiliates would be expected to become members in future years at scope of OHT functions and service expand

Services

1. ***Home and Community Care***
2. ***Care Coordination and System Navigation***



Services: ***Home and Community Care***

H&CC Services: Full Application Questions

The application consists of 7 Sections and 2 Appendices

1 About your population	2 About your team	3 How will you transform care?
4 How will your team work together?	5 How will you learn and improve?	6 Implementation planning & risk analysis
7 Membership Approval	Appendix A H&CC	Appendix B: Digital Health

These sections cover questions that the Transitions, Services, Coordination, and H&CC Co-Design Group will help answer for the Full Application

H&CC Services: Full Application Questions

Appendix A:
Home & Community Care

A1. What is your team's long-term vision for the design and delivery of home and community care? (1500 words)

- Describe CND's long-term vision for modernizing and better integrating home and community care.
- Consider local population needs and local challenges.
- Highlight proposals to strengthen innovative service delivery, increase accountability, support efficiency.

A2. What is your team's short-term action plan for improving home and community care in Year 1?

- What proportion of your Year 1 population do you anticipate will require home care? (describe patient characteristics, needs and level of complexity)
  - Describe patient characteristics, needs, and level of complexity.
  - Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives
  - Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care.

H&CC Services: Full Application Questions

Appendix A: *Home & Community Care*

A3. How do you propose to transition home and community care responsibilities? (1000 words)

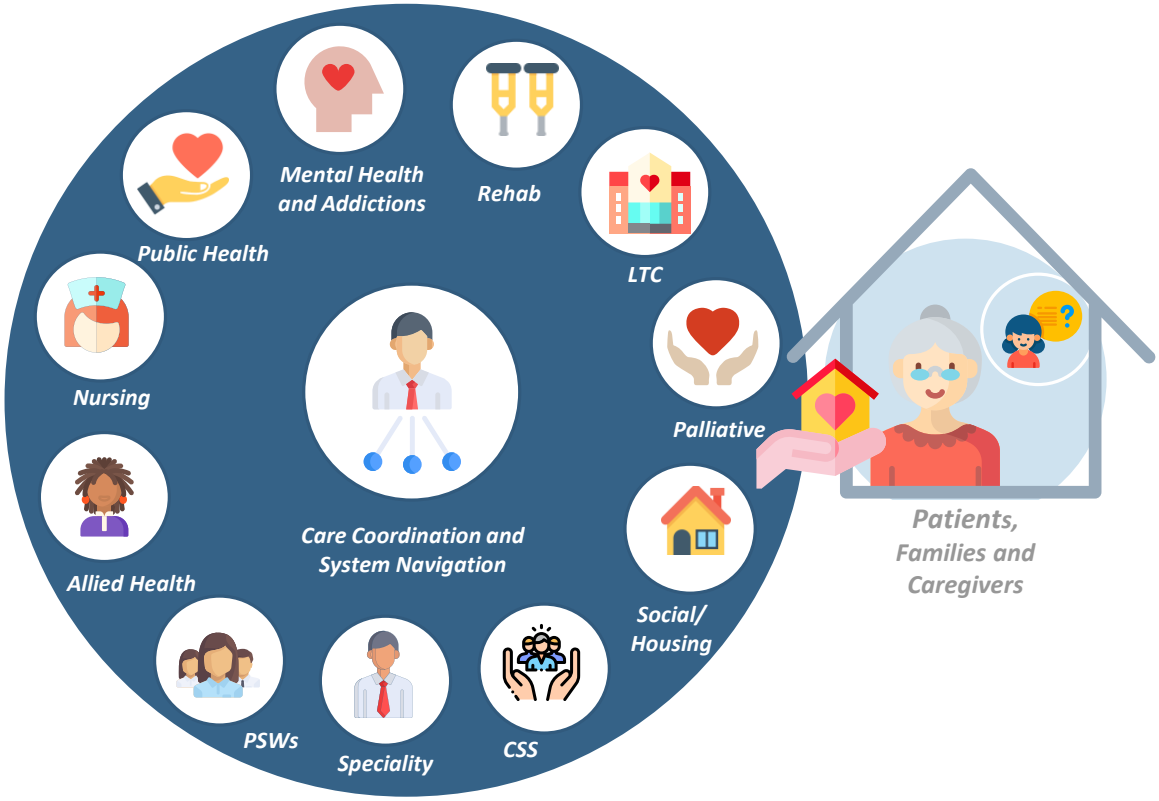
- Describe your plan to transition home care resources (coordination, digital assets, programs, local knowledge and expertise) to your OHT in Year 1.

A4. Have you identified any barriers to home and community care modernization? (1000 words)

- Identify legislative, regulatory, or policy barriers that would impede your team's vision for modernizing home care

**Answer is used to inform MOH and is not evaluated.

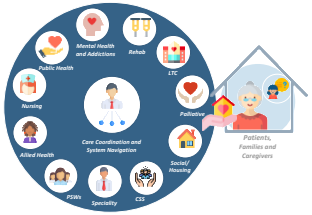
H&CC Vision



Innovations in H&CC Model

- H&CC care coordination embedded in primary care
- Expanded scope of H&CC services to be coordinated by care coordinators - including CSS, public health, MH&A, speciality services, etc.
- Interprofessional Team model across entire scope of services
- Better integrate Service Provider Organizations (SPO's) in care team.
- Increase focus on social prescribing and prevention – identify needs and connect to H&CC services earlier
- Build on the connectivity table model to identify individuals in community with care coordination needs and prevent escalation

What needs to be done to support vision?



Change Management Priorities

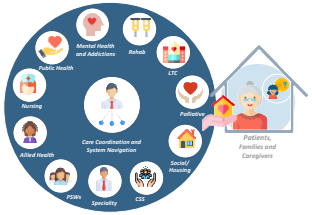
- Cultural shift – interprofessional teams are not just co-location of multiple disciplines but shared decision making and planning about patients across the care and service continuum
- High level of trust and mutual respect for each others' contributions to patient care
- New ways of working, such as ongoing case conferencing among broader interprofessional team to manage complex patients
- Support P/F/C understanding of the whole team's role in providing care – not just the primary care clinician
- Purpose-designed spaces and enhanced use of virtual tools to allow for improved collaboration

Optimize Scope of Practice

- Increased use of full scopes of practice of team members, particularly nurse practitioners and pharmacists (i.e., increased prescribing ability)
- The combination of skills and knowledge brought together by team members offers a greater value-added service to the patients, improving the quality of care they receive
- Care coordinators role can include functions such as assessment, symptom management, patient education and follow up.

Assembling multiple disciplines within a single healthcare setting does not in itself necessarily lead to interdisciplinary collaboration

What needs to be done to support vision?



Enhance role of Care Coordinators

- Patients and clinicians in teams are supported by care coordinators who:
  - Maintain relationships with patients and the care team to ensure that the appropriate services are delivered, referrals are made, patients' goals are met, etc.
- Care coordinators collaborate with primary care provider and other team members to support development of comprehensive care plan when required, coordinate the activities with the patient to meet their goals, and monitor the achievement of patient objectives and system level targets

Strengthen Digital Enablement

- Increased access to care enabled by virtual services
- All providers involved in patient care/services (i.e., food bank services, housing services, specialists) will have access to portions of the coordinated care plan and basic patient service and scheduling information
- Empower patients can easily book appointments online through the OHT website to see their service provider
- Shared records among all primary care teams, walk in clinics and hospital– allow all providers to access patients medical history to provide care

H&CC Services: Year 1 Action Plan and Priorities

Actions and Priorities

1. Attach care coordinators to primary care
2. Expand scope of H&CC care coordination to all services, including CSS and others in broader ecosystem
3. Align and streamline responsibilities to reduce redundancy of care coordinator role across CND local system (primary care, hospital, community, LTC, etc.)
4. Align and streamline assessment/care pathways across broader ecosystem; formalize roles/responsibilities, accountabilities and lines of communication among broader team.
5. Identify which current H&CC and integration initiatives to expand or scale (e.g., retirement home model, direct referrals to H&CC services; City Call, children's mental health in PC community MedRec, etc.).
6. Identify and advance alternate SPO's models (outcome-based; streamlined services).

What resources could be available in Year 1?

- Need to model estimated FTEs requirements for application
- Leverage portion of existing H&CC resources (Need to balance resources targeted at Year 1 population vs. ongoing services)

What are the mechanisms that should be used to acquire resources?

- Focus on secondment of resources for Year 1 (may help to avoid human resourcing issues)

Other resources that are needed/available?

- Telehealth, teleconference, shared records

H&CC Services: Barriers to and Opportunities in Modernizing

Barriers

Funding/ Remuneration

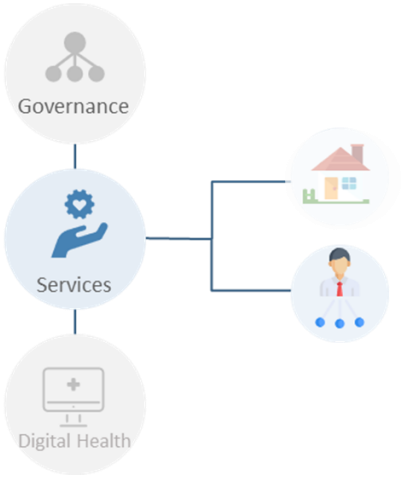
- Provider remuneration models not fully aligned with vision
- Current SPO contracting model and market share works against integrated care team model (e.g. evergreen contracts, SPO resource/service constraints, unit-based payment, etc.)
- Inflexible funding H&CC funding streams (e.g ability to move funding from contracted services to “internal” services

Policy

- Limitations of circle of care definition (HSP designation for purposes of information sharing and accessing share information system)

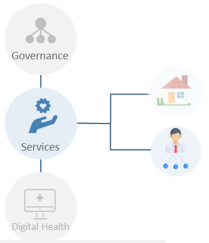
Opportunities

- Change to value based model contracts with SPOS
- Expand pilot to refer patients so SPOs from PCP
- Increase use of service-based funding, rather than fee for service
- Leverage CSS staff to better support patients
- Expand nursing model of care for frail elderly
- Early planning for long-term care



Services: ***Care Coordination and System Navigation***

Care Coordination and System Navigation: Full Application Questions



Section 2: About your team

2.7 What is your team's integrated care capacity in Year 1?

- Indicate what proportion of your Year 1 target population you expect to receive integrated care (i.e., care that is fully and actively coordinated across the services that your team provides) from your team in Year 1.
- Provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who require integrated care receive it

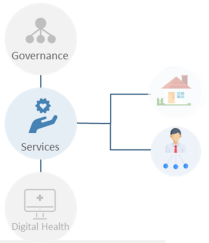
Care Coordination and System Navigation: Full Application Questions

Section 3: How will you transform care?

3.3.1 How do you propose to coordinate care (1000 words)

- Propose how your team will coordinate care for these patients
  - Describe whether any of members have experience coordinating care across multiple providers and care settings
  - Describe what activities would be in and out of scope for your care coordination service in Year 1
  - Describe which patients will have access to care coordination services, how they will access the service, and will resourced be organized differently from how they're currently deployed. Indicate whether your team will coordinate any care beyond the in-scope services provided by your immediate team
- Describe who (what type of staff, which organization) would provide care coordination
  - How many FTEs would be assigned?
  - Whether your team has existing funding capacity to meet the anticipated care coordination needs of your Year 1 population
  - Specify if your plan involved the use of LHIN care coordination resources set from baseline

Care Coordination and System Navigation: Full Application Questions



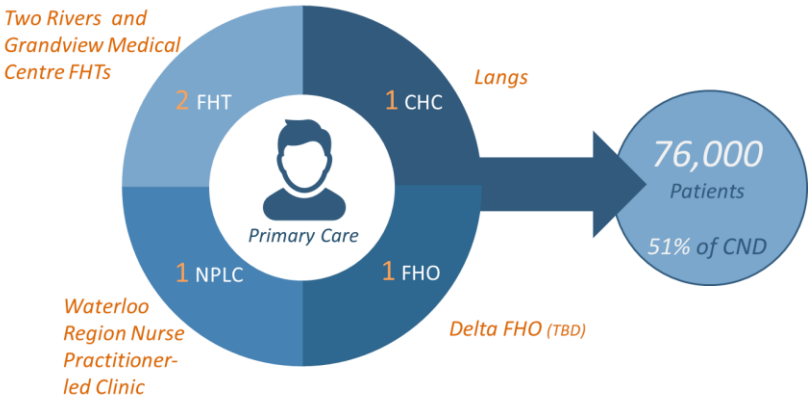
Section 3: How will you transform care?

3.3.2 How will you help patients navigate the health care system? (1000 words)

- Propose how your team will provide system navigation services for your Year 1 population
  - Describe what activities are in and out of scope for your system navigation service in Year 1
  - Describe which patients will have access to system navigation and how they will access the service
  - Indicate whether system navigation will be personalized (e.g, will the system navigator have access to patient's health information)
- Describe how the system navigation service will be deployed and resourced, and whether your team has sufficient existing capacity to meet the anticipated navigation needs of your Year 1 population

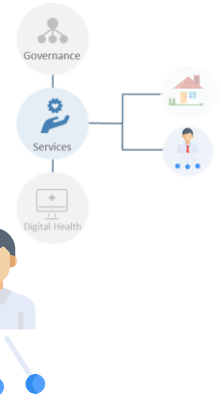
Care Coordination and System Navigation: Target Population

Patient's level of acuity and need will determine care coordination or system navigation function



Patients Level of Acuity/Needs

determines



CARE COORDINATION

AND/OR

SYSTEM NAVIGATION

- Currently reviewing various data sources to identify volume of patients that will require care coordination (frail elderly, medical complex, complex MH&A)
- Rough preliminary estimate would be about 2,500 new "intakes" across primary care, hospital and community based on current intake by portion of Year 1 Target population

General Principals

- High needs patients → care coordinator
- Lower needs → have access to system navigator

Care Coordination and System Navigation: Principles

Underlying the care coordination system of CND OHT are the following basic assumptions:

Everyone needs care coordination and system navigation

- The level and extent are variable, both between patients and over a patient's healthcare journey

Care coordination functions to ensure the right patient is getting the right services at the right time and place by the right provider

- The care coordinator ensures that the patient is receiving the appropriate complement of services from the appropriate care team

Care coordination is holistic, including both clinical and broader patient needs

- Includes social determinants of health, as well as clinical and medical factors

Sustainability of care coordination must be considered

- Activities should not be duplicated or redundant, and should be guided by evidence

Care Coordination: Roles and Responsibilities

Engagement and Assessment

- Building relationships with patients
- Performing comprehensive assessments

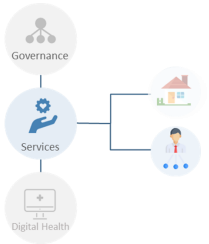
Organization and Provision of Care/Services and Care Planning

- Building care plans in collaboration with patients
- Facilitating resource, program/service, specialized care access – matching needs with eligibility
- Engaging and collaborating with care providers
- Reconciling interventions and medications
- Integrating care for complex patients
- Exchanging information amongst care team
- Developing and updating the care plan, and informing team members of relevant changes
- Developing contingency plans
- Patient, family, and caregiver advocacy

Ongoing Monitoring/Evaluation

- Monitoring and evaluating patient goal achievement, outcomes, and satisfaction
- Managing or liaising care transitions and facilitating continuity of care
- Acting as the point of contact for the patient with regards to care coordination
- Organizing case conferences as needed

Care Coordination: Proposed Approach



*Multiple entry points – goal to connect patients with a **primary care provider and care coordinator** as possible, but care coordination can be performed by various agencies using various different roles.*

- Primary Care
- Social Services
- Hospital
- Community Services

Common Assessment and Intake

Determined to require care coordination

- *Link to primary care coordinator as possible.*
- *Care Coordination provided at different points across the system.*

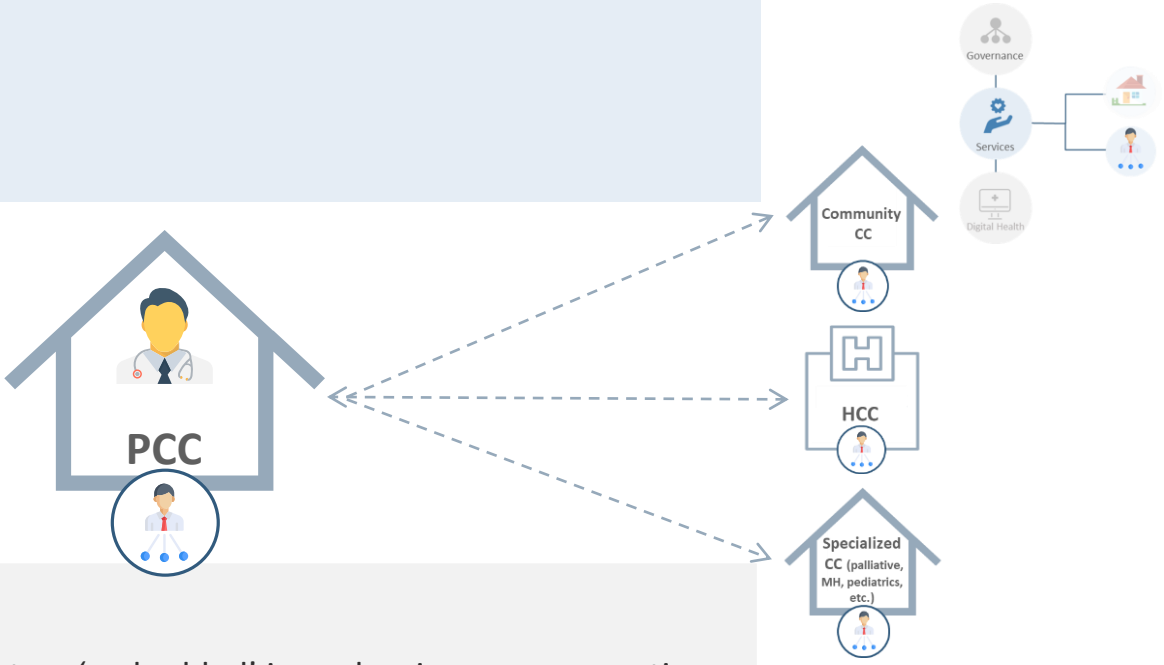
Leverage established protocols, interprofessional team roles, responsibilities and relationships; Connectivity model, etc.

Attached to appropriate care coordinator

- *Primary Care*
- *Specialized (palliative, MH&A, paediatric)*
- *Community-based (outreach workers, social workers, etc.)*

Care Coordination:
Proposed Approach

Primary Care Coordinators in CND OHT



Location

- Primary Care Coordinators 'embedded' in each primary care practice
- Ensure patient/family directed care
- Available for extend hours (shift approach)
- Assigned to PCPs and their patient population

Specific Roles/Responsibilities

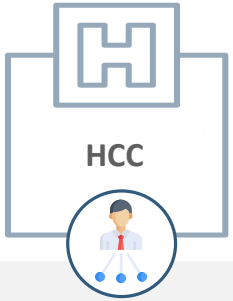
- Consult with PCP to develop care plan
- Broader assessment of patients needs
- Plan and mobilize resources
- Coordinate H&CC, SPO, CSS, and other required services
- Engage required interprofessional team
- Communicate with specialized care coordinators
- Facilitate appointments as required
- Ongoing monitoring of patients, updating care plan as required
- Maintain long term relationship with patients and families

Care Coordination and System Navigation: Recommendations

Specialized care coordinators

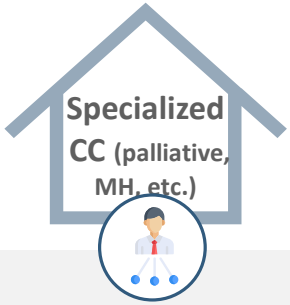
Location
- Various CSS and social agencies in CND and regionally

Specific Roles/Responsibilities
- Provide coordination of community services
- Connect individual with primary care practice, if patient agrees
- Assess patient needs
- Plan and mobilize resources
- Arrange for specialized services as required
- Facilitate appointments as required
- Ongoing monitoring of patients



Location
- Hospital Care Coordinators 'embedded' at CMH

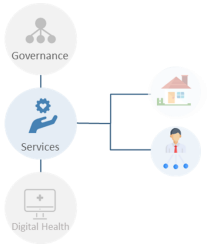
Specific Roles/Responsibilities
- Facilitate discharge planning
- Assessment of services immediately needed by patient
- Responsible for CC services up to 72 hours post discharge
- Connect with primary care care coordinator



Location
- Various service providers in CND and regionally

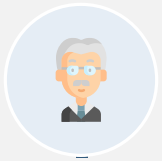
Specific Roles/Responsibilities
- Provide specialized CC depending on patient needs and goals
- Consult with PCP and PCC to develop care plan
- Deeper assessment of patients long term needs
- Plan and mobilize resources
- Arrange for specialized services as required
- Facilitate appointments as required
- Ongoing monitoring of patients

System Navigation: Proposed Approach

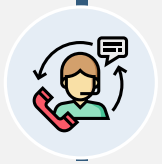


24/7 Access to care coordination and system navigation

During Regular Hours

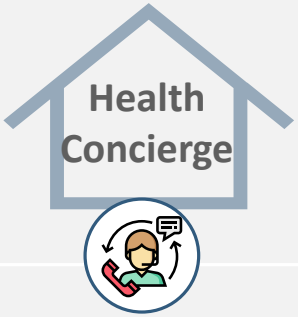


Patient



Health Concierge

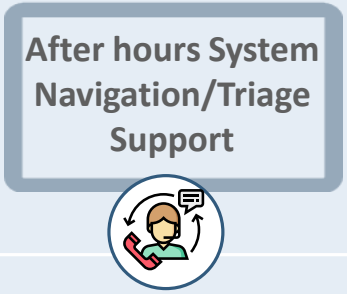
Help patients' navigate the system



Health Concierge Role includes:

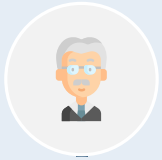
- Available as point of contact for all patients who need information/system navigation services
- Attached to primary care practice
- Information and referral
- Appointment booking
- Follow up with patients' care coordinator as necessary

After Hours



After hours SN/T Role includes:

- Point of contact for all patients who call after hours
- Conducts assessment over the phone of patients needs
- Determines patients' need and triages accordingly
- Follow up with PCC as necessary



Patient

Clinical System Navigator

System Navigation

Digital Health

1. Overview of Full Application Requirements
2. Options Presented to Co-Design Group
3. Co-Design Group Decisions
4. Remaining Questions to be Answered

Digital Health: Full Application Questions

The application consists of 7 Sections and 2 Appendices

1 About your population	2 About your team	3 How will you transform care?
4 How will your team work together?	5 How will you learn and improve?	6 Implementation planning & risk analysis
7 Membership Approval	Appendix A: H&CC	Appendix B: Digital Health

This section covers questions that the Digital Health Co-Design Group will help answer for the Full Application

Digital Health: Full Application Questions

Appendix B:
Digital Health

B2. Digital Health Plans

B2.1 Virtual Care (1000 words)

- Describe how you will expand virtual offerings in Year 1
  - If some team members have no virtual care capacity, describe how they will implement the by the end of Year 1.
- Provide an assessment of how difficult it will be to achieve 2-5% of Year 1 patients having a virtual encounter in Year 1.
- Describe how you will determine if your provision of virtual care is successful or not.

B2.2 Digital Access to Health Information (1000 words)

- Describe your plans to build on existing digital capabilities to provide patients with digital access to their health information.
- Provide an assessment of how difficult it will be to achieve 10-15% of Year 1 patients digitally accessing their health information in Year 1.

B2.3 Digitally Enabled Information Sharing (1000 words)

- Describe plans for ensuring that patient information is shared securely and digitally across the team for the purpose of integrated care delivery, and planning

B2.4 Digitally Enabled Quality Improvement (500 words)

- Describe how team members currently use digital health tools and information to drive quality and performance improvement.
- Describe how these will be built on to achieve team-level digitally enabled quality improvement

B2.5 Other Digital Health Plans (500 words)

- Describe any other information on digital health plans not captured in the previous sections

B3. Who is the single point of contact for digital health on your team?

- Fill out contact card

Digital Health: Virtual Care in Year 1

How will virtual care be expanded in Year 1?

Plans to improve provider access to virtual care tools:

- Leverage multiple virtual care platforms from digital health inventory selected as implementable tools in CND
- Change management support provided by eCE to expand number of clinicians offering eVisits

Plans to improve patient access to virtual care:

- Increase use of virtual care and other digital tools in social services sector
- Identify additional use cases: adult children with frail and elderly, palliative care, home care virtual messaging, etc.

Barriers in providing virtual care, or implementing tools:

- Virtual visit platform is not currently integrated into EMRs
- Clinician renumeration (billing codes in development)
- Licensing limitations (cost implications for expansion)

Current CND Virtual Tools

- Think Research VirtualCare
- OTN Hub - PCVC
- Cardiac Rehab and Rapid Access CHF Virtual Visits
- OTN supported by telemedicine nurses
- eShift (palliative care)
- Telehomecare Plus

CND Current Virtual eVisits Encounters

- 1.3 % of population use virtual visits

Digital Health: Digital Access to Health Information

How will CND OHT improve digital access to health information

Strategy:

- Opportunity to leverage MyChart as front end for CND patient portal
- Increase use of consumer digital health tools among patients (The Consumer Digital Health Strategy)

Barriers in providing virtual care, or implementing tools:

- Needs alignment and information across OHTs (St. Mary's and Grandriver Hospital are not using MyChart)
- Some HSP don't have access to clinical connect (nursing, PT, OT)
- Privacy barriers

Current CND Patient Portals

- MyChart (connected to Clinical Connect)

CND Current Digital Access

- 2.8% of population

Digital Health: Digitally Enabled Information Sharing

How will CND OHT ensure that patient information is shared securely and digitally across the team for purpose of integrated care delivery and planning?

Strategy:

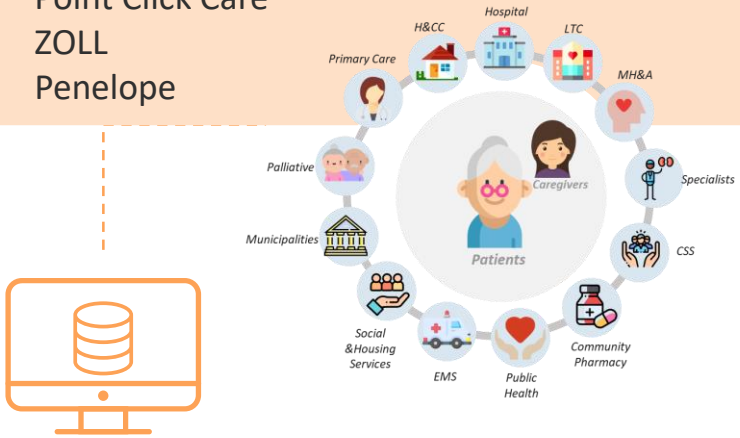
- Increase adoption of ClinicalConnect in Primary Care
- Increase adoption of eNotifications/HRM
- Leverage OCEAN for eRefreral
- Standardize and spread Coordinated Care Plans in CHRIS
- Align use/protocols for digital health use across providers
- Increase Provider to Provider Information Sharing / Messaging (Hypercare or OpenFire/Spark)

Barriers:

- Not all HSPS are considered HIC (lack of access)
- Recognize NPs as providers who can access, send, and receive digital information

Current CND Clinical Information Systems

- ClinicalConnect or Connecting Ontario
- System Coordinated Access
- eConsult
- eNotifications
- CareDove
- Hospital Report Manager (HRM)
- CHRIS
- Health Partner Gateway
- Point Click Care
- ZOLL
- Penelope



Digital Health: Digitally Enabled Quality Improvement

How will CND team members use digitally enabled quality improvement tools?

Strategy:

- Leverage QBIC EMR templates to support specific priorities
- Leverage Robotic Process Automation tool to identify high-needs patients (trigger actions in EMR)
- Leverage IDS to better understand costing data for patients

Current CND QI Tools

- QBIC Access
- QBIC CDPM EMR templates
- eConsults
- Robotic Process Automation
- OMD Dashboard

Digital Health: Other Digital Health Plans

What other digital health plans should CND OHT provide?

Strategy:

Patient Self Management

- Potential to leverage a suite of self-management tools such as
  - Online Bookings
  - Patient to provider messaging
  - Big White Wall
  - Co-Health
  - Pre-emptive (withdrawal management)
- Leverage Langs Patient Self Management Programs

Patient Experience

- Leverage POEM measures for virtual visits, discharge, eReferral)

Digital Enablers for Providers

- Leverage provider self management and care tools

Other Digital Health Plans

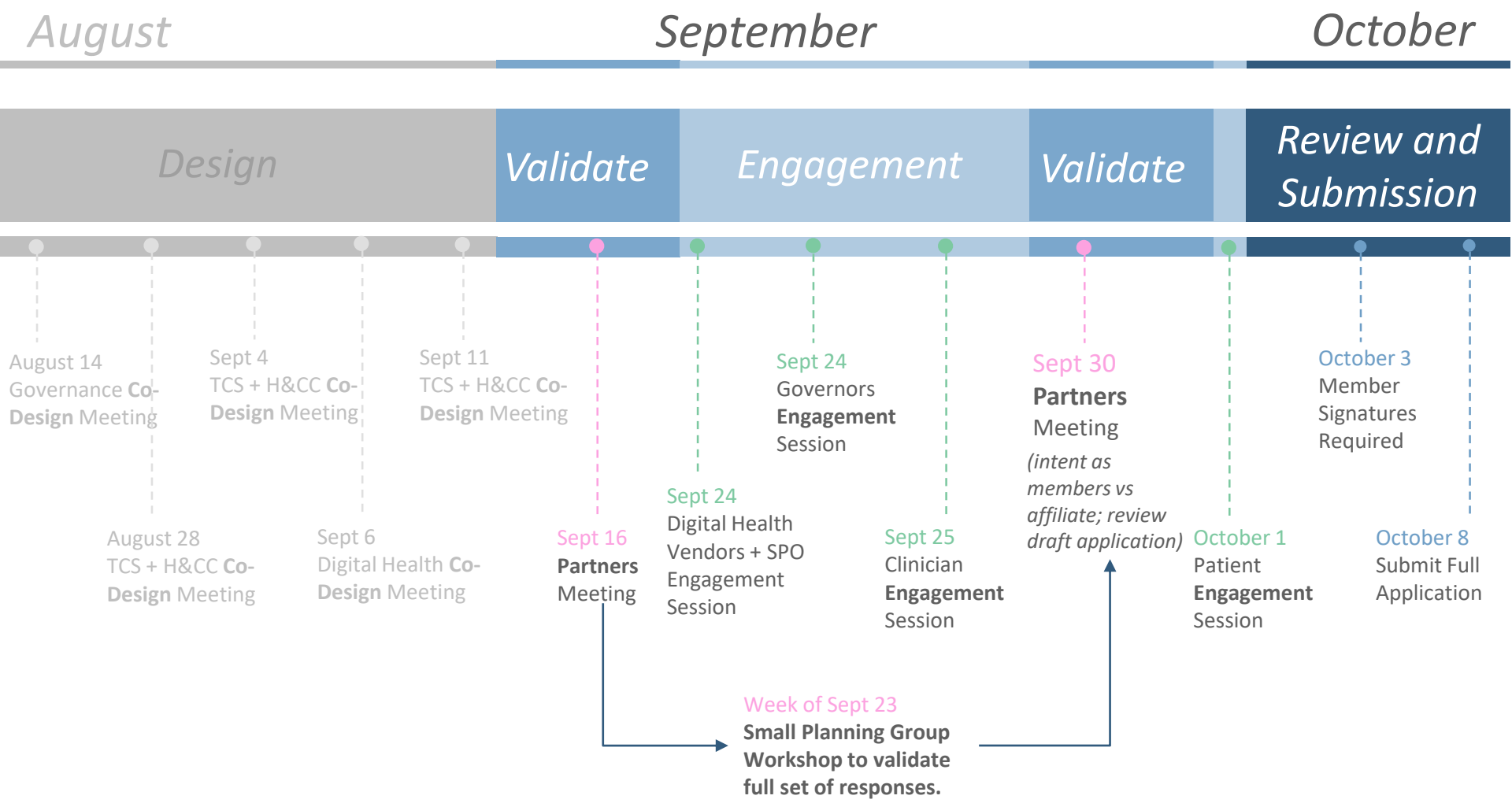
- Patient Self Management
- Patient/Experience
- Digital Enablers for Providers (minimize burnout)

Next Steps

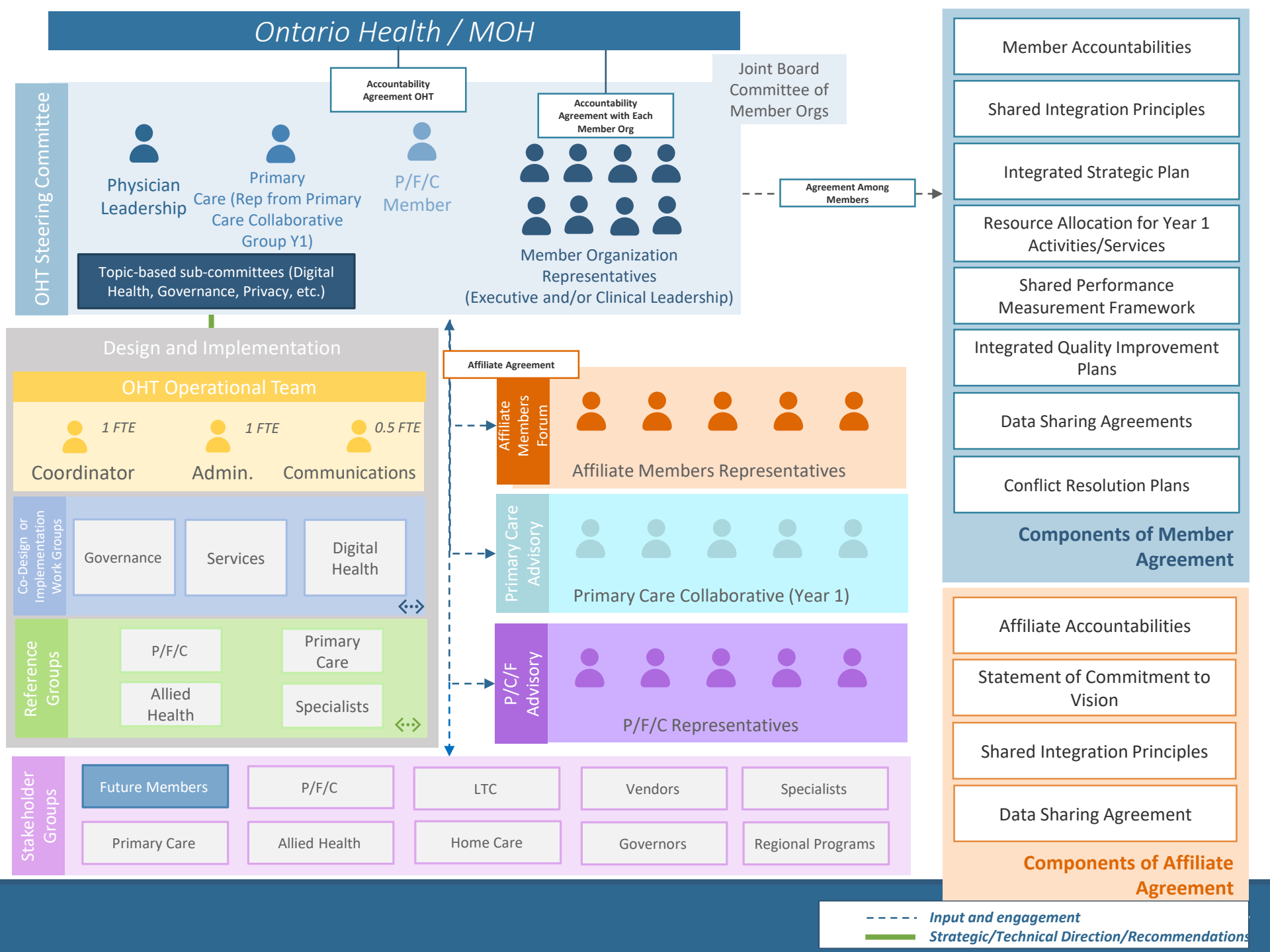
Timeline for Full Application completion and review

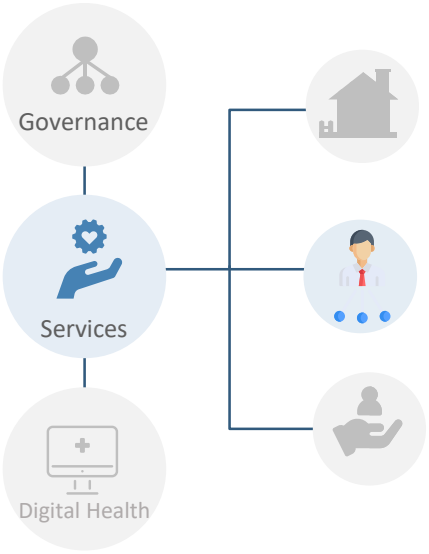
Discuss process for Full Application completion and review with Planning Group

Next Steps: Engagement Approach and Timelines



Next Steps: Process for Full Application Completion


Ontario Health / MOH
Accountability Agreement OHT
Accountability Agreement with Each Member Org
Joint Board Committee of Member Orgs
OHT Steering Committee
Physician Leadership
Primary Care (Rep from Primary Care Collaborative Group Y1)
P/F/C Member
Topic-based sub-committees (Digital Health, Governance, Privacy, etc.)
Member Organization Representatives (Executive and/or Clinical Leadership)
Agreement Among Members
Member Accountabilities
Shared Integration Principles
Integrated Strategic Plan
Resource Allocation for Year 1 Activities/Services
Shared Performance Measurement Framework
Integrated Quality Improvement Plans
Data Sharing Agreements
Conflict Resolution Plans
Components of Member Agreement
Design and Implementation
OHT Operational Team
1 FTE
Coordinator
1 FTE
Admin.
0.5 FTE
Communications
Co-Design or Implementation Work Groups
Governance
Services
Digital Health
Reference Groups
P/F/C
Primary Care
Allied Health
Specialists
Affiliate Agreement
Affiliate Members Forum
Affiliate Members Representatives
Primary Care Advisory
Primary Care Collaborative (Year 1)
P/C/F Advisory
P/F/C Representatives
Stakeholder Groups
Future Members
P/F/C
LTC
Vendors
Specialists
Primary Care
Allied Health
Home Care
Governors
Regional Programs
Affiliate Accountabilities
Statement of Commitment to Vision
Shared Integration Principles
Data Sharing Agreement
Components of Affiliate Agreement
Input and engagement
Strategic/Technical Direction/Recommendations


Governance
Services
Digital Health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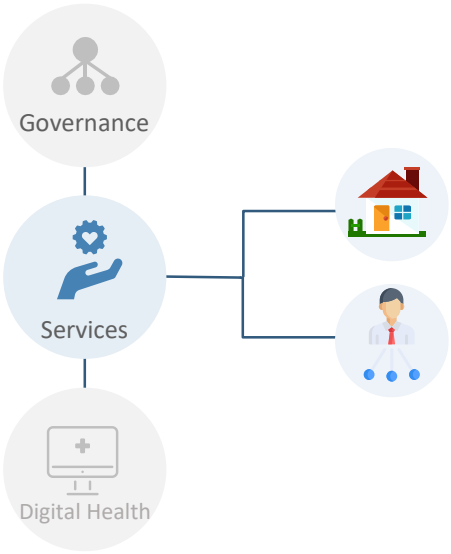
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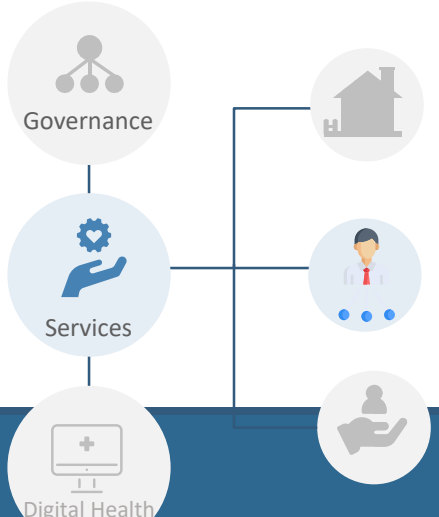
Governance
Services
Digital Health

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