Network 24 Ontario Health Team Application

Please note that "Network 24" is an interim name only. The OHT will be named following a community engagement exercise.

April 30, 2021

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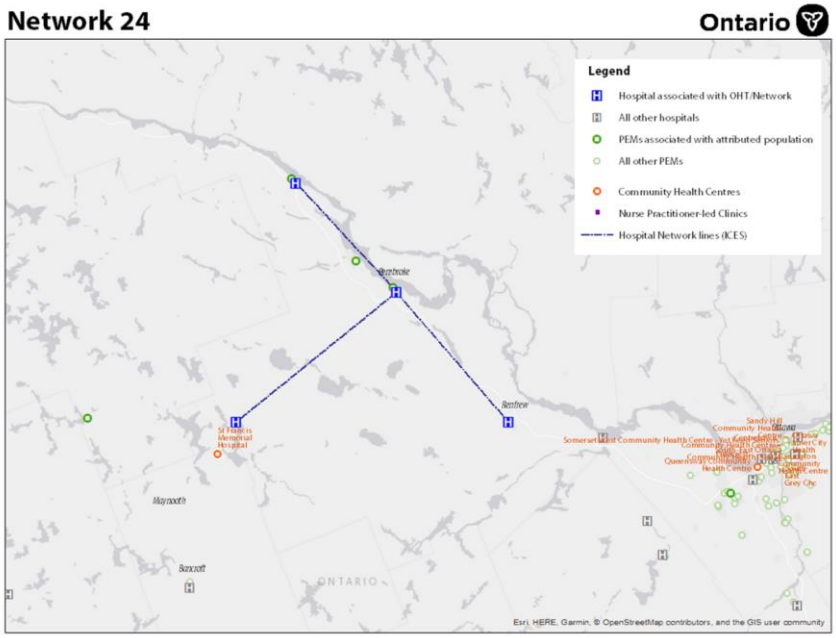
In this section, you are asked to demonstrate your understanding of the populations that your team intends to cover in Year 1 and at maturity.

1.1 Who will you be accountable for at maturity?

Based on the population health data provided to you, please describe how you intend to work toward caring for this population at maturity:

The catchment area covered by this proposed Ontario Health Team includes a broad and diverse set of communities west of Ottawa and in and around the Ottawa Valley. This area covers approximately 7,600 square kilometres. The southern tip lies about 70 kilometres from Ottawa; the eastern side is bordered by the Ottawa River; the northern tip extends to within about 100 kilometres of North Bay; and the western side is bordered by Algonquin Park in the north, and by the Counties of Lanark and West Carleton in the south. Many of the communities in the County lie within a 100-kilometre radius of the City of Pembroke. Geographically, Renfrew County is the largest Community of Care with 42% of Champlain's total area and yet only home to 8.5% of the population. This equates to an average population density of only 13 persons per square kilometre with Pembroke, Arnprior and Renfrew being the most densely populated areas. This is much lower than any other area in the Champlain LHIN. Our geography is depicted in Figure 1 below.

Figure 1: OHT Geography



Our attributed population is just over 80,000 people. Figure 2 outlines where our attributed population lives.

Figure 2: Our Attributed Population by Census Subdivision

Where does the attributed population live?		
Census Subdivision (CSD)	Attributed population	% of total attributed population
Pembroke	13,090	16.3%
Petawawa	11,396	14.2%
Laurentian Valley	10,286	12.8%
Renfrew	6,755	8.4%
Admaston/Bromley	5,121	6.4%
Deep River	4,982	6.2%
Bonnechere Valley	3,904	4.9%
Madawaska Valley	3,872	4.8%
Whitewater Region	3,470	4.3%
Ottawa	3,133	3.9%
Killaloe, Hagarty and Richards	2,640	3.3%
Greater Madawaska	1,810	2.2%
Horton	1,801	2.2%
Laurentian Hills	1,375	1.7%
North Algona Wilberforce	1,371	1.7%
Brudenell, Lyndoch and Raglan	878	1.1%
South Algonquin	803	1.0%
Arnprior	393	0.5%
McNab/Braeside	352	0.4%
Head, Clara and Maria	271	0.3%
All other communities	2,757	3.4%
	80,460	

Age – Today, there is a higher percentage of people aged 65 and older than people under the age of 19, according to the 2016 Census which states 23.1% and 22.4% respectively. This population of seniors forms one of the components of our Year 1 target population outlined further in this section.

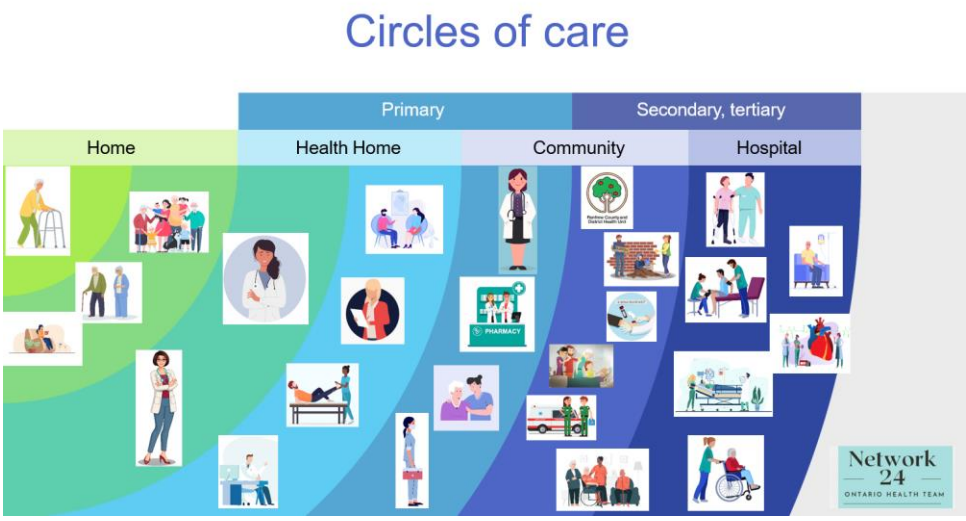
Unattached population - A significant portion of the OHT catchment population is not attached to a family doctor / nurse practitioner (NP). Estimates of unattached individuals range from 12-25% - between 10,000-20,000 individuals. With the inclusion of recent retirement and the impending move of a primary care resource next month along with expected physician retirement in the next 2 years, the forecast is that an additional 6,000 individuals will be without a family doctor / NP. While basic

attachment is an issue, access to comprehensive primary care is also a gap: In addition, a large number of attached individuals reported not having after hours access to their family doctor / NP and visited the emergency in the last year for something that could have been treated by their family doctor / NP.

Our approach to managing this diverse population will be focused on the concept of a health neighbourhood with people-centred health care at home per Figure 3 below. In this model, our population will be cared for at home as much as possible, with care supplemented by more distal services, as represented by the circles of care extending from the home as depicted in Figure 4.

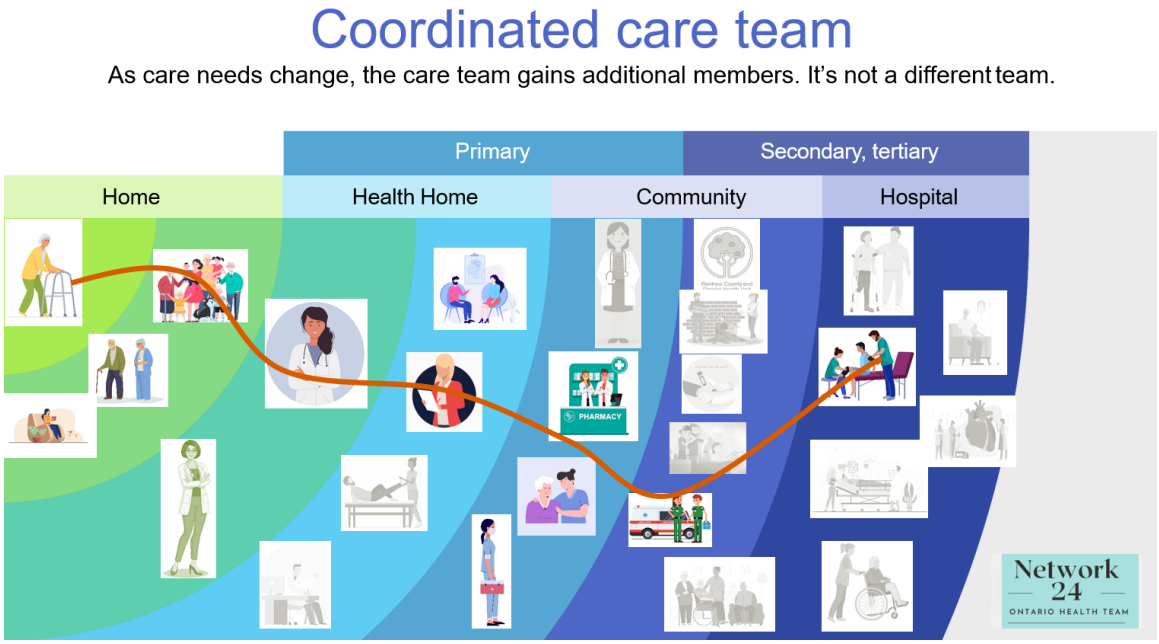
Figure 3: OHT Approach to Managing Population at Maturity

Figure 4: Circles of Care



The focal point for our population will be an integrated coordinated care team. As health needs change, the team and level of coordination changes but the approach to prevention and care at home remains a foundation in place. The coordinated care team is depicted in Figure 5 below.

Figure 5: Coordinated Care Team



1.2 Who will you focus on in Year 1?

Our Year 1 population will be focused on the more frail of our population with a focus on: 1) frail seniors and 2) those struggling with mental health and addictions. A key focus in year one will also be primary care attachment of patients in these groups as our data indicate that attachment rates here are sub-optimal and can be improved to support our proposed model of care.

Figures 6 and 7 depict the fact that our population is older than the provincial average.

The age distribution of our population as compared to the province in general is depicted in Figure 6 below.

Figure 6: OHT vs Province Age Distribution

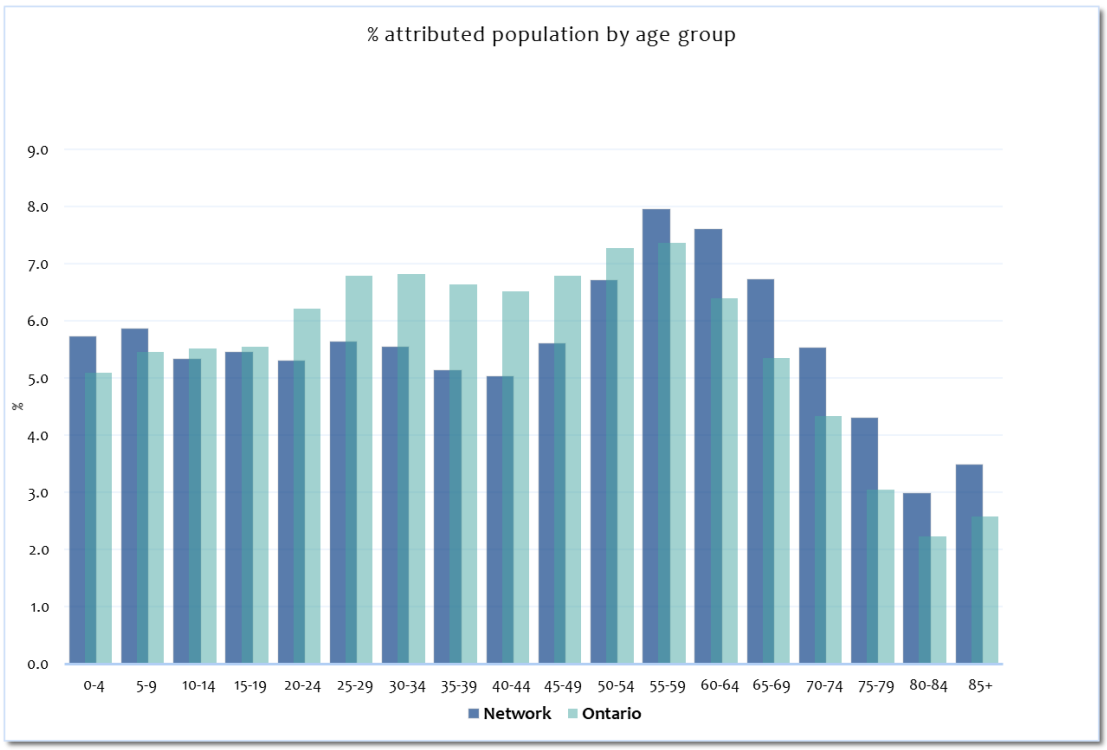
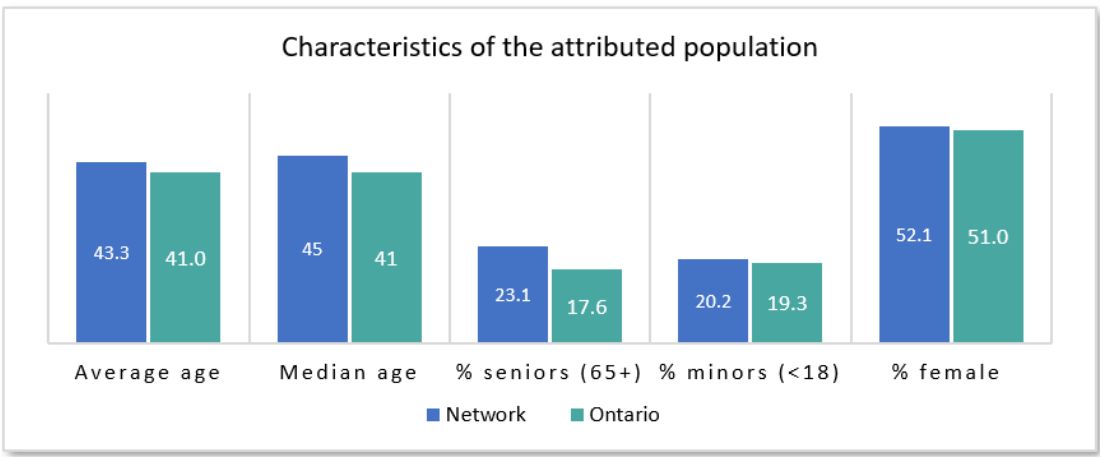


Figure 7: Age of Population



Attributed data estimates the population over 65 at 18,553 and if we focus on the most frail seniors over the age of 80, the population is 5,222 as outlined in Figure 8 below.

Figure 8: Age Distribution of Population

Attributed population

80,460

Age distribution of the attributed population

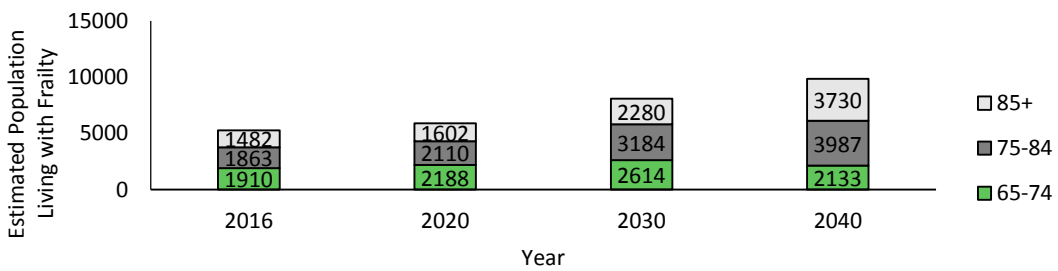
Age Group	*Population*	% of total
0-4	4,608	*5.7*
5-9	4,723	*5.9*
10-14	4,298	*5.3*
15-19	4,387	*5.5*
20-24	4,269	*5.3*
25-29	4,535	*5.6*
30-34	4,465	*5.5*
35-39	4,131	*5.1*
40-44	4,048	*5.0*
45-49	4,515	*5.6*
50-54	5,405	*6.7*
55-59	6,404	*8.0*
60-64	6,119	*7.6*
65-69	5,410	*6.7*
70-74	4,451	*5.5*
75-79	3,470	*4.3*
80-84	2,408	*3.0*
85+	2,814	*3.5*
	80,460	

The number of individuals in the County of Renfrew (Census Division) aged 65 and older is 21,315 (Census 2016). According to population projections from the Ministry of Finance, by 2040, the number of individuals in this age group is expected to increase by over 60% to a total of 34,433.

It is estimated that 16.0% of those aged 65-74, 28.6% of those aged 75-84, and 52.1% of those aged 85+ live with frailty (Statistics Canada, 2013).

Therefore, by 2040, 9,850 individuals in Renfrew County could be living with frailty. Figure 9 depicts frailty and projections.

Figure 9: Our Frail Population



Vulnerable seniors in our population face a number of challenges. According to the United Way in its *Profile of Vulnerable Seniors in the United Counties of Prescott and Russell, Lanark County, and Renfrew County*, factors such as age, income, living alone and rurality are factors of frailty – all of which are higher in our catchment than the Ontario average.

The issue of mental health and addictions is one that affects the frail senior population as well as the overall population as a whole for our OHT. The rate of hospitalizations for mental health and addictions conditions increased by 14% between 2009 and 2018 and remains higher than the provincial rate (Figure 10). This increase was partially driven by an increase in hospitalization rates among RCD residents 65+ years of age (Figure 101). Age specific rates for the 65+ population (per 100,000 population) of hospitalizations for any mental health and addictions condition in RCD rose from **297 in 2009 to 538 in 2018, an 81% increase**.

Figure10 **Age standardized rates (per 100,000 population) of hospitalizations for any mental health and addictions conditions, RCD and Ontario-less-RCD, 2009–2018**

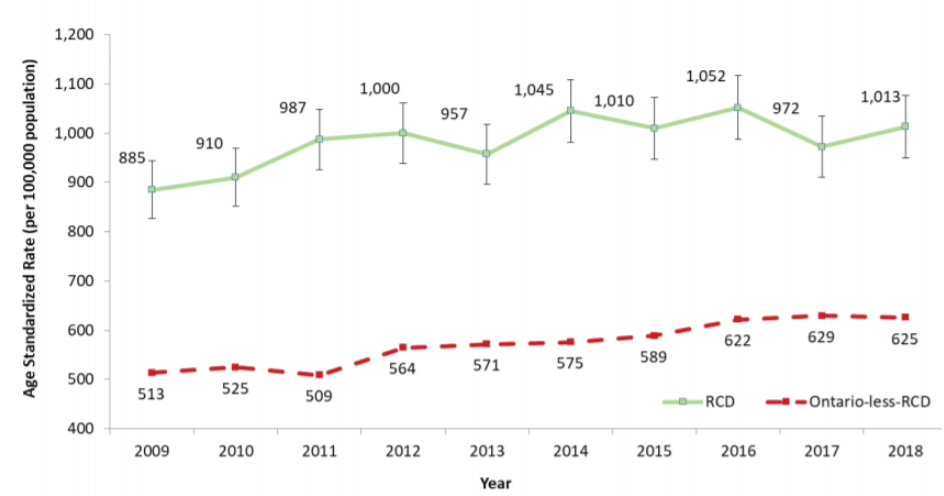
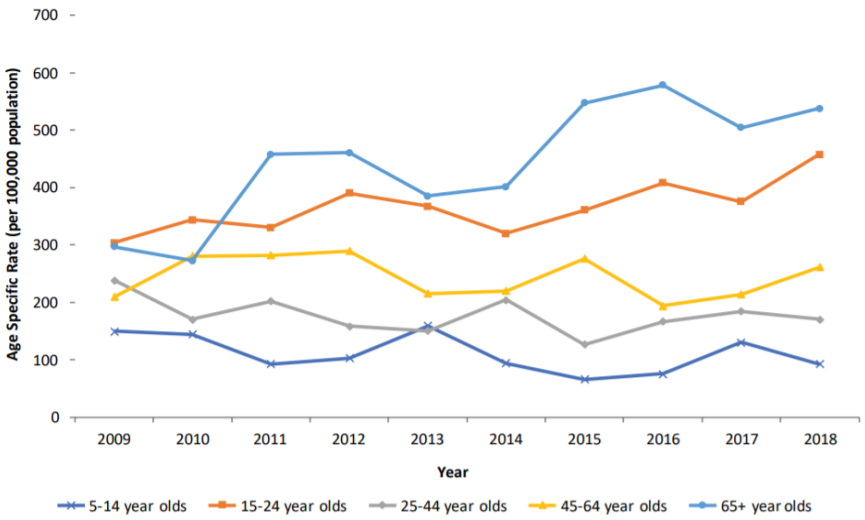


Figure 11 **Age specific rates (per 100,000 population) of hospitalizations for any mental health and addictions conditions in RCD, 2009–2018**



In Renfrew County and District, more and more people sought health care for help with mental health and addictions, mood and anxiety disorders and intentional self-harm over a ten-year period (2009–2018). In recent years (2017-2018), the use of hospital and physician-based mental health care services is significantly higher in Renfrew County and District than the rest of Ontario (Figure 11). Furthermore, in 2017, 19,938 Renfrew County and District residents made 90,456 outpatient visits to physicians for mental health and addiction conditions. (Renfrew County and District Health Unit. *Status of Mental Health in Renfrew County and District. July 2020*. Pembroke, ON: Renfrew County and District Health Unit; 2020).

Figure 12: Mental Health Indicators

MEASURE	RENFREW COUNTY AND DISTRICT (RCD)	ONTARIO-LESS-RCD
The rate per 100,000 population of emergency department (ED) visits for any mental health and addiction conditions	3,388	2,166
The rate per 100,000 population of hospitalizations for any mental health and addiction conditions	1,013	625
The rate per 100,000 population of ED visits for mood and anxiety disorders	2,350	984
The rate per 1,000 population of outpatient visits to physicians for any mental health and addiction conditions	881	741
The rate per 100,000 population of ED visits for intentional self-harm	182	141

1.3 Are there specific equity considerations within your population?

There are unique features of our population that require consideration when planning health service delivery with a profile outlined in Table 1. We have a high proportion of English-speaking residents but also a high concentration of French speaking residents in certain areas within our boundary. We also have a high percentage of low-income seniors and our population has less education than regional or provincial comparators.

Table 1: Unique Needs of Our population

2016 Census Indicators for Renfrew County OHT*	Renfrew OHT			Champlain	Ontario
Languages	Numerator	Denominator	Percent	Percent	Percent
Includes french as mother tongue	5,230	93,410	5.60%	18.50%	4.30%
Includes english as mother tongue	84,105	93,410	90.00%	64.80%	69.10%
Includes other as mother tongue	4,430	93,410	4.70%	18.60%	29.00%
Immigration / Minority Status					
pct aboriginal identity	8,230	91,820	9.00%	3.10%	2.80%
pct immigrant identity	5,125	91,415	5.60%	18.70%	29.20%
pct recent immigrant identity	325	91,415	0.40%	2.50%	3.60%
pct visible minority identity	2,395	91,830	2.60%	19.90%	29.30%
Income					
pct low income after tax age 65+	2,445	17,705	13.80%	10.90%	12.00%
pct low income after tax	11,625	91,185	12.70%	12.80%	14.40%
Education & Employment					
pct unemployed	3,370	46,980	7.20%	7.10%	7.40%
pct with out high school diploma	5,535	49,080	11.30%	7.80%	10.40%
pct with bachelor or above	7,800	49,080	15.90%	37.10%	31.90%
Family Status					
pct lone parent family	3,720	14,290	26.00%	26.60%	27.40%

*** Includes all census subdivisions within Renfrew County excluding Arnprior and including South Algonquin.**

Other features of our population include the following:

Indigenous population - Our population has a high Indigenous population at 9% - 3 times higher than the overall Champlain region or the Ontario average. Our region includes the traditional territory of the Algonquins of Pikwàkanagàn First Nation, formerly known as the Golden Lake First Nation. We must engage with Indigenous populations to explore their unique needs and collaborate on ways to address these needs.

Military - We are home to the largest of Ontario's military bases. CFB Petawawa employs approximately 6,264 Canadian Forces personnel and civilians on base and it is estimated that approximately 6,000 people directly connected to the base live in communities between Deep River and Pembroke.

Francophone population - This community is also distinguished by its Francophone population. While the region is predominately anglophone, Renfrew County, in particular, is recognized as having high concentrations of Francophones, particularly in the Laurentian Valley, Pembroke, and the Whitewater Region. Details are in Table 2 below.

Table 2: Francophone Population

Population – all age groups	Pembroke	Petawawa	Laurentian Valley	Whitewater Region	Total
Total population	13,335	17,190	9,385	6,850	46,760
Francophone population (IDF)	970	1,780	640	335	3,725
% of Francophones	**7,27%**	**10,35%**	**6,82%**	**4,89%**	**8,0%**

Socio-economic status - Our focus on the frail seniors population in year 1 must account for the literacy of our population and the income status. This catchment has some of the highest provincial rates of chronic physical and mental illness, unemployment rates above the provincial average and overall low socio-economic status. As compared with the province as a whole, we have a higher-than-average population over 65 with low income, a higher proportion (11.3%) of our population without a high school degree and lower percentage of our population with a bachelor degree or above (50% less than the broader region).

When combined with its vast rural geography, these factors pose increased challenges to health care delivery for this population at any time, but especially so in the face of this current pandemic. These geographic and socio-demographic difficulties are exacerbated by a lack of family physicians and the significant number of residents without consistent access to primary care.

Key features of our approach need to be focused on primary care attachment, home, community and social programs as well as increased after-hours access to support the needs of this population.

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

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

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

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

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

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

2.2 Confirming Partnership Requirements

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

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (i.e. meets exceptions identified previously e.g. specialized service provided such as mental health and additions services)*

2.3 How can your team leverage previous experiences collaborating to deliver integrated care?

The Network 24 partners and supporters already enjoy a vast array of collaborations and partnerships across their shared catchment and spanning the continuum of care. The following highlights four of these and each of these among our other collaborations will be essential to OHT development stand-up and success. A more comprehensive list of examples of collaborations already active within our OHT network is attached to the application.

Madawaska Communities Circle of Health

The Madawaska Communities Circle of Health (MCCH) was formed in 2010 and represents a strong and active integration of funded health service providers in the Madawaska River area of the OHT which is composed of many sparsely-populated communities. MCCH includes 27 agencies and programs: community support services (health, social services), primary care, acute care, Municipal elected, Addictions and Mental Health, Retirement, LTC, Assisted Living for High Risk Seniors, Hospice Palliative Care, St. Francis Valley Healthcare Foundation and more. All will be part of the proposed OHT. The Circle of providers plans and collaborates together in and aims to get every resident the services they need, without duplication and without anyone missing out. Because of its low population, resourcing is difficult. Together, it is less so. An example is Geriatric Emergency Management (GEM). The region's low population did not qualify it for GEM nurses, despite the aged demographic. Through collaboration, the MCCH members were able to obtain funding to train the existing RNs in GEM techniques. An identified strategy to achieve greater understanding by encouraging volunteerism on different governing boards (cross-board representation) is ongoing.

Early on in the pandemic, a COVID Partners group was convened which has enabled MCCH partners to maximize resources, knowledge and support for one another.

Renfrew County Virtual Triage and Assessment (VTAC)

VTAC is a collaboration between primary care, paramedics, hospitals and public health within Renfrew County. An important aim of VTAC has been to protect emergency departments and 911 paramedics for genuine emergencies. Residents with an urgent health concern are always encouraged to contact their own family physician first. Those without a family physician or primary care provider or those who cannot access their own family physician, now have an alternative to attending an emergency department or suffering at home in silence.

Renfrew County VTAC is a novel, centralized, 24/7 health-care service, available to all residents of Renfrew County. It provides initial virtual assessments by Family Physicians and Nurse Practitioners, home assessments, treatment and remote monitoring capability by Community Paramedics and escalation of care to a Community Acute Care physician or a Palliative Care physician as required. Renfrew County VTAC provides multiple layers of care designed to reduce attendance at, and transfer to local Emergency Departments. Any Renfrew County resident can contact Renfrew County VTAC for initial assessment. Additionally, patients may be referred directly by their Family Physician or Nurse Practitioner to any of the Renfrew County VTAC branches.

All providers share a common electronic medical record which is used to order any necessary diagnostic testing, print prescriptions and refer patients to the Community Paramedic Response Unit (CPRU), Public Health and other specialists as required. Point of care testing, including COVID-19 swabs and blood work, can be conducted in the patient's home by Community Paramedics with results relayed directly to the Renfrew County VTAC provider. Drive-thru sites for COVID-19 swabs of multiple patients have been established. Additional assessment and support can be requested from the CPRU or Community Acute Care branch of Renfrew County VTAC. In addition, Renfrew County VTAC integrates with existing community palliative care resources allowing for 24/7 access to an on-call palliative care physician and in-home support from Community Paramedics.

This has promise as an ongoing service. Telehealth, a common EMR, remote monitoring and other solutions improves access to primary care (particularly for unattached patients) and facilitates care in the patient's home wherever possible, while allowing for rapid intervention in patients requiring escalation of care to a hospital setting.

It should be emphasized that Renfrew County VTAC was created to support existing primary care, not to replace it. It has made use of existing health-care infrastructure (primary care physicians, paramedics and hospitals in Renfrew County) in order to ensure that all residents have access to acute episodic care during the COVID-19 pandemic.

Moving on Mental Health (MOMH)

This broad collaboration with the Phoenix Centre acting as Lead Agency enables Renfrew County to implement a Community Mental Health Plan in accordance with province-wide goals and objectives but taking into account regional needs and realities. The MOMH is comprised of local representatives from 17 sectors, many of whom are partners or supporters of the Network 24 OHT. MOMH has developed the Renfrew County Mental Health and Addiction Plan which will help guide the OHT at the outset and on an ongoing basis. The plan also identifies target communities to strengthen the services provided in Renfrew County unique to their needs: Francophone, First Nations and the Military. There are a number of key recommendations in the plan to improve MHA services across Renfrew County. These recommendations fall into three categories: (i) Intake/Access, which addresses concerns about not knowing where to go, not having quick access,

issues about sharing information between service providers, having a wide assortment of intake instruments, and patients having to tell their stories over and over ; (ii) Pathways to Care, which focuses on creating formal protocols that assist in case co -ordination or case management between agencies; and (iii) Integrated Crisis Systems, which will build on an already clear model that has emerged and work in this area will help to eliminate patients falling through the cracks and in having a common protocol between Emergency rooms in hospitals and community agencies. MOMH has been very active in providing MHA tools and supports to the COVID-19 response.

Western Champlain Health Link (WCHL) – now Integrated Care for Complex patients

The Western Champlain Health Link covers a large rural territory with a population of 154,575. The former Advisory Committee included nineteen local organizations, many of whom are involved with this proposed OHT. WCHL is a champion of the dispersed model of care coordination that trains service providers to coordinate care when the traditional model of care is not working for complex patients. WCHL supports a network of eighty care coordinators working in 21 agencies. Coaching, administrative support, and regular communiques help sustain awareness of the Integrated Care for complex patients approach. The care model has successfully reduced revisits to the Emergency Departments as well as hospitalizations for complex patients.

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3.1 Has your response to the COVID-19 pandemic expanded or changed the types of services that your team offers within your community?

In response to the COVID-19 pandemic, health care partners in across our team came together immediately to address the various actions that this crisis. We started with communication structures that brought primary care, hospitals, Public Health, EMS and long-term care together and that are still in place now. A key example of this response is the ***Renfrew County Virtual Triage and Assessment Center (VTAC)*** referenced earlier in this application.

Throughout Ontario, physical assessment centres were established to test patients for COVID-19 in the out-of-hospital setting. Given the geographical makeup of our community, health-care providers recognized that a single assessment site would have been unsuitable and that an alternative solution, specific to local needs, was required.

It should be emphasized that Renfrew County VTAC is a COVID-19 assessment centre. It has unique features that have made it viable, effective and efficient for the unique circumstances of Renfrew County but it was approved, implemented and remains funded as a temporary service, in the same way as all other COVID-19 Assessment Centres in Ontario. Strong representation has been made to ensure that the assessment aspect of VTAC will be able to continue post pandemic.

Since launching on March 27, 2020 Renfrew County VTAC has carried out over 22,000 family physician virtual assessments, almost 5000 in-home assessments by community paramedics and over 46,000 COVID-19 tests. A clinical review shows that almost three quarters of the assessments would likely have resulted in the patient attending the Emergency Department if Renfrew County VTAC had not been available.

Where communities are unable to recruit family physicians locally, access to a named family physician via virtual means, with support from locally available allied health professionals, may offer a better alternative to the Emergency Department as the only current option for unattached patients to access primary care in the future. Since March 2020, approximately 50% of the family physician assessments have been to “unattached” patients, however this percentage has increased over time. Currently, approximately 75% of the family physician assessments are provided to unattached patients. A significant proportion of assessments provided to attached patients are to patients of four family physicians, working with extremely large roster sizes, who have found the transition to providing virtual care during the pandemic extremely challenging. At least two of these four physicians will leave Renfrew County or retire in the next few months.

In terms of mental health and addictions, OHT partners sit at the ***Champlain Region COVID Pathways*** table and the Phoenix Centre leads the Virtual Care Project. Funded by United Way to provide technology and or connectivity to individuals requiring access to mental health or addiction services within the Champlain region. To date over 400 patients had received support. In addition.

the ***Moving on Mental Health*** Planning Table provides a collaborative forum to identify local COVID challenges, particularly ensuring accessibility to virtual care. Our community and social support services have also been part of our response on several fronts including wellness checks and support for vaccination appointment booking. From the beginning of the pandemic, community and social supports assisted living services have maintained service levels, ensuing safety for our frail elderly community dwelling population with visits, discharge support and prevention of unnecessary ED visits and admissions.

3.2. Do you anticipate continuation of these services into the fall?

We expect continuation and growth of these services as the pandemic continues and the way we deliver care has been permanently transformed by our COVID response. We expect to continue our VTAC service as well as our vaccination clinic program. In our current OHT geography we have four local care communities, Deep River and Area, Barry's Bay and Area, Renfrew and Area, and Pembroke, Petawawa, Whitewater Region. Each one of those local planning tables has representatives from primary care, public health, municipal sector, local pharmacies and EMS who work collaboratively to build vaccination clinics and develop methods for vaccine delivery to vulnerable patients. We all align around the principle that was developed at the regional leads table to have a mass immunization clinic structure in those four areas with some dispersed clinics. The mass immunization clinics are a true collaborative effort between many health care partners and others such as Algonquin College, Red Cross, and many volunteers in order to staff various positions in the clinic to provide an efficient service to our residents. Health care partners also collaborate on creating a list of patients who are unable to attend the clinics and a plan for EMS to provide the vaccine to their homes. Hospitals work with long term care and retirement homes to vaccinate residents, staff and caregivers in the most efficient way possible. The degree of integration and collaboration that we see demonstrated here is unprecedented.

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

4.1 Based on the population health data that has been or will be provided to you, please identify between 3 and 5 performance measures your team proposes to use to monitor and track success in Year 1.

The planning and delivery approach of the proposed Network 24 Ontario Health Team reflects the shared values of patient and family engagement and providing care close to home. With membership across the care continuum, our expectation is that we will work together to leverage our collective skills and strengths to benefit the unique needs of our attributed population. In Year One we will focus on seniors with health needs requiring care and community supports to be able to stay at home as well as individuals with mental health and substance abuse disorders.

Transforming through focus, integration and coordination

We propose to implement a high performing integrated care delivery system focused in Year 1 on our most vulnerable patients building on our current successes. Our proposed approach is focused on the delivery of seamless, fully coordinated care focused initially on our **frail seniors population and those with mental health and addictions issues**. We propose to operate in a manner that reflects the unique needs of our population across our region including our **francophone and First Nations populations, as well as addressing the needs of our higher than average number of unattached patients**. As such, our approach to meeting the needs of our population includes their direct and consistent participation in the design and delivery of our integrated model of care. What we propose is the initial seed of organized population-based care linked to outcomes and cost management.

Our proposed Health Team reflects the intention to service the **whole of our attributed population** with the associated organizations, facilities, services and providers aligned to meet their needs and reflective of existing patterns of care. We are building a **learning health syste**m that will participate in the Central Program Evaluation that supports rapid cycle learning, model refinement and ongoing implementation learning to enhance our operations and associated outcomes.

Care at home and in community

Our approach to transforming care is focused on what our patients are asking for most – **care at home with the tools to navigate and be part of the care process**. This aligns with the goals of the system to maximize health outcomes and contain costs. There is no benefit in patients landing in hospital or long-term care when they could better be managed at home. Much of our focus will be on addressing the community human resources required to enable the OHT to meet the objective with support for the aging-in-place philosophy and ensuring goals of care are patient focused. This will support better utilization of health care resources. Overall, our approach to delivery is focused on the development of strong partnerships with regional and provincial programs to increase capacity and potentially free up local resources. Community Support Services are proven to be more cost effective, and therefore an appropriate utilization of health care resources.

Data as a foundation and guide with digital supports

Understanding the available services in our region will help support our aging population to live healthfully in their home through appropriate referrals and matching patient needs to the correct service. This also holds true for our mental health and addictions population who require increased capacity in the community in order to avoid emergency visits – particularly readmissions.

We will work to advance digital health and information sharing across the providers. Improved information sharing will not only help family doctors / NP to coordinate patient care but also allow the OHT to measure number of referrals to services, wait times, and other metrics. Expansion of existing digital solutions across the network and incorporation of novel digital solutions will address the care needs of priority population We would propose to make better use of existing platforms like OLIS, connecting Ontario, HRM, e-referrals will help support both attached and unattached patients through timely access to information and capacity to track referrals and service engagement.

Our Key Metrics

We have looked carefully at each of our target strategies and have developed a range of actions and associated measures. We will narrow them down and focus them as we move forward based on this list of ten.

The following outlines our key Year 1 objectives as it relates to our target population and prescribes associated indicators. Many tables across our collaborative have provided input on our approach and these metrics with much additional detail available on potential measures to support this approach. The key ones are included below. In all cases, the method of calculation will require further assessment as the Network 24 Ontario Health Team completes deeper population analysis.

OHT Year 1 Objectives	**Associated Performance Measures**	**Method of Calculation**
Increase primary care attachment and primary care supports (patient and provider)	**1.** # patients attached to care provider **2.** # unattached patients receiving FHT/CHC services **3.** # MDs, NPs and Physician Assistants attached to FHT / CHC models **4.** # of patients served by VTAC	• Healthcare Connect / local survey • ED/VTAC visits • Internal OHT systems across the continuum – primary care and CSS/ VTAC/ Caredove referral system/ CIMS

OHT Year 1 Objectives	Associated Performance Measures	Method of Calculation
Increase access to 24/7 community support and specialized services	**5.** #ALC days for priority populations **6.** Readmissions for priority populations	• Internal OHT systems across the continuum – primary care and CSS/ VTAC/ Caredove referral system/ CIMS • CSS agency and CCSN data collection
Improved care planning and coordination across providers and agencies	**7.** Direct admissions from community to LTC **8.** Patient and family experience with patient reported outcomes metrics (in development)	• Caredove (referrals) • Experience survey TBC
Improve access and quality (i.e. evidence-based) mental health and addictions care	**9.** Wait times for community mental health services from identification of need for MH services and first session	• Hospital information systems • Community agency Caredove referral system
Expand virtual and digitally enabled care to serve priority population	**10.** # virtual visits billed and/or completed	• Local billing systems • Provincial billing data • Other data capture for non-billed visits to be confirmed

4.2 How will your team provide virtual and digitally enabled care?

The proposed Health team will work to enhance and expand its virtual and digital care capabilities, leveraging existing technology investments and learning from our experience with virtual care during COVID-19. The focus of the virtual and digital enablement of our proposed Health Team will be **the patient**. Bringing care and services to the patient - particularly in our remote areas – in a responsive and coordinated manner is going to be our focus and will highly dependent on the technology we employ.

Access to primary care

Currently, individuals in our catchment benefit from the **Virtual Triage and Assessment** (VTAC) portal that has evolved during the pandemic to become an important tool for rapid assessment and triage of patients without a family doctor/NP. VTAC was particularly impactful for our unattached and mental health patients as it provides a point of access to get immediate service and wayfinding in the system. We are further exploring the opportunity of creating a **virtual family health team** model to support our population.

We would propose to supplement phone with **other digital tools** such as a patient portal and video and virtual care technology - but the phone truly is a critical piece for this particular population as we have known historically and this has been further reinforced during the pandemic.

Navigation

With that in mind, collaborating to build **patient navigation capability** where “no door is the wrong door” is key to our success. Building on the regional coordination model for mental health (accessmh.ca), we would look to other opportunities to coordinate services to enable patients and providers to find the right service at the right time. It is important to note that a component of our Year 1 target population of frail seniors may not be able to use the types of virtual and digital care solutions that are increasingly becoming the norm and the expectation of the majority of Ontarians. We expect to **continue to advance our phone support services** and other lower tech solutions to provide multiple ways for our seniors to reach their most responsible provider to get access to care and have their needs assessed and met.

We plan to leverage the Ontario Telemedicine Network (OTN) for virtual care delivery as well as some instances for MS Teams and Zoom for health care. It is expected that a single platform for virtual care will be adopted across the OHT at maturity and will align with provincial direction and guidelines around functionality, security, privacy and possibly a shared investment in a common provincial solution.

Home monitoring and home to primary care connectivity

We would look to **expand self-monitoring technologies** that are in place with plans to enhance remote monitoring, home-based technologies as well as secure texting and emailing options. These are areas of future investment and advancement for our OHT as part of our overall goal of keeping patients healthy at home longer.

Continuity of care

Enabling **continuity of care** is essential to our model and priority will be given to enabling the necessary secure information sharing across core patient health record systems within our OHT. In this case, we will build around our anchor systems across the collaborative focusing on shared data across the continuum of care leveraging tools like the ConnectingOntario Clinical Viewer as a possible foundation for sharing digital health records across the OHT. Integration of data across these core systems will be achieved in line with the principles in the Digital Health Policy Guidance of the **Digital Health Playbook** as we expand and scale our capacity and build efficiency with increasing options available to patients and enabling their engagement in the care process. We are committed to increasing patient access channels including virtual ones and ensuring that they are bilingual (English/ French) with opportunities for specific French Language Service virtually with Francophone professionals. As part of our approach to digital and virtual care, we would propose to work collaboratively with other Ontario Health Teams to learn from and leverage their experiences and approaches to digital and virtual care as we build a sustainable foundation, while maintaining our focus on the unique needs of our Year 1 population.

Note:

An important point of note as it relates to equitable access to digital health – the high rurality and nature of the socio-economic status of our population means that availability of the required network and Wi-Fi infrastructure is limited. Our OHT will benefit from the provincial investments in infrastructure to enable rural and more remote communities to

have access to internet services and support for those who cannot afford internet to ensure equitable access.

Contact for digital health	Name: John Saunders
	Title: Chief Information Office
	Organization: Pembroke Regional Hospital
	Email: john.saunders@pemreghos.org
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4.3 How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples, racialized communities and Francophones in the planning, design, delivery and evaluation of services for these communities. Considering your response to question 1.3 and according to the health and health care needs of your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

4.3.1 How will you work with Indigenous populations?

Describe how members of your team current engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term. How will members of your team provide culturally safe care? Does your team include Indigenous-led organizations as members or collaborators? Why or why not?

The Truth and Reconciliation Commission established reconciliation as an ongoing individual and collective responsibility and seeks to embed principles such as accessible, 'do no harm', inclusive and representative across our reconciliation journey. Within the network coming together to form this OHT, we are proud that - while there is still much to do - Indigenous engagement already takes the shape of widespread cooperation and strong collaborations. The Algonquins of Pikwakanagan First

Nation and the Renfrew County and District Friendship Centre are member partners of this OHT (active participants of the CLHIN Indigenous Health Circle Forum). Across Canada, Indigenous communities are charting a path in transforming their systems of health and "wellness" and that includes Renfrew County.

At present, the Algonquins of Pikwakanagan First Nation provides an array of health services including:

- Family Health Team
- Community Health Nurse
- Community Health Representative (NIHB)
- Physical Fitness & Heart Wise
- Diabetes Navigation Services
- Dietician
- Foot care clinic
- Children's Oral Health
- Mental Health – adults
- Children & Youth Mental Health
- Addictions Counsellor
- Supportive Housing and Assisted Living (Tennisco Manor)
- Home Care and Aging at Home
- Palliative Care
- Respite Services
- High-risk seniors
- Medical transportation
- etc.

These services are linked closely with other Network 24 partners including: hospitals, primary care providers and others along with various committee and collaborative mtgs. In terms of mental health and addictions, Pikwakanagan is partnered with both Renfrew County Addictions Services, The Phoenix Center for Child and Families, and Moving on Mental Health.

Collaboration in patient care takes the form of coordinated care plans, shared discharge planning, community service plans etc. There is also Indigenous representation at the Renfrew County Virtual Triage and Assessment Centre (VTAC) table.

The Renfrew County and District Friendship Centre acts as a referral service to help connect Indigenous people to the health programs and services available for them. The Centre works in active affiliation with a number of our OHT partners and we anticipate this growing across the OHT.

There is still much to do in strengthening the capacity of Indigenous organizations and those they collaborate with to provide accessible, quality and culturally appropriate health care services to Indigenous peoples within our catchment.

In terms of the OHT's Year 1 Population, under 5% of Renfrew's total seniors' population identifies as Indigenous; not surprisingly, the greatest number live on or near Pikwakanagan First Nation between the communities of Killaloe and Eganville. However, it is important to note that in some areas (northern edge of Algonquin Park), close to 20% of individuals over age 65 identify as Indigenous. These seniors may not be as well connected to culturally appropriate community supports as those living on or near Pikwakanagan First Nation.

While Indigenous seniors represent only a small fraction of the OHT catchment population, they represent a particularly vulnerable subpopulation. It has been noted that compared with the larger Canadian population, a significantly larger proportion of Indigenous seniors live on low incomes and are in poorer health, with multiple chronic conditions and disabilities. This group shares many of the challenges of the mainstream seniors population, not only health and socioeconomic, but also rural and remote barriers. Services need to be accessible, trauma informed, culturally appropriate and aligned with actual need.

Steps to be taken by the OHT will include:

- The OHT will work with Indigenous representation, on and off the First Nation, to establish a framework for ongoing collaboration, communication and engagement. Indigenous representation will be included across OHT planning and implementation tables paying attention to a current lack of representation for Indigenous peoples and including Inuit and Métis residing off the First Nation.
- We will map OHT services related to Indigenous and First Nations. Working with the Indigenous and First Nations community and with Indigenous service providers and programs, the OHT will identify gaps of access to services, culturally appropriate services, data needs and processes to collect appropriate data.
- We will work to identify and provide cultural competency training for individuals within and across OHT partner organizations.
- In planning for our Year 1 population both Indigenous and non-Indigenous, we have much to learn from programs and services already being provided to Indigenous and First Nations individuals. For example, the Algonquins of Pikwakanagan already focus on high-risk seniors by providing practical supports for at-risk seniors to remain in their own homes as well as call help services and referrals.

A collective response to COVID-19 has served to strengthen Indigenous and non-Indigenous provider partnerships with the added benefit of introducing virtual care solutions that look promising for ongoing improvements in access to high quality care. The goal of the OHT is to protect, enhance and expand these collaborations which are already in place.

4.3.2 How will you work with Francophone populations?

Does your team serve a designated area or are any of your team members designated under the French Language Services Act or identified to provide services in French?
Describe how the members of your team currently engage with the local Francophone community/populations, including the local French Language Health Planning Entity and/or address issues specific to your Francophone patients in service planning, design, delivery or evaluation. (This includes working towards implementing the principle of Active Offer). Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Francophone health or health care needs in Year 1 or longer-term.

All aspects of patient-centred care are maximized if individuals can communicate in their preferred language. Facility to communicate well impacts not only service experience and quality of care but can impact care outcomes. Individuals can better communicate their situation (particularly in an emergency) and are better equipped to understand care choices (and provide informed consent) based on their health needs.

The OHT is committed to comply with the *French Language Services Act* (FLS Act) by ensuring provisions in French in its catchment area. Relevant to Network 24, areas designated under the FLS Act include the City of Pembroke and the Townships of Stafford and Westmeath. According to the Ministry of Health's Guide to Requirements and Obligations Related to French Language Services, four of our OHT partners are formally identified to provide services in French to varying degrees. We do know that other partners also provide some services in French as per their accountability agreements. In a recent report by the Renfrew County FLS Committee examining current accessibility to FLS (in general), the Phoenix Centre was highlighted by survey respondents as one of the most widely accessed agencies offering FLS. We are confident that increased collaboration between the partner health service providers within our OHT will increase compliance and commitment toward the improvement of FLS across the OHT.

In addition to individual partner Francophone engagement and activities, and considering our Year 1 population and our population at maturity, the OHT will undertake the following:

- Recognizing that data specific to the Francophone population is limited, we will conduct an inventory of FLS capacity and accessibility across all partners (e.g. staff survey of FLS competency) as an early step in better understanding the needs of Francophones in our catchment. We will map current services across the continuum of care we intend to build beginning with our Year 1 population in order to understand current capacity and potential linkages to expand capacity. For example, we will anticipate being able to utilize the findings of le Réseau's soon to be released capacity analysis in the area of mental health and addictions in our OHT planning.
- We will ensure general OHT information intended for patients and the general public is also offered in French.
- We will identify and prioritize gaps. We will assess opportunities to improve FLS accessibility by coordinating between partners. Where one HSP cannot provide services in French, we will provide connectivity to HSPs that can do this (in or outside the OHT).
- We are committed to active engagement of Francophone representation at all levels and in all aspects of the OHT collaborative structure in order to surface and work to address issues specific to Francophone patients in OHT planning, design, delivery and evaluation.
- We have been, and will continue to, work in collaboration with the le Réseau. As one example, le Réseau is exploring implementation of a Francophone citizens' group in Renfrew County that could help the OHT in its planning and engagement.

In implementing the principle of Active Offer, our OHT goal is to ensure navigation, case management and care coordination services are available in French. In addition, to better respond to the Francophone health needs, the OHT will collect linguistic data. Where first language is neither French nor English, we will record which of Canada's official languages they are most comfortable using.

4.3.3 Are there any other population groups you intend to work with or support?

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

Our attributed population is diverse with unique features of our population as highlighted throughout this application. It will also be important for our Health Team to focus on the specific needs of our rural and military populations. For those in more **rural or remote** areas – regardless of their age or health issue – we must work to identify and design outreach and sustainable care delivery programs to meet their needs. This will likely include a blend of telephone, face to face visit as well as the introduction of increasing virtual care as the network infrastructure and population readiness allows.

Another population group our Health Team will focus on are those residing on the **Petawawa military base.** While this population overlaps with our Francophone community in large part, we will seek to better understand the specific health needs of the military community and their families to support their care. In the case of these populations, we would propose to focus on the primary care needs as this is the first line of care and approach to these groups and aligns well to our overall approach to integrated patient-centric care. This will be particularly aligned to our focus on patient attachment in these communities – both rural/ remote and military – will require that as the cornerstone for our model of care.

In addition to these groups, we are aware of the fact that our attributed population has less education than the regional or provincial comparators. We will need to be mindful of how we communicate and engage to ensure we are using language that is accessible for various education levels and that we are also working in parallel to advance literacy and education attainment with our education and social system partners. As we evolve and learn more about the needs of our population – and the overlap in various characteristics and associated impact – we will work to ensure we lead with the right approach and continually engage patients, families, and our community in the process. Overall, a focus on increasing health literacy will be a focus for all of those in our attributed population.

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

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

Our proposed OHT – and part of the Year 1 target population – includes populations that are vulnerable for COVID-19 and influenza. Both their age and the number in congregate settings such as long-term care, retirement home and assisted living make a significant number of our residents at higher risk. Based on the 2017/18 data provided regarding our attributed population, approximately 23% of our population over 70 live in long-term care homes and we have a slightly higher than provincial average number of seniors overall in our population. Partners in the proposed OHT are well aligned on protocols that emphasize vaccination priority for vulnerable populations and will work together to advance a coordinated approach. Working with Indigenous populations on and off First Nation will be a focus for this effort as well as a focused effort on bringing virtual care to these populations, acknowledging the technology limitations of adoption by the population and network challenges. Telephone and engagement of family and supports to enable care will be leveraged. In addition, as part of our approach moving ahead, we would approach this population as a subset of the overall virtual care plan. We are also acutely aware of the impact the pandemic has been having on the mental health of our population as a whole – including our providers and related services. As our OHT evolves and the pandemic subsides, we will work to understand the true extent of the impact and adapt our approach to respond. From an overall management perspective, our supplies of PPE are in place and we will continue to take direction from the province on its guidelines around pandemic management as we accelerate innovation as part of our OHT while balancing the reality of the global pandemic.

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

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

Patients, families, and caregivers are at the core of what we do and, as such, have been well represented in the development of this submission with multiple points of engagement throughout the process. Patient, family and caregiver input is critical to ensure services continue to meet the needs of our community. As a collective, we have a long history of working with our patients, families and caregivers to ensure that their voices are at the heart of our provision of outstanding care.

Throughout the OHT application process, patient, family and caregiver advisors with experience contributing to health care service-improvement projects participated on the steering committee and helped guide the direction of this application.

Patients, families and caregivers' experiential knowledge is essential to health care redesign. We will continue to partner with patients, families and caregivers to better understand their experiences in order to help drive system improvements. Our OHT will ensure patients, families and caregivers are partners at the table, not guests.

We will involve patients, families and caregivers in the design, development, delivery, assessment and evaluation of health care across our community through this OHT. Engagement and involvement will take place through governance, policy, education, membership and communication. We believe bidirectional communication is critical. We will incorporate a combination of (a) delivering

key information to the community via print, radio and social media, (b) doing surveys of (and focus groups with) patients, families and caregivers within various societal sectors (like seniors, youth), and (c) doing surveys of (and focus groups with) township representatives and with various health care sectors (like community support services). All projects and programs will be evaluated ('*post-mortem*') when completed so we can continually improve our methodology.

Most of our partners already demonstrate meaningful patient, family and caregiver engagement. This occurs through patient, family and caregiver representation on councils and boards, and through involvement in design and quality improvement initiatives. Collectively, we commit to strengthen patient, family and caregiver partnering in the design and development of our model.

In Year 1, we will undertake the following patient, family and caregiver engagement activities, all of which are based on the Ontario Declaration of Patient Values:

- Review existing patient, family and caregiver engagement and relations' processes to ensure feedback is addressed collectively when appropriate. Some issues will only need to be addressed locally.
- Develop a comprehensive engagement and involvement strategy.
- Develop a patient, family and caregiver advisory strategy to co-design the processes we will need to serve the target population in an integrated care model.
- Ensure patient, family and caregiver representation on our OHT steering committee and working groups.
- Align the questions from the most appropriate multiple local patient, family and caregiver experience surveys for each health care provider type so that the OHT can undertake longitudinal benchmarking.
- Have bilingual resources in place to serve French-speaking patients, families and caregivers and find ways to accommodate other languages of choice if at all possible.
- Work with the Algonquins of Pikwàkanagàn and indigenous health networks to provide culturally sensitive services.
- Enhance patient, family and caregiver relations' processes where patient, family and caregiver concerns are responded to within 5 days 100% of the time.

The OHT has resources currently in place to meaningfully engage health care partners, community and social services partners, and patients, families and caregivers in order to identify gaps and opportunities for the design of the OHT at 'maturity' (noting that society and health care evolve, and we will need to be able to adapt as needed). We have already initiated this consultation with a view to having it assist us in prioritizing improvement projects for the short and long term. Although the rural nature of our population can pose challenges with engagement, we will leverage opportunities where patients, families and caregivers gather and by the use of electronic platforms.

Finding new and innovative ways to work directly with our patients, families and caregivers is key to our future. We are all patients, families and/or caregivers in this community as well as health system administrators and providers. We acknowledge this oneness and embrace a path where we work as a team focused on the same vision and goals, working with the same values.

As part of our initial planning in Year 1, we will develop a specific patient, family and caregiver engagement plan with clear metrics for evaluating the extent and impact of this engagement. We will learn where and how it works best, clearly also looking at best practices from other OHT. This is all part of our overall learning health system approach to delivering care.

5.1 What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3 (e.g. virtual care, population health equity etc.)? Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 3.1. Note that the Ministry is aware that implementation planning will likely be affected by the trajectory of the COVID-19 pandemic, and applicants will not be penalized should the priorities identified within this section need to be adjusted in future as a result. In anticipation of this likelihood, responses should therefore be reflective of the current health sector context and include contingency planning for ongoing COVID-19 pandemic activities.

Our OHT will organize around our Year 1 priority population and will adopt a project management approach to the detailed planning and delivery on our Year 1 priorities across the following areas with a distinct workstream to focus on performance and monitoring metrics described in section 4.1:

1. Collaborative Decision Making and Program Management
2. Service Delivery Design and Implementation
3. Digital Enablement and Virtual Care
4. Assessment and Evaluation
5. Change Management and Communications

Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 3.1.

Note that the Ministry is aware that implementation planning will likely be affected by the trajectory of the COVID-19 pandemic, and applicants will not be penalized should the priorities identified within this section need to be adjusted in future as a result. In anticipation of this likelihood, responses should therefore be reflective of the current health sector context and include contingency planning for ongoing COVID-19 pandemic activities.

The following is our proposed high-level implementation plan highlighting the key deliverables at Year 1 milestones by workstreams as identified above.

Implementation Work Plan

Workstream	Description	Month 3 Priority Deliverables	Month 6 Priority Deliverables	Month 12 Priority Deliverables
Collaborative Decision Making and Program Management	• Strategic plan with mission, vision, values statement • Membership and collaborative decision making model • Resource allocation model (evolving) • Patient and Family collaboration and partnership	• Initial resource allocation model (including identified recipient of MOH funding for OHT etc.) • Detailed project plan including working groups • Outreach/engagement with priority populations • Initial governance and decision-making structure • Governance model and work groups defined	• OHT Terms of Reference • 6 month status report • Recommended ongoing governance model (e.g. staging, levels of participation etc.) • Patient/Resident Declaration of Values	• OHT Members agreement addressing membership (levels of , etc.), resource allocation, information sharing, inter-team performance, conflict of interest, dispute resolution etc. • Project summary and next phase implementation plan
Service Delivery Design and Implementation	Activities to design and deliver care to Year 1 target population focused on integration and coordination of care to address key outcomes focusing on home and community capacity development	• Process for comprehensive inventory/gap analysis across all priority areas • Initial PCP attachment strategy • Identification of target services for capacity building and strategy model for delivery	• Inventory of related programs and baseline measurements across all key activities • Updated care maps for priority population • OHT health human resource plan for new service delivery model • Service flow mapping with input from patients, families and stakeholders	• Implement frail seniors primary care attachment and coordination model • Implement expanded community capacity for mental health • Implement expanded capacity for frail seniors home care
Digital Enablement	Assessment, planning, design and implementation of virtual care and digital health information tools	• Harmonized information technology and information management plan • Comprehensive inventory and	• Identification of data sharing tool(s) and approach for target population • Build virtual care capacity focused on phone for frail	• Implement 2.0 patient care tool • Implement enhanced virtual care capacity

Workstream	Description	Month 3 Priority Deliverables	Month 6 Priority Deliverables	Month 12 Priority Deliverables
	to share key health information across the continuum and with patients and their families in a secure and compliant manner	assessment (functionality, performance, privacy, security, scalability) • Establish table for focused virtual care for COVID-19 response	seniors and expanded VTAC platform • Develop virtual approach for congregate patients and COVID-19 and flu vulnerable	across target populations
Assessment and Evaluation	Identification of strategic, operational and experience metrics and associated data collection and reporting strategy to measure and assess progress and ongoing learning	• Inventory of current reports and data collection methods • Operational reporting strategy and plan • Baseline data collection	• New reports and data collection in place • Evaluation plan and data collection and analysis plan with catchment details in place	• Year 1 final assessment report
Change Management and Communications	Assessment of key impact areas of Year 1 service delivery and development of plan to support required changes and manage the new model of care including communication with and to partners, communities and stakeholders	• OHT formal name, brand and communications plan • Provider and key stakeholder change management plan	• Communications materials • Translation into French of key OHT documents • New role descriptions • Training plan • Community survey • Communication strategy to support PCP attachment and other key OHT activities	• Community survey results • Training materials • New services targeted communication delivery

5.2 What non-financial resources or supports would your team find most helpful?

Please identify what centralized resources or supports your team would need to be successful in the coming year, if approved. This response is intended as information for the Ministry and is not evaluated.

The following are the key non-financial supports we would seek to receive as part of our process.

Data and Privacy Support

Ongoing access to Ministry data to support governance (e.g. data ownership options, privacy options), measurement and evaluation as well as any additional insights that may become available as we develop our programs and approach. We would also benefit from support to ensure we are meeting data privacy standards. Consistency between OHTs would be helpful from both a public and provider perspective. Sharing of tools and solutions (and evaluations of both) between OHTs would be more efficient as well.

Human Resources and Funding Models Supports and Enhanced Flexibility

See section below for proposed enhancements to physician and other health provider funding models, programs and services to help expand accessibility and capacity in the face of challenging health human resource realities. This includes preserving and expanding virtual services and billing codes. It would also be useful to understand what has been addressed in the way of cross-sector strategy to address common human resource issues (eg PSW shortage).

Learning From Others and Practical Templates

Our OHT would benefit from the experiences of others who are further along in their journey. We would benefit from conversations with leaders in comparable OHTs in addition to the RISE platform resources. The build out of our governance structure and the design of our PFAC structures are areas of importance and best practices or Ministry advice in these areas would be beneficial. A repository of shared resources: lessons learned, best practices, engagement, and communication strategies, as well as template documents for policies, agreements and structures from other OHTs ahead of us. Practical template documents in a repository including policies, agreements, and memoranda of understanding which could be modified to suit our local needs would help reduce the duplication of effort across OHTs and also help ensure consistency across the province. Specifically, model pathways for mental health and frail seniors care would be helpful as well as guidance around virtual care for this population that has not adopted technology with ease.

Communications and Branding Guidance

Province wide branding and communication: consistent messaging for the general public to raise awareness and understanding of Ontario Health Teams would be beneficial. When people move, they should have access to the same health care in all areas of the province and how to access primary care and enter a health team.

Governance Support

A “partnership table”: composed of designated leaders from the consortium and Ministry personnel. Meetings on a regular basis can be extremely helpful to have the ongoing communication and provincial lens and support our first year of operations. This table will enable sharing of experience in the field and possible policy or regulation changes requested as well as patient and family experiences to be reflected in the approach to OHTs

5.3 Have you identified any systemic barriers or facilitators for change?

Please identify existing structural or systemic barriers (e.g., legislative, regulatory, policy, funding) that may impede your team's ability to successfully implement your care redesign plans or the Ontario Health Team model more broadly. This response is intended as information for the Ministry and is not evaluated.

The following are the recommended barriers and facilitators for change.

COVID-19

The most significant issue we face is that of COVID-19 and its impact on our target population. We will need support to our community through this time. An increased focus on leveraging virtual visits will help manage patient access in the setting of barriers to in-person encounters. The ability of the OHT to proceed at all with its plan and approach will be significantly impacted by the pandemic which continues to challenge our health system. This must be acknowledged as a risk area for progress. This may also impact our progress toward objectives and metrics identified in this application.

Lack of infrastructure regionally to support alternative placements for those persons designated as Alternative Levels of Care (i.e. Long-Term Care Bed capacity) continues to have significant impacts across the entire health system that has been further exacerbated as a result of the COVID pandemic.

Funding Models

There are many different funding models involved within our developing OHT (e.g. Hospital, Family Health Organization, Family Health Team, Community Health Centre, etc.) and some of these models disadvantage one another with their incentives or penalties. It is important to point out that there are many policy barriers related to funding models that significantly impact the ability to shift key quadruple aim performance metrics, particularly related to health system utilization and physician funding. For example, Emergency Department Alternative Funding Arrangements (EDAFA) and the essential role they play in stabilizing the provision of ED services particularly in rural hospitals may be destabilized with re-direction of CTAS 4 and 5 cases back to the primary care setting in the absence of other physician funding changes. Contractual exemptions for after-hours care under the blended capitation models recognize the unique multifunctional role that family physicians have in rural settings. However, this exemption may have contributed to increased utilization of hospital resources due to a shift of primary care services to the hospital ED setting. A

thoughtful but pragmatic solution or shift in policy may be needed, as this observation may limit the extent of progress on several indicators.

Resources and Infrastructure

Insufficient community resources (i.e. Community Support Workers) that could be a barrier to enable implementation for our priority Year 1 population. Lack of infrastructure due to the rural nature of the area and requirements for connectivity and networks to support virtual care delivery.

A strong approach to health human resource planning during health system transformation will be essential to matching resources to needs in the population we serve. We anticipate both challenges and opportunities will arise with increased demand for family and personal caregivers in the face of shortages in key providers such as PSWs.

Clear and transparent principles should be articulated for service providers during this transformation. There are concerns among members of the prospective OHT that we will struggle to meet staffing demands due to shortages in trained staff such as PSWs and family physicians, particularly serving our rural areas.

With resources siloed in many organizations, incentives do not promote the implementation of tools and strategies to establish truly coordinated services, creating a lack of common IT tools. There is static capacity in needed resources such as long-term care, despite the ever-increasing demand due to chronic disease, insufficient community resources, and our aging community.

The culture of resource allocation needs to shift to accountably address population needs, and this may present a barrier to the OHT particularly before the maturation of the OHT governance and accountability structure. There are challenges in human resources that limit capacity to respond to population needs. Through shared planning, resource allocation, and utilizing an improved digital platform, we can improve the capacity of the system to deliver the services that each member of our community needs. Improved coordination and resource allocation can help recruitment and retention of human resources to maintain a robust OHT.

New and innovative funding models for physician involvement in our OHT will be critical, particularly for primary care physicians whose current funding models do not provide the financial resources to be optimally involved in the creation of an OHT. We would also explore innovative ways that specialists can be involved, and to explore potential alternate funding plans for primary care. Given the focus of OHTs on primary care, it will be important to emphasize efforts to strengthen the whole care team, reducing duplication and administrative hassles to free up capacity. As physician remuneration remains outside of the OHT funding envelope, we will need to be aware of the challenges of navigating care redesign initiatives within existing funding structures.

Accountability and Governance

Current accountability frameworks for publicly funded health agencies using service accountability agreements (e.g. H-SAA, M-SAA, etc.) may contribute to potential discordance as management and governors strive to exercise fiduciary responsibilities to their own organizations while engaging in change projects that may impact organizational performance and accountabilities while advancing other system level changes.

Further regulatory reform is needed to enable OHTs to fully encompass home and community care services as they assume responsibility for the attributed population across the full continuum of care. In addition, stronger linkages are required with other non-health sectors and related ministries and other public entities who principally provide funding and services related to the social determinants of health.

Current contracting rules around home and community care impede efficiency. Our lack of adequate LTC spaces, older population, our rural geography and shortage of PSW's point to the need to strengthen home and community care, which could be a significant challenge within existing contracting rules. There are many challenges in implementing virtual care including: OHIP billing codes which do not remunerate virtual care in a similar manner to in person care, lack of reliable internet in rural areas, the cost of implementing virtual care for those physicians in private practice who do not have access to ministry funding, the lack of IT support for physicians in private practices outside of team based models, as well as the multitude of virtual care options which in most cases are not interoperable and require workarounds to move data across systems.

Virtual Care Accommodation

Improved OHIP billing codes which support virtual care through all PHIPPA compliant platforms, government support for widespread high-speed internet, regulations requiring virtual care vendors to provide interoperability, and funding for IT support, would mitigate some of these concerns. Alignment of billings and incentives around virtual care will support advancement in this area over the pandemic and beyond.

6.0 Membership Approval

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

Team Member	
Name	
Position	
Organization (where applicable)	
Signature	
Date	
Please repeat signature lines as necessary.	

Appendix A: Current Collaborations within Network 24

Organized as follows:

- **Renfrew County Network Collaborations**
- **Champlain Local Health Integration Network Collaborations**
- **Local Community Network Collaborations**

Renfrew County Network Collaborations			
Name of Network	**Purpose / Description**	**County-Wide**	**Link to Champlain or Provincial Network**
Assisted Living Services-Supportive Housing Program	Located at Carefor Mackay Centre. Provides housing support for lower income aging adults 55+ in a congregate setting with homemaking and health monitoring support	Yes	Yes
Addictions Treatment Service (ATS) sponsored by RVH Advisory Committee	School Boards, Pikwakanagan Mental Health, Phoenix Centre, Adult and Youth Probation Parole Services, RVH Board representative and client / service users' representative to provide advice and direction to increase addiction services and form partnerships in order to expand services and fill existing gaps	Yes	
Bonnechere Algonquin Community Health Services	Indigenous Referral Program	Yes	Yes
Community Safety and Well Being Advisory Committee	Health Services, Police, County, provincially mandated to develop a safety and well being plan for municipalities	Yes	
Crisis Response for Youth at Risk	Renfrew County School Boards, Mental Health Services of Renfrew County (MHSRC)	Yes	
District Stroke Center Steering Committee	PRH, EMS, HCC, Arnprior Regional Hospital (ARH),RVH, Deep River District Hospital	Yes	Yes

	(DRDH), Champlain Regional Stroke Center – Planning and implementing best practice care for stroke treatment		
End Violence Against Women-Renfrew County	Violence Against Women (VAW) Services Provider collaboration to improve connections and resources for local victims of Domestic Violence/Sexual Assault	Yes	
French Language Services Committee	Inter-ministerial, multi sectorial MHA committee promoting FLS in Renfrew County	Yes	
GLAD Program	PRH, Hawkesbury, Glengarry, Montfort, Almonte, Queensway Carleton Hospital (QCH) regarding service delivery model for people who do not qualify for joint replacement surgery	Yes	
Going Home Program	LHIN funded program available in all areas of Renfrew County and provides up 14 days of support for individuals being discharged from hospital	Yes	Yes
Homelessness Prevention and Partnership Working Group	MHSRC, The Grind, Police, County - Meet to identify resources for the homeless population.	Yes	
Human Service Justice Local Committee (HSJCC) (Renfrew County, PRH/CMH is the Lead)	Phoenix Centre for Children and Youth, Upper Ottawa Valley (UOV), Renfrew, Killaloe Ontario Provincial Police (OPP), Ministry of Attorney General, Pembroke Regional Hospital, Elizabeth Fry, Legal Aid, Pathways Treatment Service, You Turn Youth Services, Algonquins of Pikwakanagan-Collaboration to support individuals with MHA (ABI and disabilities) involved with justice system	Yes	Yes
Integrated Renal Program Council	Regional Renal Program for Champlain to ensure standardization, provincial directions and new practices for renal patients	Yes	Yes
Integrated Virtual Walk in Partnership with the Jewish	Led by Phoenix and Arnprior Health Team. MHSRC, Family Health Teams (i.e.) West Champlain Family Health Team (WCFHT),	Yes	

Family Services in Ottawa	Phoenix, Community Mental Health, Pathways and Addictions Treatment Services offer staff to provide e-walk in clinics (intake and brief counselling)		
Mobile Crisis Response Team	OPP and MHSRC- Memorandum of Understanding (MOU) to provide services to prevent ED visits and hospital admissions for MHA	Yes	Yes
Moving On Mental Health (MOMH)	Phoenix lead – All County sectors represented including social, health, legal, education, etc.- education, collaboration, public awareness.	Yes	
Non Urgent Transportation	EMS and area hospitals – collaboration re strategies for cost effective transportation of patients	Yes	
PRH Cardiac Rehab Program	Satellite of the Ottawa Heart Institute Cardiac Rehab Program, accepts patients from across the County, works with Whitewater Bromley Community Health Centre (WBCHC) on providing virtual cardiac rehab care	Yes	
Primary Care Pathways	Local Physicians, Phoenix Center, MHSRC, Addictions Treatment Services collaborative to improve MHA pathways to care	Yes	
Renfrew County Active Aging Network	Public Health, several HSP and SS, planning and implementing strategies for well being of seniors	Yes	
R.C.A.T.S. + Renfrew County Addiction and Mental Health Committee	Addictions Treatment Service, MHSRC, Phoenix Center, Pikwakanagan Mental Health Services and Pathways collaborative to align/integrate and address service gaps	Yes	
Renfrew County Children's Coordinated Access Committee (RCCCAC)	School boards, Phoenix Center, Bernadette McCann House (BMH), Youth probation and Parole Services, Columbus House, Addictions Treatment Services sponsored by RVH, and Family & Children Services (FCS) collaborative to aid schools and parents / students access section 23 classroom placements, suggest local resources, review	Yes	

	complex special needs cases		
Renfrew County Community Support Service Providers	Representative of agencies providing CSS services within Renfrew County and area	Yes	Yes
Renfrew County Diabetes Network Steering Committee	Collaborative composed of PRH, RVH, DRDH, WBCHC, Pikwakanagan, EMS, Access Health Care, PCFHT, Mulvihill, LTC, SFMH, Renfrew County District Health Unit (RCDHU)	Yes	Yes
RC LTC Administrators Group	Information sharing across region LTC homes	Yes	Yes
Renfrew County Palliative Care Program	Collaborative of HCC, Hospice Renfrew and SFMH, Bruyere specialized treatment team, physicians, Carefor, Marianhill, PRH	Yes	Yes
Renfrew County Telemedicine Committee	Collaborative of PRH, DRDH, RVH, SFMH, Marianhill, SEOCHC,WBCHC , PCFHT, WCFHT, County fo Renfrew, TOH, OTN		
Regional Dialysis Program	RVH provides Dialysis Services at Satellite Clinics at PRH and SFMH	Yes	Yes
Regional Geriatric Day Hospital	County wide Geriatric Day Hospital Service that operates at two sites - RVH and PRH - with one team that travels between the two sites	Yes	
Regional Patient Flow Committee	All hospitals in Champlain have met since onset of pandemic to plan regional patient flow	Yes	Yes
Regional Trauma Network	All hospitals in Champlain with ERs meet to review trauma best care for patients.	Yes	Yes
Response to Elder Abuse Prevention and Awareness Coalition	Sharing of best practices to eliminate elder abuse	Yes	
Safe Shelter for Youth	Collaboration between FCS, Phoenix Centre, Columbus House to provide emergency housing and support for youth under 18 years of age	Yes	

Situation Table	Collaborative of Police, School Boards, Phoenix Centre, Probation and Parole, Addictions Services, Regional Assault Program, County of Renfrew Paramedics Service, Family and Children's Services, Bernadette McCann House	Yes	
Violence Against Women Collaborative	Involves FCS, BMH, MHSRC	Yes	
Violence Threat Risk Advisory Committee	Formal collaboration made up of School Boards, MHA Services, Police, Family & Children Services (FCS), Probation and Parole, You Turn	Yes	
Well Baby Program	PH and PRH working together to implement best practices for well babies	Yes	
Young Parent Support Network	Columbus House, St. Mary's Home, Youville Centre, Emily Murphy Non-Profit Housing, Salvation Army Bethany Hope Centre – Ottawa agencies and Columbus House supporting pregnant and parenting youth	Yes	

Local Community Network Collaborations			
Name of Network	**Purpose / Description**	**County-Wide**	**Link to Champlain or Provincial Network**
Algonquins of Pikwakanagan Family Health Team	Cultural Competence and Indigenous Cultural Safety training for partner agencies.		
Barry's Bay and Area Senior Citizens Home Support Services	Shared governance with MV Hospice and		

	Palliative Care. Shared site with SFMH and Madawaska Valley Family Health Team (MV FHT). Supported by SFMH housekeeping, Information Technology (IT), maintenance.		
Champlain Gardens Retirement Home	Hosts RC Paramedic mobile clinic. Hosts Adult Day program in collaboration with Valley Manor LTC.		
Child Poverty Action Network	Hosted by Phoenix Centre, through support from over 100 agencies organizations and 400 members practical assistance is provided to children and youth who are living in poverty in Renfrew County.	Yes	

Champlain Local Health Integration Network (LHIN) Collaboration			
Name of Network	**Purpose / Description**	**County-Wide**	**Link to Champlain or Provincial Network**
Champlain Addictions Coordinating Body (CACB)	CACB meets to discuss issues and to try to align to fill gaps in services	Yes	Yes
Chief Executive Officer (CEO) Leadership Forum	All CEOs in Champlain meet regularly		
Champlain Centre for Healthcare Ethics Regional Committee	Hospitals in Champlain LHIN that belong to this include Renfrew Victoria Hospital (RVH) /St. Francis Memorial Hospital (SFMH); discuss ethical issues, plan education and regional ethics rounds		Yes
Champlain Community Service Network (CCSN)	A network of Champlain Community Support Service agencies for information and resource sharing and to collaborate in the planning of community support services	Yes	Yes
Champlain Community Transportation Consortium (CCTC)	Provide non-urgent transportation to medical appointments for vulnerable low-	Yes	Yes

	income seniors, and those with disabilities - collaboration among Community Support Services (CSS) agencies across the region		
Champlain Community Support Network (CCSN)	Representative of CSS service providers across Champlain and linked to CSS provider groups in Renfrew County, Ottawa, and Eastern Counties	Yes	Yes
Champlain Critical Care Network	All hospitals in Champlain with Intensive Care Unit		Yes
Champlain Dementia Network	Implementation of the regional dementia strategy including a range of OHT members e.g. Dementia Society of Ottawa and Renfrew County	Yes	Yes
Champlain Elder Abuse Consultation Team	Consultation with expert service providers on complex Elder Abuse cases		Yes
Champlain Medical Assistance in Dying (MAID) Steering Committee	Involves leads from all Champlain hospitals		Yes

Champlain Emergency Services Network	All hospital in Champlain with Emergency Medical Service (EMS) from all three Champlain Regions		Yes
Champlain GI Endoscopy Communities of Practice	RVH, Pembroke Regional Hospital (PRH), Ottawa Area Hospitals		Yes
Champlain Hospice Palliative Care Program (CHPCP)	Representation across the Champlain LHIN of hospice palliative care providers, linked to Ontario Palliative care network and to the Renfrew County Network.		Yes
Champlain Infection Control Group	Representatives from Acute Care, Long Term Care (LTC) and Retirement Homes (RH) to review best practices and align policies and protocols		Yes
Champlain LHIN Forum for Chief Nursing Executives	All hospitals in Champlain		Yes
Champlain LHIN Repatriation Working Group	All hospitals in Champlain, Home and Community Care (HCC)		Yes
Champlain LHIN Vision Steering Committee	RVH, PRH, Ottawa Area Hospitals		Yes

Champlain Maternal Newborn Regional Program	PRH, Ottawa Area Hospitals, Public Health (PH), HCC, Primary Care and Other		Yes
Champlain Orthopedic Bundled Steering Committee	All hospitals in Champlain that provide orthopedic services		
Champlain Region Diagnostic Imaging Work Group	All hospitals in Champlain meet monthly to align practices and make recommendations to Ontario Health (OH) regarding service distribution and service augmentation.		Yes
Champlain Regional Cancer Program Operations Committee	RVH, PRH and Ottawa Area Hospitals coming together to align practices in order to improve transitions in care for cancer patients		Yes
Champlain Regional Cancer Program Steering Committee	All service providers who provide cancer services meet regularly with the regional cancer centre to align practices and activities with the provincial strategic plan for cancer services and review performance.		Yes

Champlain Regional Fall Strategy	Collaborative with several Health Service Providers (HSP) to review national and international best practices in fall prevention.		Yes
Champlain Regional Inter-Hospital Services Planning (CRISP) Committee			Yes
Champlain Regional Orthopedic Network (CRON)			Yes
Champlain Regional Orthopedic Network Leadership Council	All hospitals in Champlain that provide orthopedic services.		Yes
Champlain Region Pathways Mental Health and Addiction	All MHA providers in Champlain and MOH re COVID-19 related issues	Yes	
Champlain Regional Stroke Network (Steering Committee) (CRSN)	Involves PRH and Ottawa Area hospitals, HCC, stroke specialists, primary care and EMS		Yes
Champlain Regional Surgical Oncology Committee	All hospitals in Champlain that provide cancer surgery		Yes
Champlain Sub-Acute Capacity Planning Executive Steering Committee	CEOS across the LHIN meet to review performance and implement subacute capacity plan		Yes

Champlain Sub-Acute Capacity Planning Steering Committee	All providers of subacute care (rehab and complex medical management) meet to develop best practices and build capacity in subacute care		Yes
Geriatric Emergency Management	All hospitals with Geriatric Emergency Medicine (GEM) programs		Yes
Integrated Rehabilitation Hubs Work Group	Project team with PRH and Bruyere that developed a new service delivery model for rehab services (project stalled due to COVID)		Yes
Kids Come First (OHT)	Children's Hospital of Eastern Ontario (CHEO) lead – Champlain-wide collaborative to improve paediatric mental health and addiction system		Yes
Kids Health Alliance	PRH, CHEO collaboration with Sick Kids and GTA community hospitals to provide improved care for children in ED		Yes
Local Primary Care Executive Director Network	Renfrew County group of Executive	Yes	Yes

	Directors (FHT & CHC)		
Memory Clinic	The Ottawa Hospital (TOH), ConnectWell, Petawawa Centennial Family Health Team (PCFHT), West Champlain Family Health Team (WCFHT)	Yes	Yes
MRI Central Intake	CEOs of hospitals with MRI services		
Ontario Health East Digital Health Advisory Council	RVH and PRH representation on this group		
Ontario Structured Psychotherapy (OSP)	Regional program	Yes	Yes
Ottawa LEAN Cluster Steering Committee	Four hospitals in Champlain that have implemented LEAN management principles as their business performance management system		Yes
Oversight Committee Regional Coordinated Access for Mental Health and Addictions (MH & A)	Representatives of MHA service providers in Champlain in collaboration to implement one number to call, one website to access in order to get access to MHA services (just started, very		Yes

	successful)		
Provincial Council for Maternal and Child Health	PRH with several Ottawa area hospitals and community providers		Yes
Response to Elder Abuse Prevention and Awareness Coalition (REAPAC) – Renfrew County	Elder Abuse consultation and capacity building to respond through education	Yes	Yes
Regional Acute Care Medicine Committee	All hospitals in Champlain		Yes
Regional Central Intake Steering Committee	All hospitals in Champlain		
Regional Emergency Standard of Care Committee	All hospitals in Champlain with EMS from all three Champlain Regions		
Regional Geriatric Advisory Committee	Representatives from various HSPs		Yes
Regional Geriatric Central Intake and Triage Steering Committee	Central intake for geriatric referrals in region		Yes
Regional Integrated Care for Complex patients (*Former Health Links*)	Champlain Sub Regional collaboration re implementation of coordinated care plans and new best practices for all care coordinators across the region		Yes
Regional Surgery Steering Committee - COVID	All hospitals in Champlain that provide surgical services		

Rehabilitation Advisory Committee	Representatives of HSP that provide general and specialized rehab services		Yes
RGAC Senior Friendly Hospital Steering Committee	Representatives from local senior friendly hospital committees to align work plans with the provincial framework		Yes
Total Joint Assessment Clinics	PRH, Cornwall, Montfort, TOH and Queensway Carleton Hospital (QCH) meet to review staffing, wait list, funding, align practices		
West Champlain Family Health Team (WCFHT)	Shared dietitian resources with other Family Health Teams (FHTs) in network	Yes	

Community Inclusion Project	Improving inclusion and bully prevention led by Phoenix Centre, a large collaborative of community agencies, municipal and public representation	Yes	
ConnectWell Community Health Healthier Communities Committee	Standing committee of ConnectWell Community Health – Renfrew County sites; initiates and co-ordinates activities and advocacy towards the achievement of common goals ConnectWell and community partners, consistent with the Strategic Directions of ConnectWell Community Health. West Champlain Family Health Team (WCFHT) offers *falls prevention* and *immunizations* in partnership with ConnectWell.	No	Yes
Eganville & District Seniors	Home Support and SALC	No	Yes
Homes for Special Care	Carefor and MHSRC – space a support for clients identified by MHSRC with specialized support from MHSRC- MOU.	Yes	
Hospice Renfrew		Yes	Yes
Infant Mental Health Working Group (MOMH)	A sub group of the Moving on Mental Health Planning Table led by Renfrew County Public Health	Yes	
Information Technology (IT) Support	PRH is providing IT support to Marianhill LTC, WCFHT, PCFHT		
Integrated Care for Complex Patients (*Former Health Links*)	PRH transition planner uses coordinated care plans with Primary Care, EMS, HCC and others to prevent ED visits and hospital admissions	Yes	
Killaloe Community Resource Centre	Collaborates with Rainbow Valley CHC on social programs. FCoordinates 211 services for region. Operates seniors' and youth programs in variety of municipal settings. St. Francis Memorial Hospital supports the CRC for IT services.		

Madawaska Communities Circle of Health	Health and social service spanning multiple sectors works collaboratively to wrap care around patients		
Madawaska Valley Family Health Team	On site as a tenant of SFMH. Supported by housekeeping, MDRD, IT, maintenance of SFMH. Physicians support hospital, Hospice, LTC (Valley Manor). Dietitian collaboration with SFMH Diabetes Education Program. Nurse Practitioner/ RPN/ MD collaboration with the Renfrew County Community Paramedics & Lung Health Program.		
Madawaska Valley Hospice Palliative Care	Located at the St. Francis Memorial Hospital (SFMH). Resident care supported by registered nurses of SFMH inpatient unit. PSW services to residents provided by SFMH. Housekeeping, maintenance IT supported by SFMH. Shared Board of Directors with Barry's Bay and Area Senior Citizens Home Support Services. Provides all of the MCCH agencies with volunteers, education, equipment to facilitate discharge, and clinical support including care planning.		
MHA Intake Community of Practice	Same intake and screening tools for intake workers at 16 county-wide MHA organizations		
Pembroke Family Medicine Teaching Unit	Program located and supported by PRH that provides training and support to family medicine residents and provides family physicians to all locations in Renfrew County		
PRH Fall Prevention Pilot Project	PRH and EMS pilot project to identify patients at high risk of falling and connect them with community paramedics on transition out of hospital		

Petawawa Centennial Family Health Centre	Family Health Team that collaborates with many partners on projects across the County		Yes
PICC Insertions	PRH provides support to DRDH and SFMH for Peripherally Inserted Central Catheter (PICC)		
Primary Care Geriatric Assessors	Aligned with the Regional Geriatric Program of Eastern Ontario for the Renfrew Victoria Hospital and the St. Francis Memorial Hospital		Yes
Procurement of Supplies	PRH supports DRDH, EMS, Carefor and Marianhill LTC with procurement services		
Radiology services	PRH provides radiology services to DRDH for Mammography and Ultrasound		
Renfrew County Anti-Human Trafficking Committee	Improving public education and services related to human trafficking victims. Led by VICARS.	Yes	
Renfrew Home Support and Drop-in SALC Centre	Home Support and SALC	No	Yes
Renfrew Victoria Hospital and St. Francis Memorial Hospital	Voluntary partnership since 1998. Multiple shared positions (CEO, CFO, IT Director, Director of Pharmacy, Shared risk/quality and safety, etc.)		
Senior Friendly Hospital Committee PRH	PH, HCC, ALS, PRH – Improving care for Seniors while inpatients and on transition		
South Algonquin Family Health Team	Provides a client meeting space for Renfrew County Community Mental Health Services		
St. Francis Memorial Hospital (SFMH) and Rainbow Valley Community Health Centre (CHC)	Rainbow Valley CHC governance shared with SFMH. Shared administration. Shared payroll, IT, housekeeping, maintenance, clinical oversight. Only CHC in the province administered by a hospital.		

St. Francis Valley Healthcare Foundation	Innovative collaboration for joint fundraising for SFMH, Valley Manor Long Term Care and MV Hospice and Palliative Care. Offices at SFMH and back office function support by SFMH. Precedent setting in the province.		
Telemedicine and Telederm Service	Telemedicine staff provide services at LTC and RH		
Timely Committee	Improving ED pathways from ED to Community agencies. Led by CHEO, Partners, with Pembroke Regional Hospital, Phoenix Centre, Community Mental Health Services, ATS, Pathways, Education.	Yes	
Transition House Pembroke	Local crisis shelter provided by The Grind with services from MHSRC – MOU.	Yes	
Valley Manor Long Term Care	Shared IT services with SFMH.		
Virtual Care Project	Over 50 regional partners supporting transition to virtual care for mental health and addiction agencies. Led by Phoenix Centre and partner with Champlain Mental Health and Addictions Pathways.	Yes	