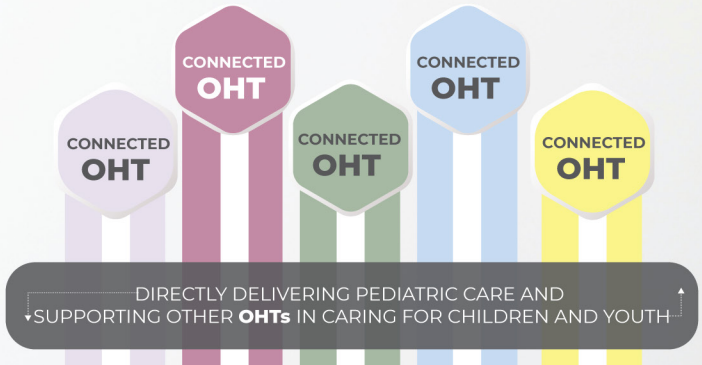
Ontario Health Team Full Application



Kids Come First
Health Team

Les Enfants Avant Tout
Équipe de Santé

Submission Date:
October 9

The “To be Named by Kids OHT - ESO Nommée par les Enfants”

HAS BEEN NAMED BY KIDS

Grade 1 student **Rémi Lamoureux, age 6,** suggested **“Kids Come First”** «Les enfants avant tout». He learned of the naming contest from his dad Michael, who was notified by their family physician, Dr. Lee Donohue at Your Health Votre Santé. Michael and Rémi, along with mom Désirée and brother Sacha brainstormed the family’s favourite and entered the naming contest.

We launched a naming contest in September to anyone under the age of 21. The contest was promoted through social media by our partners. Over 120 name suggestions were received and narrowed down to just three by a group of youth. Over 1,200 votes were cast and Rémi’s contest entry "Kids Come First" is the winner!

#NameOurOHT was a success!

We Are 61 Organizations

1,089 Physicians

2,535 Individuals commited to Youth Health

We will make Ontario's new OHT system work for kids

Connecting child and youth health services for better quality, faster access and easier transitions

Helping OHT's and primary care providers deliver `care to their pediatric patients and clients

We are unique

Only "innovative model" given the green light by the Ministry of Health to submit a Full Application

Based on THRIVE, Canada's first-ever regional child and youth health services capacity plan

Shifting from engagement with kids and families to true partnership and co-design

Committed to delivering care in both official languages

Driving digital health and virtual solutions to bring care closer to home

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Introduction

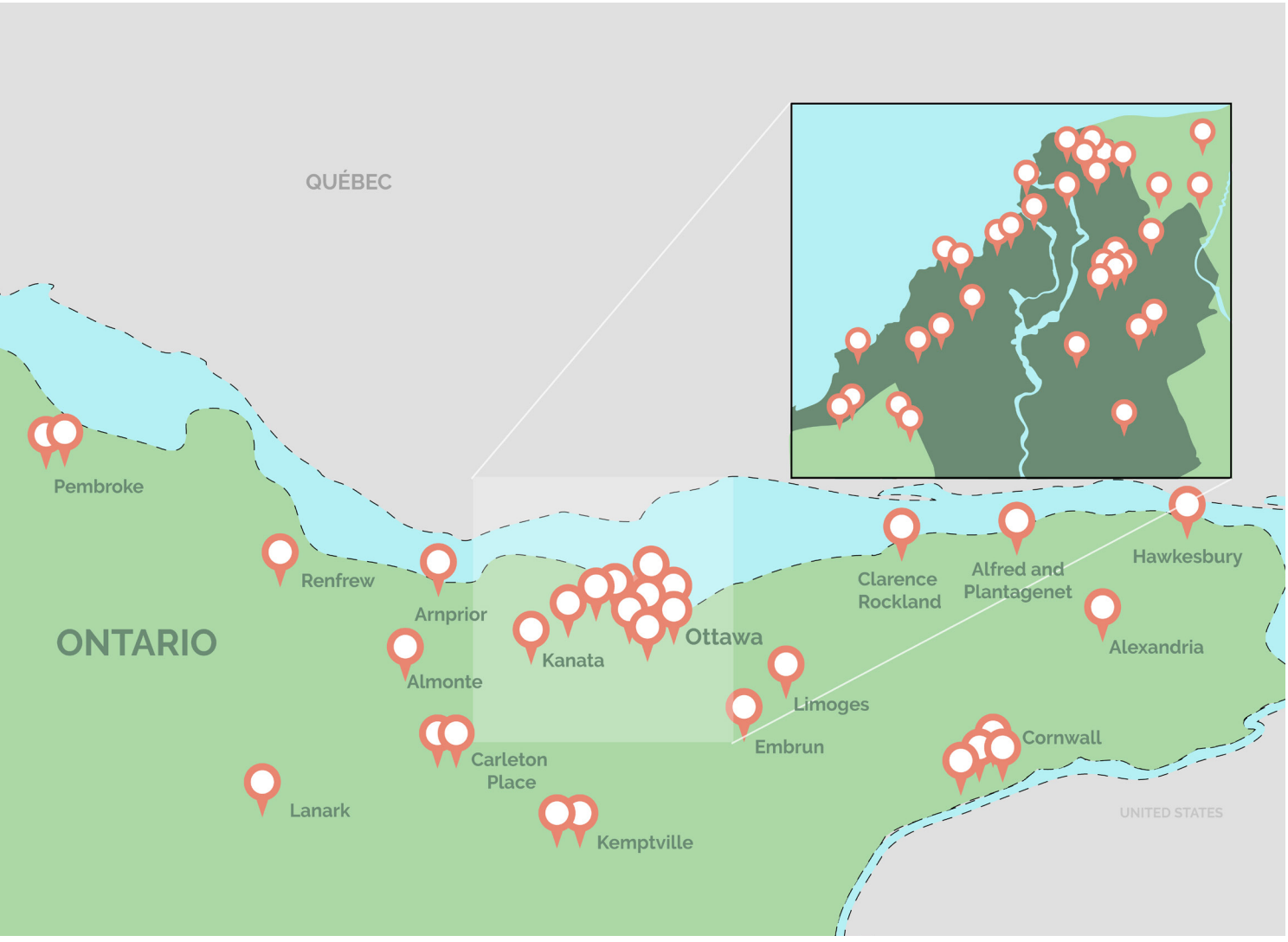
Ontario Health Teams will help to transform the provincial health care landscape. By building high-performing integrated care delivery systems across Ontario that provide seamless, fully coordinated care for patients, Ontario Health Teams will help achieve better outcomes for patients, improved population health, and better value for the province.

Based on the evaluation of Self-Assessment submissions, your team has been invited to submit a Full Application, which is the next stage of the Ontario Health Team Readiness Assessment process. In the Self-Assessment stage, your team collectively assessed its ability to meet the minimum readiness criteria to become an Ontario Health Team, as set out in 'Ontario Health Teams: Guidance for Health Care Providers and Organizations' (Guidance Document). This Full Application builds off the Self-Assessment. In this stage, your team is being asked to propose plans and provide detailed evidence of what you previously assessed that you could do.

This application form consists of seven sections and two appendices:

1. *About your population*
2. *About your team*
3. *How will you transform care?*
4. *How will your team work together?*
5. *How will your team learn and improve?*
6. *Implementation planning and risk analysis*
7. *Membership Approval*
8. *Appendix A: Home & Community Care*
9. *Appendix B: Digital Health*
10. *Appendix C: Tables*
11. *Appendix D: Commitment to Collaborate*

The Ontario government's Ontario Health Team process has led to the LARGEST mobilization of child and youth health providers and families in the history of Eastern Ontario! Our 61 partners organizations have come from all across our region and are laser focused on children and youth!



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Readiness Criteria

The form is designed to provide reviewers with a complete and comprehensive understanding of your team and its capabilities and capacity. The questions in this form are aligned to the eight components of the Ontario Health Team model and the corresponding minimum readiness criteria set out in the Guidance Document.

- *your ability to propose a plan, you are now asked to provide that plan;*
- *a commitment, you are asked to provide evidence of past actions aligned with that commitment; and*
- *a demonstrated track record or ability, you are asked to provide evidence of this ability.*

Please read and fully respond to the questions. Clear, specific responses and the use of verifiable examples and evidence are encouraged.

Note that a core component of the Ontario Health Team model is alignment with the Patient Declaration of Values for Ontario, as well as comprehensive community engagement. This form includes discrete questions related to patient partnership and community engagement, but your team is also encouraged to consider patient, family and caregiver perspectives and opportunities for patient partnership and community engagement throughout your submission.

The Readiness Assessment process will be repeated until full provincial scale is achieved. The first group of Ontario Health Team Candidates will help set the course for the model's implementation across the rest of the province. Although the core components of the model will remain in place over time, lessons learned by these initial teams will help to refine the model and implementation approach and will provide valuable information on how best to support subsequent teams. The first Ontario Health Team Candidates will be selected not only on the basis of their readiness and capacity to successfully execute the model as set out in the Guidance Document, but also their willingness to champion the model for the rest of the province.

Applications will be evaluated by third-party reviewers and the Ministry of Health (the Ministry or MOH) according to standard criteria that reflect the readiness and ability of teams to successfully implement the model and meet Year 1 expectations for Ontario Health Team Candidates, as set out in the Guidance Document.

Following evaluation of the Full Application there are two possible outcomes. Teams will either: 1) be invited to move to the final stage of evaluation, or 2) continue to work towards readiness as a team 'In Development'. Those teams that are evaluated as being most

[1] Stukel TA, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, Henry DA. Multispecialty physician networks in Ontario. Open Med. 2013 May 14;7(2):e40-55.

ready to move to the final stage of evaluation may also be invited to participate in community visits, which will then further inform the final selection of the first cohort of Ontario Health Team Candidates.

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

These networks reflect and respect the health care-seeking-behaviour of residents and describe the linkages among residents, physicians, and hospitals. An Ontario Health Team does not have to take any action for residents to be attributed to their Team. As per the ICES methodology.

- *Every Ontario resident is linked to their usual primary care provider;*
- *Every primary care physician is linked to the hospital where most of their patients are admitted for non-maternal medical care; and*
- *Every specialist is linked to the hospital where he or she performs the most inpatient services.*

Ontario residents are not attributed based on where they live, but rather on how they access care which is important to ensure current patient-provider partnerships are maintained. However, maps have been created to illustrate patient flow patterns and natural linkages between providers which will help inform discussions regarding ideal provider partnerships. While Ontario Health Teams will be responsible for the health outcomes and health care costs of the entire attributed population of one or more networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

To help you complete this application, your team will be provided information about your attributed population.

Based on resident access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams over time to finalize their Year 1 target populations and populations at maturity.

Participation in Central Program Evaluation

To inform rapid cycle learning, model refinement, and ongoing implementation, an independent evaluator will conduct a central program evaluation of Ontario Health Teams on behalf of the Ministry. This evaluation will focus on the development and implementation activities and outcomes achieved by Ontario Health Team Candidates and a selection of teams In Development. Teams are asked to indicate a contact person for evaluation purposes.

Key Contact Information

Primary Contact For This Application

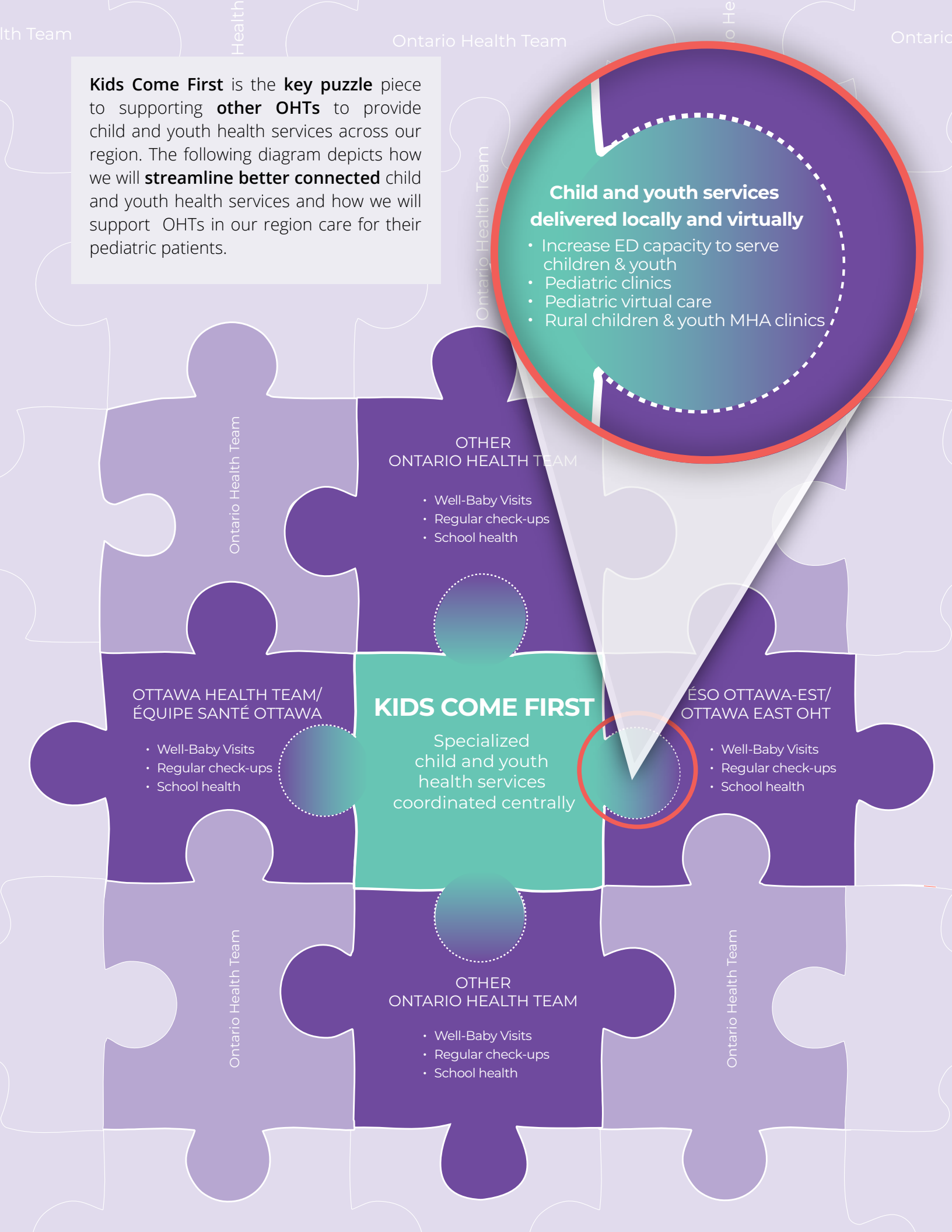
Alex Munter - CHEO
President & Chief Executive Officer | Président-directeur général
amunter@cheo.on.ca
Tel/Tél.: (613) 737-7600 | Fax/Télec.: (613) 738-4288

Claire Dawe-McCord
Full-time student and Youth Advisor
Co-Chair, Steering Committee, Kids Come First / Les Enfants Avant Tout
clairedawemccord@gmail.com

Contact For Central Program Evaluation

Jennifer Proulx - CHEO
Director, Integrated Care Delivery
jproulx@cheo.on.ca
Tel/Tél.: (613) 737-7600 x6103| Fax/Télec.: (613) 738-4288

Kids Come First is the **key puzzle** piece to supporting **other OHTs** to provide child and youth health services across our region. The following diagram depicts how we will **streamline better connected** child and youth health services and how we will support OHTs in our region care for their pediatric patients.



About Your Population

About Your Population

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

Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 populations and populations at maturity.

1.1 Who will you be accountable for at maturity?

Recall, at maturity, each Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a attributed population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

Your team will be provided with information about its attributed population based on most recent patient access and flow data. These data will include attributed population size, demographics, mortality rates, prevalence of health conditions, utilization of health services by sector, health care spending data, etc.

Also, recall that in your Self-Assessment, your team proposed a population to care for at maturity.

Please rate the degree of alignment between the population and service area that your team originally proposed during the Self-Assessment and your team's attributed population (high, moderate, low). Where alignment is moderate or low, please explain why your initial proposed population may have differed.

Considering given information about your attributed population and any other data sources you may have, what opportunities and challenges (both in Year 1 and longerterm) does your team foresee in serving and being accountable for your attributed population as you work towards maturity? In your response, reflect on whether your team has experience implementing a population health approach or if this is a competency that will need to be developed. Note: If there is discrepancy between the given information about your attributed population and data that your team has, please comment on the difference below.

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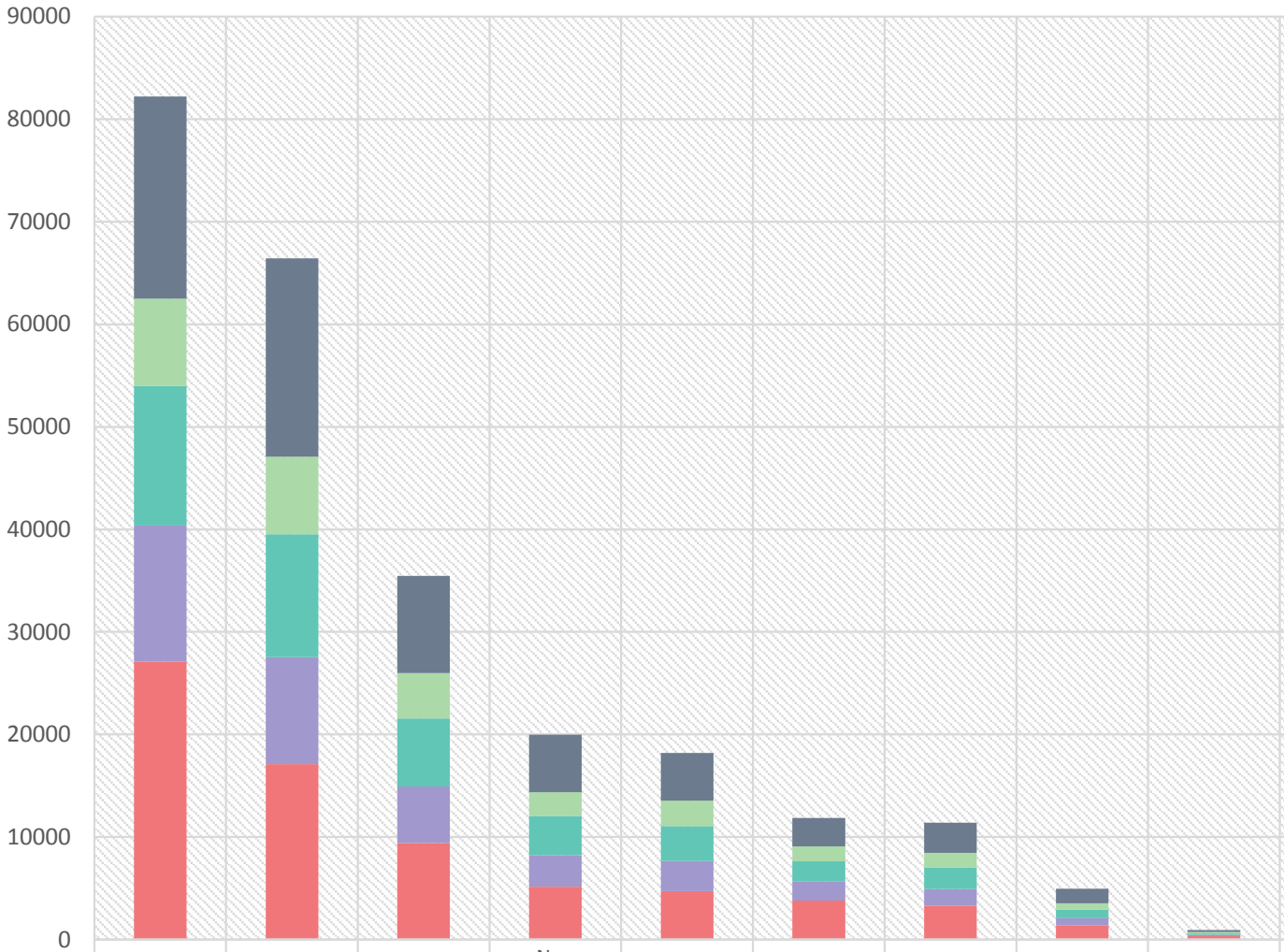
Regional Child and Youth Population Segmentations



	Healthy, Minor or No Conditions	Healthy, Moderate Acute without Hospitalization	Non Complex Static Chronic, without Acute Hospitalization	Non Complex Static Chronic, Mental and Developmental, w/o Hospitalization	Complex Chronic, without Life Limiting Diagnosis	Newborns & Neonates, Minor or No Acute	Complex Chronic, Life Limiting Diagnosis, Not Palliative	Major Acute without Acute Hospitalization, Life Limiting Diagnosis	Newborns & Neonates, Moderate Acute
Western Ottawa	19,737	19,329	9,471	5,590	4,659	2,760	2,959	1415	227
Western Champlain	8,510	7,554	4,430	2,327	2,448	1,469	1,412	623	121
Eastern Ottawa	13,579	12,004	6,611	3,819	3,425	1,963	2,101	810	123
Eastern Champlain	13,273	10,437	5,525	3,058	2,939	1,845	1,637	694	142
Central Ottawa	27,123	17,095	9,419	5,169	4,718	3,809	3,299	1,406	332

The **Kid's Come First** region's **254,000 children** and youth were assigned one of 19 clinical segments. The child and youth population were also segmented by demographic, geographic, and social determinants of health. The segments were used to measure and report regional variations in population morbidity, access, outcomes, and resource needs. The table above shows the segments along with the number of children and youth in each segment by subregion (THRIVE Report).

Non Complex Static Chronic, with Non Major Acute Hospitalization	Moderate Acute with Hospitalization	Newborns & Neonates, Major Acute	Non Complex Static Chronic, Mental and Developmental, with Hospitalization	Complex Chronic, Life Limiting Diagnosis, Palliative	Non Complex Static Chronic, with Major Acute Hospitalization	Major Acute without Acute Hospitalization, without Life Limiting Diagnosis	Major Acute with Acute Hospitalization, Life Limiting Diagnosis	Major Acute with Acute Hospitalization, without Life Limiting Diagnosis	Minor Acute with Hospitalization Limiting Diagnosis
93	146	56	60	53	36	29	9	5	1
59	61	41	32	29	26	33	11	0	4
101	77	39	50	42	29	22	10	1	3
120	149	31	46	34	35	38	20	6	5
150	131	105	76	70	42	34	29	4	2

1.1 Who will you be accountable for at maturity?

- At maturity, the **Kids Come First Team** will ensure every child and youth in the Champlain Region has access to comprehensive child and youth health services by: (1) Better connecting a currently-fragmented, difficult-to-access child and youth health system; and (2) Providing family physicians, other providers and the region's lifespan OHT's the supports they need to care for pediatric patients and clients.

- Data-driven and built by youth, families and providers, our Full Application is highly aligned to our Self-Assessment. Work on what has become an Ontario Health Team proposal began in 2016 when hundreds of children, youth, family and providers came together to produce THRIVE, Canada's first-ever pediatric health services capacity plan. THRIVE outlined the child and youth population's current health needs against a poorly navigable system of service silos, gaps in access and quality and challenges with transition.

- Our Kids Come First Team is the most significant mobilization of providers and organizations serving children and youth in our region's history. Beyond MOHLTC funding, it includes partners who also receive funding from the Ministry of Children, Community and Social Services, Ministry of Education, local municipalities and/or philanthropy. Our immediate focus will be children and youth with mental health needs, addictions and medical complexity.

- Children and youth are unique. Compared to adults, they must grow and develop, they suffer from different illnesses, have a different experience of mental health and addictions, rely on a wider range of providers, have parents/guardians who co-manage their care, and most attend day care or school.

- When children are sick, families and providers often do not know where to go or how to access services, becoming frustrated by an uncoordinated care system. This impacts quality and outcomes.

- There are significant geographic disparities in access in our region - families in rural areas often struggle to access appropriate child and youth health services and vulnerable populations tend be proportionately younger than the general population.

- Our Kids Come First Team addresses these challenges: bringing together everything kids need, organized around kids, and delivered by child and youth experts and those committed to their well-being.

Opportunities and Challenges

- Specialized child and youth health services (hospitals, home care, child and youth mental health, rehabilitation, developmental services, etc.) operate at a much smaller scale than comparable services for adults. This creates risks to quality and access when these services are fragmented. This also creates the opportunity to use our team to create the scale required to increase reach, quality and efficiency.

- Many non-specialized providers of care for kids (family physicians, general hospitals, community health centres, etc) indicate a lack of evidence-based support and structured clinical pathways for the children and youth they serve. Our team will help them provide care closer to home and equip them to achieve their goal of meeting more of their youngest patients' needs.

- In its initial work, our Kids Come First Team will produce tangible, meaningful improvements to quality and access for our region's families and for all providers who care for them. Our collective will:

    - Partner with families by embedding a co-designed patient/family experience measurement, reporting strategy and accountability framework for continuous quality improvement. We will not just say we partner, we will measure the effectiveness of doing so.

    - Establish a fully-integrated pediatric home care program, focused on the needs of patients and families, and connecting care and providers across acute, post-acute, home and community settings.

    - Establish an interconnected regional child and youth mental health system across the continuum of care by linking together the services of our specialized child and youth mental health providers. This will include one call/one click access for youth, families and primary care providers as well as co-ordinated care for children and youth with complex mental health and/or addiction needs who are often either at severe or imminent risk of suicide, self harm or harm to others and whose needs are not being met by the current system. These children and youth typically have chronic mental health disorders, with complicating factors like substance use/addictions, a concurrent developmental disorder, involvement with child-welfare system etc

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- Increase access to in-person, culturally relevant, specialized services for families living in rural areas.
- Implement digital solutions to allow families to self-schedule and get care from a location and time of their choosing, access their health records, and submit Patient Reported Outcome Measures (PROMs) data. Families can stay where they are, freeing up time and resources, and making impacts faster.
- Simplify and declutter the transition from child and youth health services to the adult system, in partnership with other OHT's.
- Address the needs of Francophone children and youth by developing a data-driven, population-specific strategy led by Franco-Ontarian providers, young people and organizations. This work has already started.
- Address the needs of Indigenous children and youth by developing a data-driven, population-specific strategy led by Indigenous providers, young people and organizations. This work has already started.
- Help Francophone children, youth and their families by providing prompt and direct access to French language services and culturally appropriate care throughout the care continuum (e.g. prevention, intervention, and specialist).
- Increase access to specialists and increase care closer to home through enhanced use of Telemedicine, eConsult, and eReferral.
- Help primary care providers and community pediatricians be more effective and efficient: they will know who to call, for what, and when, to support their children and youth.
- Ensure adequate consultation and linkages with indigenous communities (FNIM) and Indigenous service provision organizations to improve access to care for Indigenous children, youth, and their families.

Population Health

- Our collective of youth, families and providers has taken a population health approach to the needs of children and youth. We have mobilized specialized child and youth health organizations and providers as well as health care generalist providers. We have also included many entities whose work is fundamental to the well-being of children (including public health, housing, child welfare, social care and education – to name just a few). Many of these are venues for the delivery of care and all are significant contributors to the social determinants of health. This coalition of individuals and organizations understands that a population health approach is the glue that should hold together individual health care transactions.

1.2 Who will you focus on in Year 1?

Over time, Ontario Health Teams will work to provide care to their entire attributed population; however, to help focus initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

To support the identification of Year 1 areas of focus, you will be provided with information about your attributed population including health status and health care spending data.

Describe the proposed population that your team would focus on in Year 1 and provide the rationale for why you've elected to focus on this population. Include any known data or estimates regarding the characteristics of this Year 1 population, including size and demographics, costs and cost drivers, specific health care needs, health status (e.g., disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

If this Year 1 population differs from the one you proposed in your Self-Assessment, please provide an explanation.

Our Year 1 Patient Population

In our team's first year we would focus on the 50,052 children and youth identified in THRIVE with mental health /addictions and children with complex/palliative care needs in the Champlain region.

Mental Health & Addictions

In Ontario, 20% of children and youth are effected by an incidence of mental health. There has been a 53% increase in the number of CHEO Emergency Department mental health visiting in the past four years in which suicidal ideation or suicide attempt was the primary diagnosis.

Every $1 spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.

27% of youth in mental health crisis who seek treatment at CHEO's Emergency Department return within 6 months. They need better connected care.

Investments in child and youth health, wellness, and education pay countless dividends. It is estimated that every $1 spent in early childhood saves up to $9 in future spending on health, social and justice services.

Complex & Palliative Care

There are 17% more children with complex chronic disease living in high risk neighborhoods, relative to low risk neighborhoods. These children had 22% more hospital inpatient day than expected.

Child and youth with complex-care needs are very different and require a higher intensity of allied health and nursing services than senior clients in addition to separate home care strategies and deliver models.

23% of the total patient population makes up 68% of the hospital activity

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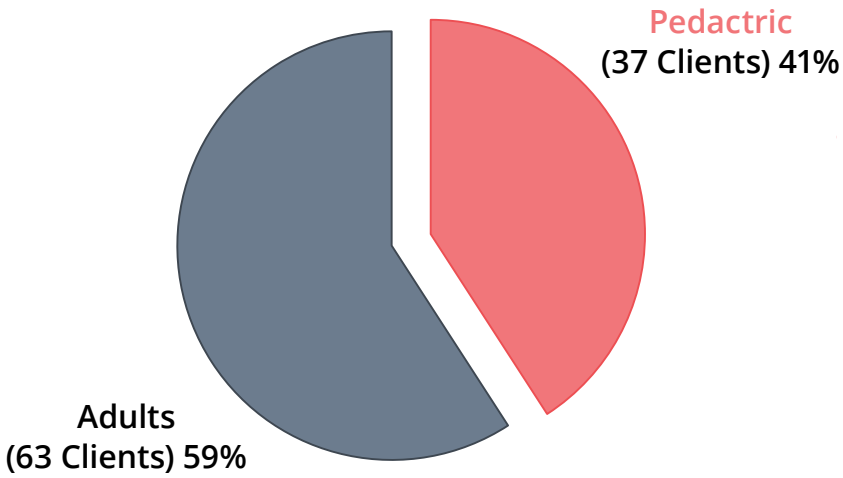
Children and Youth with Medical Complexity

The following table shows how resource use varies by child and youth population segment. For example, although the 228 children and youth in the "Complex Chronic, Life Limiting Diagnosis, Palliative" segment represent only 0.1 % of the LHIN's child and youth population, they account for 6% of hospital admissions and 18 % of home care costs. The average home care expenses for children and youth in that group was $20,400 and the average hospital expense was $13,500. Measuring resource need variations by segment is important for resource allocation because it can quantify need differences across sub-regions that are associated with morbidity.

The **Kid's Come First** regions' **254,000 children** and youth were assigned one of 19 clinical segments. The child and youth population were also segmented along demographic, geographic, and social determinants of health axes. The segments were used to measure and report regional variations in population morbidity, access, outcomes, and resource needs. The table above shows the segments along with the number of children and youth in each segment by subregion (THRIVE Report).

*Top **100 highest cost home care clients** in the region over the past 12 months*



	Share of Population Resources					*Cost Per Person*			
Pediatric Segment	*Champlain Children & Youth*	*Percent of Child & Youth Population*	*Physician Services*	*ED Visits*	*Hospital Admiss-ions**	*Home Care Costs*	*OCTC Serv-ices*	*Acute Inpa-tient*	*Home Care*
Complex Chronic, Life Limiting Diagnosis, Palliative	228	0.1%	2%	0.4%	6%	18%	9%	$13,523	$20,400
Complex Chronic, Life Limiting Diagnosis, Not Palliative	11,408	4%	11%	11%	36%	30%	35%	$1,914	$400
Complex Chronic, without Life Limiting Diagnosis	18,189	7%	13%	14%	22%	16%	29%	$507	$200
Non Complex Static Chronic, Mental and Developmental, with Hospitalization	264	0.1%	0.4%	1%	6%	1%	0%	$9,129	$400
Non Complex Static Chronic, Mental and Developmental, without Hospitalization	19,963	8%	9%	7%	0%	13%	23%		$100
Non Complex Static Chronic, with Major Acute Hospitalization	168	0.1%	0%	0%	4%	0.02%	0%	$5,070	$20
Non Complex Static Chronic, with Non Major Acute Hospitalization	523	0.2%	1%	1%	11%	0.1%	0%	$4,152	$40
Non Complex Static Chronic, without Acute Hospitalization	35,456	14%	15%	18%	0%	7%	3%		$30
Major Acute with Acute Hospitalization, Life Limiting Diagnosis	79	0.03%	0.1%	0.2%	1.7%	0%	0%	$4,838	$10
Major Acute with Acute Hospitalization, without Life Limiting Diagnosis	16	0.01%	0.01%	0.03%	0.3%	0%	0%	$5,206	
Moderate Acute with Hospitalization	564	0.2%	1%	1%	12%	0.1%	0%	$4,252	$20
Minor Acute with Hospitalization	15	0.01%	0%	0.02%	0.3%	0.0%	0%	$2,400	
Major Acute without Acute Hospitalization, Life Limiting Diagnosis	4,948	2%	3%	4%	0%	0.3%	0%		$10
Major Acute without Acute Hospitalization, without Life Limiting Diagnosis	156	0.1%	0.1%	0.1%	0%	0.03%	0%		$30
Healthy, Moderate Acute without Hospitalization	66,419	26%	23%	26%	0%	7%	0%		$20
Healthy, Minor or No Conditions	82,517	32%	11%	10%	0%	6%	0%		$10
Newborns & Neonates, Major Acute	272	0.1%	1%	0.2%	501	1%	0%	$84,800	$600
Newborns & Neonates, Moderate Acute	945	0.4%	1%	1%	1,286	0.4%	0%	$9,600	$100
Newborns & Neonates, Minor or No Acute	11,846	5%	9%	5%	12,701	0.3%	0%	$1,700	$4
Total	**253,976**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**$400**	**$100**

*shares exclude newborn and neonate hospitalizations

  - The Champlain region has the 4th fastest expected child and youth population growth in Ontario. It is anticipated to increase by 21% over the next 20 years. An OHT focused on children and youth will ensure that providers across our region are equipped and supported to provide the care kids need and that kids and families have access to the services they need.

- As identified in the THRIVE report, **children and youth with mental health and addictions and those with medical complexity have the highest care needs.** These children and youth will be our focus for Year 1. Across our region there are 50,052 children and youth with complex/palliative care needs, or with mental health and addictions. In addition, nearly 50% of all Francophone children and youth in Ontario live in the Champlain region and they, along with Indigenous children and youth in our communities, are at high risk for unmet care needs.

- Today, it can be overwhelming for parents/caregivers and physicians to navigate the current system and they carry the burden and frustration of not knowing who to call, what services are available, or how to access them. Kids come First will change this so that parents/caregivers, family physicians, and community pediatricians, can access services through one number to call or one link to click, anytime, anywhere. Our vision is that parents/caregivers no longer need to be care coordinators or case managers but rather able to spend more time with their children and families. Physicians will be able to spend their time on what matters most – seeing children and youth – not trying to figure out a complex service system.

- Our team will establish interoperability amongst our partners to improve the care provided to children and youth with mental health and addictions and for those with medically complex needs.

- Kids come First will improve access to care, including specialists, and increase care closer to home through rural sites of service and by enhancing the use of Telemedicine, eConsult, and eReferral. We will increase access to in-person, culturally relevant, specialized services for families living in rural areas. We will ensure adequate consultation and linkages with Indigenous communities (First Nation, Inuit, Métis) and Indigenous service provision organizations to improve access to care for Indigenous children, youth, and their families. We will help Francophone children and youth and their families by providing prompt and direct access to French language services and culturally appropriate care throughout the care continuum (e.g. prevention, intervention, and specialist)

Year One Priority Population:

Children and youth with mental health and addictions:

- The current health care system often fails to meet the needs of children and youth with complex mental health and/or addiction needs who are often either at severe or imminent risk of suicide, self-harm or harm to others. The system's current gaps result in children and youth having to access services repeatedly, often with poor outcomes. Due to insufficient supports being in place in the community, they are seeking help by visiting emergency departments which compounds the pressures associated with high occupancy and longer wait times. Over the last four years, there has been a 53% increase in the CHEO Emergency Department mental health visits of children and youth with suicidal ideation or suicide attempt.

Children and youth with medically complex needs:

- There are approximately 6,200 children and youth across the Champlain region that depend upon home and community care services. The 5,500 kids who require school-based physiotherapy, occupational therapy and other rehabilitation services have their care co-ordinated by CHEO. The remaining 700 children have the most medically complex needs, represent approximately half the pediatric home and community care budget and receive services from specialized home care service provider organizations. All of these 700 hundred children and youth also receive specialty and rehabilitative services at CHEO. Currently, 68% of acute care activity at CHEO comprises the care provided to children with complex medical needs. There are 17% more children with complex chronic diseases living in high risk neighborhoods, relative to low risk neighborhoods, and these children had 22% more hospital inpatient days than expected. In partnership with our Kids Come First, Community Health Centres (CHCs) have the expertise to help address this disparity.

- By focusing on these children and youth in Year 1, we will be able to improve the care journey and experience while also reducing the system-level strain and pressure that we see today. We will do this by establishing a fully-integrated pediatric home care program, focused on the needs of patients and families, and connecting care and providers across acute, post-acute, home and community settings. We will remove the burden of the care coordinator role that parents/caregivers and physicians are fulfilling and ensure that parents have confidence in the care. An aim of this program would be to help to shift care closer to home for our complex care population.

Measuring Our Collective Impact

- We will measure and monitor our collective impact for children and youth with mental health and addictions and those with medically complex needs through the following system performance metrics:

- **Access to care** (e.g. wait times across the continuum — emergency departments, specialist appointments, home care, community programs, alternate level of care status due to lack of appropriate home or community care, etc.)

- **Effectiveness of care** (e.g. avoidable emergency department visits; avoidable hospital visits; decreased length of stay; child, youth and family reported outcome measures (PROMs)

- **Experience of care** (e.g. child, youth and family reported experience measures, as well as the experience of family physicians and community based pediatricians.

- **Equity of care:** (e.g. stratify outcomes by key demographic variables of interest such as ethnicity, culture, language, neighborhood, etc.)

BEFORE and AFTER

Amira is a 4 month old baby girl with medically complex needs

Right Now: Amira was discharged home from hospital late Friday afternoon. The home care nurse arrived on Saturday and had limited knowledge of the careplan. Amira's parents told the nurse about their daughter's care needs, including what medications she was taking. The nurse completed her shift and reported to her supervisor that she wasn't comfortable returning because she wasn't used to providing care to babies with medically complex needs. The home care organization called to say they were looking for another nurse.... Amira's parents hung up feeling anxious about what was going to happen.

Kids Come First: Four days before Amira's planned discharge from hospital, her parents, the hospital care team and the home care nursing staff held a care meeting at the hospital to review her care plan together. Once Amira was home, her home care nurse, who had previously participated in Kids Come First pediatric skills sessions, arrived as expected and had electronic access to the care plan that they had reviewed together during the care meeting. The nurse completed her shift and let Amira's parents know that she would return at the same time tomorrow. Amira's parents felt reassured knowing that their daughter's care needs were in good hands.

Drawn by: Aryin age 13

1.3. Are there specific equity considerations within your population?

Certain population groups may experience poorer health outcomes due to sociodemographic factors (e.g., Indigenous peoples, Francophone Ontarians, newcomers, low income, other marginalized or vulnerable populations, etc.). Please describe whether there are any particular population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

1. Indigenous Community

- Our team will would focus on Indigenous children and youth as a population within our mental health and addictions Year 1 population.

- Kids Come First is fully committed to work with Indigenous partners towards fulfilling the Ministry's expectations outlined in Bill 74, The People's Health Care Act as it relates to Indigenous health and continue meaningful engagement and consultation with Indigenous-led organizations, health leaders and communities in the region.

    - Please refer to section 3.7.1. for additional commitments and description of our Team's partnership with Indigenous-led organizations.

Current State Of Inequalities In Canada And The Region.

- Although Indigenous peoples are the most youthful and fast growing segment of Canada's population, they do not enjoy the same health outcomes as other Canadians.

- In the Champlain region on average, 4 in 10 Aboriginal people are under the age of 25.

- The birth rate is 1.5x higher for Indigenous women than other Canadian women.

- First Nations, Inuit, and Métis individuals, families, and communities experience a disproportionate burden of ill health compared to their non-Indigenous counterparts, including higher rates of infant mortality, unintentional injury and death, tuberculosis, obesity and diabetes, mental illness and suicide.

- The impact of poverty, food insecurity and unsafe or precarious housing were contributing factors to their mental health challenges or negatively affecting their journey towards a healthy and more balanced life.

- Too often, Aboriginal youth in our region, province, and country face inequities, and struggle to deal with the impacts of violence, racism, or drugs - some even consider taking their own lives.

Based on report from the Champlain region titled "My Life, My Wellbeing Aboriginal Youth Needs and Capacity Assessment Mental Health and Addictions in the Champlain LHIN," the results of the study demonstrate that the there is a high need for mental health and addiction services for Aboriginal youth:

- Rates of depression are almost 9x higher among Aboriginal youth compared to non-Aboriginal youth in Canada (55% vs 6.5%)
- Rates of suicidal ideation are more than 2x higher among Aboriginal youth compared to youth overall in Ottawa (16.4% vs 8%)
- Rates of reported anxiety are more than 2x higher among Aboriginal youth in Canada (58% vs 11% men and 19% women)
- 29% of youth reported symptoms consistent with substance dependence.
- A quarter of the youth reported they did not have a place to live that is safe and comfortable.
- Despite these statistics Indigenous youth use less mental health and addictions services than non-Aboriginal youth and reported that racism and disrespect were the main reasons they hesitated to access services.

2. Francophone Community

- Our team will serve the largest Francophone population in Ontario; representing 42.7% of all the province's Francophones.
- The official language minority percentage for francophones is more than **450% above the provincial average.**
- The existing data about our Year 1 population does not provide information about official languages sub-populations. This is a serious **data gap** that does not allow optimal service planning for this important subset of our Year 1 population.

- There is a sizeable **rural sub-group** within Champlain region. The Canadian Institute for Health Information data (May 2019) notes that the increase in access to hospital services by our Year 1 population is much sharper in urban areas, which might be indicative of the **barriers to access for rural children and youth** who lack access to affordable transportation or reliable Internet access and need to face higher costs and distances to access regional health services.

- The four Champlain child and youth mental health (CYMH) lead agencies, who cover many areas designated under the French Language Services Act (FLSA) note current challenges to offer the full range of mental health services in French to children and youth. Our Kids Come First team would provide opportunities to increase access to these sought-after resources.

- Children and youth identifying as **LGTBQ2S+** also face additional challenges in accessing care relevant to our Year 1 population.

- Year 1 population children **living in low socio-economic status families** are more vulnerable and likely to require services from our team, but face more barriers to accessing them.

- Children and youth **living in children's aid societies' extended care** are more likely to be part of our Year 1 population (OACAS, 2019).

- A majority of caregivers to children and youth involved with Children's Aid Societies (CAS) have identified that it is difficult for them to navigate the mental health service system to get their children the care they need.

Drawn by: Maryn age 4


About
Your Team

Team Composition

In this section, you are asked to describe the composition of your team, what services you are able to provide, the nature of your working relationships, and the approach you used to develop this submission.

Our Team

Our Team members!

1. Almonte General Hospital
2. Arnprior Regional Health
3. Bayshore HealthCare Ltd.
4. CanImmunize
5. Carleton Place & District Memorial Hospital
6. Carlington Community Health Centre
7. Centre de santé communautaire de l'Estrie
8. Centre des services communautaire Vanier
9. Centre of Excellence for Child and Youth Mental Health
10. Centre Psychosocial
11. Centretown Community Health Centre
12. Champlain Maternal Newborn Regional Program
13. Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre
14. Children's Aid Society
15. Children's Mental Health of Leeds & Grenville
16. Citizen Advocacy Ottawa
17. CommuniCare Therapy
18. Cornwall Community Hospital
19. Crossroads Children's Mental Health Centre
20. Dave Smith Youth Treatment Centre
21. Deep River & District Hospital
22. Eastern Ontario Regional Laboratory Association (EORLA)
23. Paramed - Extendicare
24. Family Services Ottawa
25. GEM HealthCare Services
26. Hawkesbury & District General Hospital
27. Hôpital Glengarry Memorial Hospital
28. Inuuqatigiit (formerly Ottawa Inuit Children's Centre)
29. Kemptville District Hospital
30. Lanark Renfrew Health & Community Services
31. Maison Fraternité
32. Open Doors for Lanark Children & Youth
33. Orléans-Cumberland Community Resource Centre
34. Ottawa Children's Coordinated Access and Referral to Services
35. Ottawa Child and Youth Initiative
36. Ottawa Community Housing Coporation
37. Ottawa Public Health
38. Ottawa Rotary Home
39. Pediadent
40. Pembroke Regional Hospital
41. Pinecrest-Queensway Community Health Centre
42. Parent's Lifeline of Eastern Ontario - (PLEO)
43. Rainbow Valley Community Health Centre
44. Renfrew Victoria Hospital
45. Rideauwood Addiction and Family Services

46. Roberts/Smart Centre
47. Roger Neilson House
48. Sandy Hill Community Health Centre
49. Seaway Valley Community Health Centre
50. Somerset West Community Health Centre
51. South East Ottawa Community Health Centre
52. Saint Elizabeth Health Care
53. St. Francis Memorial Hospital
54. St. Mary's Home
55. The Phoenix Centre for Children and Families
56. The Safehaven Project for Community Living
57. Valoris for Children and Adults of Prescott - Russell
58. Wabano Centre for Aboriginal Health
59. Winchester District Memorial Hsopital
60. Youth Services Bureau of Ottawa/Bureau de services à la jeunesse d'Ottawa
61. Centre Youville Centre

Our Family and youth Full Application Team members!

62. Amélie March
63. Angie Hamson
64. Bonnie Schryer
65. Christie Kopczyk
66. Cindy Manor
67. Claire Dawe-McCord
68. Denise Gilby
69. Erica Schumacher
70. Hilary Allen
71. Kate Stevens
72. Kimberley Waara
73. Kyle Humphrey
74. Laura Lea McPherson
75. Michelle March
76. Natasha Baechler
77. Rae-Anne Van de Lande
78. Shelby Brady-Dwornik
79. Stephanie Paravan
80. Troy Kopczyk

Our Pediatricians and Family Physician Team members!

81. Dr. Jane Liddle, Community Pediatrician
82. Dr. Sumeet Sadana, Community Pediatrician
83. Dr. Stephen Grodinsky, Community Pediatrician
84. Dr. Kathy Keely, Community Pediatrician
85. Dr. Mark Bialik, Community Pediatrician
86. Dr. Janina Milanska, Community Pediatrician
87. Dr. Julie Nault, Chief, Montfort Hospital Pediatric Group
88. 88. Dr. Andrzej Rochowski, Community Pediatrician
89. Dr. Jane Schuler, Montfort Hospital Pediatric Group
90. Dr. Kristian Goulet, Community Pediatrician
91. Dr. Hilary Myron, Montfort Hospital Pediatric Group
92. Dr. Sunita Nayar-Kingwell, Community Pediatrician
93. Dr. Erica Corsi, Montfort Hospital Pediatric Group
94. Dr. Kelley Zwicker, Community Pediatrician
95. Dr. Aarathi Sambasivan, Montfort Hospital Pediatric Group
96. Dr. Elham Farhadi, Community Pediatrician
97. Dr. Nicholas Dust, Montfort Hospital Pediatric Group
98. Dr. Corina Francu, Community

Pediatrician
99. Dr. Michael Saginur, Montfort Hospital Pediatric Group
100. Dr. William James, Community Pediatrician
101. Dr. Zave Chad, Community Pediatrician & Allergist
102. Dr. Judy van Stralen, Community Pediatrician
103. Dr. Alfred Sisto, Community Pediatrician
104. Dr. Fionnaula O'Kelly, Community Pediatrician
105. Dr. Maheen Ahmed, Community Pediatrician
106. Dr. Shawn Kelly, Community Pediatrician
107. Dr. Tobey Audcent, Community Pediatrician
108. Dr. Mary Ann Beimers, Community Pediatrician
109. Dr. Leigh Fraser-Roberts, CommunityPediatrician
110. Dr. Mahassen Ghobrial, Community Pediatrician
111. Dr. Jessica Gammon, Community Pediatrician
112. Dr. Fatemeh Kojori, Community Pediatrician
113. Dr. Genevieve Michaud, Community Pediatrician
114. Dr. Ilana Prehogan, Community Pediatrician
115. Dr. Tessia Falsetto, Community Pediatrician
116. Dr. Rob Laberge, Community Pediatrician
117. Dr. Joanna Jablonska, Community Pediatrician
118. Dr. Elizabeth Esselmont, Community Pediatrician
119. Dr. Karen Palayew, Community Pediatrician
120. Dr. Lauren Segal, Community Pediatrician
121. Dr. Irfan Moledina, Community Pediatrician
122. Dr. Fred Lapner, Community Pediatrician
123. Dr. Uday Chadha, Community Pediatrician
124. Dr. Therese Hodgson, Community Pediatrician
125. Dr. Aftab Shariff
126. Dr. Ciaran Duffy, Chair & Chief, Department of Pediatrics, University of Ottawa & CHEO
127. Dr. Claire Liddy, Chair, Department of Family Medicine, University of Ottawa
128. Dr. Alison Eyre, Family Physician, Centretown Community Health Centre
129. Dr. Jolanda Turley, Family Physician, Bruyere Family Health Team
130. Dr. Lee Donohue, Family Physician, Your Health -Votre Santé
131. Dr. Juan Bass, Chief, Department of Surgery, CHEO
132. Dr. Kathi Pajer, Chair & Chief, Department of Psychiatry, University of Ottawa & CHEO
133. Dr. Elka Miller, Chief, Department of Medical Imaging, CHEO
134. Dr. John Veinot, Chair & Chief, Department of Lab Medicine, University of Ottaw & CHEO
135. Dr. Gail Graham, Chief, Department of Genetics, CHEO
136. Dr. David Rosen Chief, Department of Anesthesiology and Pain Medicine, CHEO
137. Dr. Michael O'Connor, Chief, Department of Ophthalmology, CHEO

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

In this section, you are asked to describe the composition of your team, what services you are able to provide, the nature of your working relationships, and the approach you used to develop this submission.

Please complete the tables below identifying the proposed physicians, health care organizations, and other organizations (e.g., social services) that would be members of the proposed Ontario Health Team.

Note:

In Year 1, Ontario Health Team Candidates will have an agreement in place with the Ministry ouvtlining their responsibilities as a team, including service delivery and performance obligations. Organizations and individuals listed as Ontario Health Team members in tables 2.1.1 and 2.1.2 would be party to this agreement and are expected to deliver services as part of their team. If there are organizations who intend to collaborate or be affiliated with the Ontario Health Team in some way but would not be party to an agreement with the Ministry (e.g., they will provide endorsement or advice), they should be listed in section 2.5. Note that a Year 1 agreement between an Ontario Health Team Candidate and the Ministry is distinct from any existing accountability agreements or contracts that individual members may have in place.

Generally, physicians, health care organizations, and other organizations should only be members of one Ontario Health Team, unless a special circumstance applies (e.g., provincial organizations with local delivery arms, provincial and regional centres, specialist physicians who practice in multiple regions, etc.).

2.1.1. Indicate primary care physician or physician group members

Indicate primary care physician or physician group members

Note: If your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as members, please also list them and their specialty in this table. The information in this table will be used to assess primary care representation and capacity/coverage.

2.1.2. Indicate member organizations (not including physician(s)/ physician groups)

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

2.2. How did you identify and decide the members of your team?

Please describe the processes or strategies used to build your team's membership. Are there key members who are missing from your team at this point in time? Are there any challenges your team sees in moving forward with respect to membership? In your response, please reflect on whether your team is well positioned to care for your Year 1 and maturity populations. Identify any strategic advantages your team has in relation to the health and health care needs of your Year 1 and maturity populations.

- The Ontario Government's OHT process has led to the largest mobilization of child and youth health providers and families in the history of Eastern Ontario. We've built on the work that began in 2016 when hundreds of children, youth, family and providers came together to produce THRIVE, Canada's first-ever pediatric health services capacity plan. THRIVE outlined the child and youth population's current health needs against a poorly navigable system of fragmented service silos, gaps in access and quality, and challenges with transition.

- The Ministry's decision that ours is the only "Innovative Model" to proceed to Full Application has fuelled the momentum of THRIVE and other previous joint planning activities. In addition to the comprehensive list of partner organizations, practitioners and families that were previously involved, the opportunity to join the emerging OHT system has led to a region-wide effort to re-imagine how to better connect child and youth health services.

- While our May 15 self-assessment built on the strength and depth of existing networks, additional members have indicated their interest in joining the team, including pediatric clinicians and organizations, rural hospitals and social care organizations. Our collective is well positioned to take a population health approach to the well-being of children and youth.

- Our team consists of the key members who will deliver a full continuum of services to our Year 1 populations consisting of children and youth with mental health and addictions as well as medically complex children and youth.

- We will better connect child and youth health services and support all OHTs and all family physicians and community pediatricians in our region to care for their pediatric patients.

- Some of our members provide care to adults as well as children and youth; as such, they will need to be able to participate in our team as well as future OHTs in our region.

- Our team members are united by a relentless focus on the well-being of kids.

- Unprecedented in Ontario, providers, boards, and families who care about child and youth health have come together to submit this application. Beyond MOHLTC funding, it includes partners who also receive funding from the Ministry of Children, Community and Social Services, Ministry of Education, local municipalities and/or philanthropy.

- Organizations comprising Kids Come First have extensive experience in child, youth and family engagement/partnership. We can immediately leverage best practices, models and frameworks and do not have to lose any time developing this expertise from scratch.

- Recent joint planning includes the THRIVE pediatric capacity plan, special needs strategy, and the work accomplished through mental health system planning of lead agencies. Across our team, there are countless examples of virtual and distributed service delivery involving groups of our team's members. Many can be scaled up for broader impact.

- Kids Come First providers will work together to enhance transitions between child and youth age groups and from the child and youth to adult systems. A proactive transition process across the continuum will be co-created with youth and families and key stakeholders. Across our region we will engage and expand the use of care navigators and adult providers in these efforts, focusing on communicating the needs of soon-to-transition youth in order to better equip the adult providers to meet youths' shifting needs.

- The pediatric providers in Kids Come First, have worked for many years at reducing hospital costs by increasing community capacity and improving quality and access for families. We look forward to scaling up these kinds of initiatives by creating an integrated child and youth health system, through an integrated funding envelope, with shared savings reinvested to expand service offerings.

2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

2.4. How have the members of your team worked together previously?

Please describe how the members of your team have previously worked together in a formal capacity to advance integrated care, shared accountability, value-based health care, or population health (e.g., development of shared clinical pathways or shared patient care, participation in Health Links, Bundled Care, Rural Health Hubs; shared back office, joint procurement; targeted initiatives to improve health on a populationlevel scale or reducing health disparities).

As part of your response, identify specific initiatives or projects that illustrate the success of your teamwork. Include detail about project scale and scope (e.g., patient reach), intended outcomes and results achieved (including metrics), which team members were involved, and length of partnership. Note: information provided should be verifiable through documentation by request.

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the team who have never previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

- Our team includes over 60 partner organizations, all of whom have worked together on various initiatives aimed at improving the care of children, youth and families within and across different care domains, and through transition into adulthood.

- Past initiatives vary in the number of organizations involved, scope and impact, but are grounded in a strong commitment to streamline and integrate care through these partnerships. These initiatives, when replicated or scaled across the full pediatric health system of our team, provide an excellent starting point.

- The most notable examples of initiatives that clearly demonstrate the impact of partnership andintegrated care include:

- **The Champlain Complex Care Program** is an outstanding example of successful collaboration among six of our OHT partner organizations (CHEO, Champlain LHIN, Coordinated Access, Ottawa Rotary Home, Roger Neilson House, and Service Coordination Ottawa). The program has served over 200 children with significant medical complexity by providing care coordination, service advocacy, access to the right care in the right location at the right time, consolidated information and care plans that follow the patient, and peer support for parents and caregivers. The program has benefited from strong partnerships with parents helping to design the care for their own child but also the care and services of the program. As a result of the program, there has been a 23% reduction in emergency department visits, a 50% reduction in pediatric intensive care unit days, and a 75% reduction in days in hospital, with an estimated savings to the health system of $3.5M. Parents report very high satisfaction with the program and 95% of survey respondents felt that they had experienced improved care coordination as a result of participating in the program. As a result of the success of the Champlain Complex Care Program, a NP lead satellite program has been developed in conjunction with the Timmins and District Hospital, the North East Local Health Integration Network (NELHIN), and the Cochrane Temiskaming Children's Treatment Centre to serve children and families in that community.Specialists at CHEO conduct virtual visits with these patients and families along with local providers to help build knowledge and capacity outside the tertiary care centre while also helping families avoid long commutes for care.

- **The Bridges Program** is a unique collaboration born out of clinical need. Youth suffering with mental health issues were presenting to CHEO's Emergency Department in crisis and being admitted to the inpatient psychiatric unit for stabilization. As a result of the significant increase in the numbers of these teens presenting in crisis, inpatient care had evolved from a traditional model of lengthy hospitalization to allow time for both stabilization and treatment initiation to a much shorter stay of just a few days until they were no longer actively suicidal or in crisis. Longer-term treatment was to follow in the community, but increased demands in that care domain resulted in long waits for service. The youth would frequently fall back into crisis before treatment could start, repeating the cycle of emergency department visits and crisis inpatient admissions. Something was needed to bridge the transition between the two domains of care. In response, Youth Services Bureau, Ottawa Public Health, the Royal Ottawa Mental Health Centre and CHEO developed the Bridges Program. Following a crisis admission, youth and their families are admitted into the program while they await individual services from psychiatrists, psychologists, or psychotherapists aligned to various community programs. Participation in the Bridges Program involves attending group therapy and psychoeducation, helping the youth and their parents better cope with feelings of self-harm, anxiety, conflict and

stress. Since its inception in 2013, over 230 youth have completed the program, with an average length in program of 23 weeks. Through a formal evaluation, significant improvements in the youths' depression, anxiety, psychosocial stressor scores, as well as improvement in the parents' concern about psychosocial stressors, have been found. As well, youth in the program are much less likely to present to an emergency department with mental health concerns or need to be admitted, helping to take pressure off the system.

- The **Integrated Plans of Care** program connects cross-sectoral service providers from over 20 partner organizations with children and youth with complex needs and their families. The goal is to create coordinated care plans that focus on the strengths and needs of children, youth, and their families. Programming is committed to language and cultural sensitivity for priority populations (Francophone and Indigenous). For Inuit families, elders participate to ensure that care plans are culturally sensitive. Some guiding principles include the importance of care continuity, client decision-making, family engagement, holistic care plans and strong inter-agency dialogue.

- In conjunction with many of our partners, Centre Psychosocial offers the **Infant Mental Health Program** within the **Young Mothers programs (Programme jeunes parents) at the Youville Centre** for women 14 to 25 years of age who are pregnant or have a child or children and who wish to complete their High School studies. Support to young moms focuses on their future and the future of their children through holistic, trauma-informed programs addressing mental health and addictions, medical needs, attachment-based parenting, child development, and crisis intervention. At any given time, the centre is supporting 65 teen mothers and 55 children.

- **Roger Neilson House (RNH)**, an eight-bed **pediatric palliative care and respite centre**, offers several programs in conjunction with CHEO to support children, youth and their families with life-limiting conditions, or in grief following the loss of their child. RNH services include a transition program to support patients and families leaving the acute care hospital but needing more time to get acclimatized to the treatments, medications and equipment making up the heavy burden of care they will be providing to their child once they are back home. In October 2019, RNH will become integrated with CHEO's Epic electronic health record, streamlining the care and information exchange for these medically complex patients as they transition between inpatient and outpatient care at the acute hospital, respite care at RNH, and ongoing supportive care in the community.

- All of the lead community mental health agencies in the region have come together to do **common strategic planning**, in partnership with clients and their families. This has resulted in three priority areas of improvement: common intake/access approaches,

common care pathways, and an integrated crisis system. Regarding intake/access, four agencies are working together to implement the **Choice and Partnership Approach (CAPA)** model, which is a validated intake/wait-time management approach that engages clients and their families in decision-making. This initiative is helping to connect those in need with the right resources without theclient or family having to navigate different agencies and their offerings.

- The **Vanier Social Pediatric Hub** is a recent venture between CHEO, Montfort Hospital, Centre Psychosocial, Vanier Community Service Centre, Sandy Hill Community Health Centre, local schools and several other community partners. Located in one of Ottawa's poorest and most challenging neighborhoods, the hub provides a welcoming, culturally safe atmosphere where strength-based, trauma-informed, holistic, integrated health and social service care is provided to children, youth and their families. A significant proportion of the community is disadvantaged by poverty, addiction, violence, literacy, language and cultural barriers, newcomer status or a combination of these factors. Most referrals come from the school system, seeking help to address mental health, development and behavioral challenges, and social challenges such as housing and food stability. The comprehensive nature of care is helping to reduce sporadic care through the CHEO Emergency Department, assist in keeping kids healthy and thriving in school, and is making a long-term investment in these kids reaching their full potential.

- **Several home care service provider** organizations are partners in our team. They have provided care to children and youth across the region for years. Through our proposed pediatric Integrated Home and Community Care Strategy, these organizations will strengthen their partnership with hospitals, hospices and respite services to ensure that medically complex children and youth are supported with the comprehensive services they need at home. Through the partnership, we expect that both the capacity and expertise of pediatric home care providers will increase, allowing earlier, transition to home and step-down/step-up of care in the community.

- **Crossroads Children's Mental Health Centre** works with several partners and sectors outside of typical mental health providers to create a collaborative community focus around infant and early childhood mental health. This work is focused on treatment approaches, quality and performance as it relates to a system of coordinated and streamlined care yielding best possible outcomes for children and their families.

- **Ottawa Public Health - Healthy Baby/Healthy Child** initiative is operated in partnership with hospital Neonatal Intensive Care Unit and newborn nurseries. Public Health nurses perform screening visits with parents while they are still in the hospital following the birth of their child. When medical or social challenges are identified, follow-up home visits, community supports and services (provided by OPH or partner organizations) are

offered, helping to support the health, development and mental health of babies and their parents from the very start.

- The **Situation Table Project** at the **Cornwall Community Hospital Child and Youth Mental Health** program brings together multiple cross-sector stakeholders (police, youth justice, education, municipality, health, child welfare, addictions, mental health, etc.) to be more responsive to urgent needs identified around the most vulnerable children and youth. This has helped to efficiently connect children and youth who are acutely at elevated risk with the health and social supports they need. A similar approach to integration and partnership occurs in other geographic hubs throughout our region, including Open Doors for Lanark Children and Youth and the Phoenix Centre serving Renfrew county.

- **Rideauwood Addiction & Family Services** has partnered with Service Action to Recover (SAR), the local school boards, and several Community Health Centres in the region to offer a **Youth and Parent Rapid Access Opioid Team (ROAT)** to ensure that those identified as having an opioid addiction have immediate access to support, harm reduction, early intervention, and withdrawal management services. This is so important as waiting for these services leaves those with addiction to opioids at great risk of accidental death as well as further deterioration of their fragile health and social wellbeing.

- **Parents' Lifeline of Eastern Ontario (PLEO**) provides peer support and navigation assistance to parents of children and youth with mental health and addictions issues. In partnership with the **CHEO Emergency Department** and an implementation study of an integrated care pathway **(TIMELY)** helping to connect ED patients to the right community services, PLEO now receives referrals for all patients presenting with mental health and addictions. PLEO staff are able to connect with patients and parents within 24 hours or 7 days, depending on perceived urgency, to ensure a warm and supportive handoff to the community while the patient and family await additional services.

2.5. How well does your team's membership align to patient/ provider referral networks?

Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through this analysis, your team has been provided with information about which patient/provider referral networks the physician and hospital members of your team are part of.

How would you rate the degree of alignment between your current membership and the provider networks revealed through analysis of patient flow and care patterns (high, moderate, low)? Where alignment is moderate or low, please explain why your team membership may have differed. Given the provided data, have you updated your team membership since the Self-Assessment?

- All partner members of our team are highly aligned with the delivery of health care to children, youth and their families in our region. Most are specialized providers, ranging the full continuum from hospital to community care, including community-based pediatricians. Others are lifespan organizations that have demonstrated commitment and expertise to care for pediatric patients and clients. This broad coverage of the pediatric health system within our application is evident from that fact that our membership includes:

    - Community-based mental health and addictions agencies focused on children and youth, or having programs focused on children and youth within their broader mandate.
    - All community health centres in the region, where a significant proportion of child and youth primary care occurs.
    - The regional pediatric palliative care and respite hospice (Roger Neilson House) and regional family respite care home (Ottawa Rotary Home).
    - Community hospitals who see children and youth through their emergency departments, including the only community hospital (Cornwall Community Hospital) with any remaining inpatient pediatric beds.
    - The regional tertiary care and academic pediatric referral hospital (CHEO), accounting for all other pediatric admissions (6,700 per year) along with annual activity of 77,000 Emergency Department visits, 180,600 ambulatory care visits, 7,800 surgical procedures, and 10,800 medical day unit visits.
    - Home and community care service providers currently engaged to provide services to children and youth.
    - Organizations supporting teen mothers and their children.
    - Several community-based organizations with important health and social services programs, especially for marginalized populations including Francophone and

Indigenous children and youth.
- Public health units, representing the development and implementation of health policies, programs, and services to individuals and communities that promote improved health and prevent disease.
- Several additional members of our team do not provide direct care, but provide support, care navigation, partnership, or infrastructure for care provision by others.

- The majority of physicians involved in providing specialized pediatric care are aligned to our team's member organizations, or are independent community pediatricians. They are uniformly supportive of a pediatric-focused OHT and include:

  - Community-based pediatricians providing primary care, secondary care/consultative services, subspecialist care, nursery and hospital coverage, and remote outreach
  - Academic hospital-based pediatricians and subspecialty pediatricians
  - Academic hospital-based pediatric surgeons
  - Academic hospital-based pediatric anesthesiologists
  - Academic child and youth psychiatrists
  - Academic pediatric ophthalmologists
  - Academic pediatric radiologists
  - Academic geneticists, supporting the regional genetics program
  - Academic pediatric laboratory medicine specialists

- Several key leaders among community pediatricians, family physicians and other primary care providers have participated in the development of the application, ensuring that the most important challenges facing community and primary care providers are addressed in the navigation, care coordination and other integration programming to be offered by the team:

  - Dr. Jane Liddle, community pediatrician
  - Dr. Sumeet Sadana, community pediatrician
  - Dr. Alison Eyre, Centretown Community Health Centre
  - Dr. Jolanda Turley, Bruyère Academic Family Health Team
  - Dr. Alicia (Lee) Donohue, Your Health -Votre Santé
  - Dr. Claire Liddy, Interim Chair, Department of Family Medicine, University of Ottawa
  - Dr. Nabil Ouatik, community dentist with Healthy Smiles Ontario

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

2.6.2. Other Collaborating Organizations

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

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

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

- Our entire Year 1 target populations of children and youth with complex mental health and/or addiction needs, as well as children and youth with medically complex needs will have access to integrated care across our partners. We will accomplish this by:
    - Providing youth, families and all 1,400 of the primary care physicians and community pediatricians with streamlined access to mental health services, addictions services and home care services for children and youth through one number to call/one link to click. This will save them time and resources and put patients first.
- Better connecting specialized child and youth mental health and addictions services through developing a regional, bilingual, Coordinated Access and Navigation Service.
- Establishing a fully-integrated pediatric home care program that focuses on the patient, and connects care across acute, post-acute, home and community settings, we will be

able to provide a full continuum of care to our entire Year 1 population of children and youth with medically complex needs.

- Implementing digital health solutions to support the spread of virtual visits, so that we will be able to offer greater flexibility to children, youth and families as well as reach our most vulnerable children and youth across the region.

- In Year 1, our Francophone and Indigenous partners will be leading the work to conduct needs analyses of their respective children and youth populations, so that population-specific strategies can be developed. Kids Come First will begin meaningful engagement with Indigenous service organizations and communities on how to increase equitable funding and access to health services for Indigenous children, youth and their families.

2.8. What services does your team intend to provide in Year 1?

Provide a description of each service, indicate whether the service would be available to your entire Year 1 population or a subset (with rationale), and indicate which member of your team will provide the service.

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

2.9. How will you expand your membership and services over time?

At maturity, Ontario Health Teams are responsible for offering a full and coordinated continuum of care. Teams are expected to expand the population they serve each year, working towards providing care for their entire attributed population. Describe your plan for phasing in the remaining continuum of care for your population, including proposed timelines. Your plan should include explicit identification of further members, collaborators, and services for inclusion for Year 2. Include in your response commentary on whether your team anticipates any challenges in expanding the types of services your team provides or meeting demand for services beyond year 2, given your attributed population.

If you do not have all primary care providers in your network involved at this point, please describe what efforts have been made to date to involve these providers and your plan for how you will expand primary care partnerships to meet population need at maturity.

- Kids Come First is ready to provide the full continuum of care for our Year 1 populations

of children and youth with mental health and addictions as well as medically complex children and youth. Our partner organizations will provide: primary care, secondary care, acute care, home and community support services, mental health and addictions services, health promotion and disease prevention, rehabilitation and complex care, palliative and hospice care, transitional care, emergency health services, laboratory and diagnostic services, and other social and community services.

- In year two, we will continue to work in partnership with families to think about expansion through a patient and caregiver lens, to ensure we identify opportunities to meet families where they are including outside of direct health care delivery and in support of all social determinants of health. These collaborative organizations will include school boards, additional publich health units, additional community housing organizations, and any future OHTs in the region.

- In year two, we will expand the number of collaborative organizations to include school boards, additional public health units, additional community housing organizations, and any future OHTs in the region.

- Children and youth deserve to be cared for by highly skilled providers who are trained to work with a pediatric population. We need to be focused on building a stable, pediatric trained workforce who are experts when it comes to caring for kids. A thorough child and youth health human resource strategy should be developed to ensure that every child is in good hands and every family can have peace of mind that their child will receive the best care.

- There are gaps in the data available for outcomes and performance measurement. More data is needed to measure and improve our region's child and youth health system performance. There is currently no available data on the family as provider system which is the most important sector of the child and youth health system. Furthermore, no data exists to directly measure outcome and access variations for special child and youth sub-populations, including Francophones, Indigenous populations, and newcomers. We will work collectively to change this.

2.10. How did you develop your Full Application submission?

Describe the process you used to develop this submission. Indicate whether it was an participatory process across all members and if your submission reflects a consensus across the entire membership. If so, describe how consensus was achieved. Indicate whether any third parties external to your team were involved in the completion of this form (e.g., grant writers, consultants).

Also consider in your response: If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership, engagement, or consultation activities that took place and whether/how feedback was incorporated.

If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.

If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your team's attributed population/ network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

- Throughout the preparation of our Self-Assessment and Full Application, our team established a collaborative and participatory approach to our work. We have adopted inclusive and transparent decision-making processes by establishing a project structure that included strong representation from across our partners reflective of our urban and rural geographies, specific populations (e.g Indigenous and Francophone), and youth and family partners. The project structure was endorsed by our partners in advance of work beginning on the development of the Full Application.

- Our participatory approach involved the creation of a Steering Committee, 13 Working Groups which were responsible for both of our Year 1 populations as well as foundational components of our OHT (e.g. governance,specific populations Francophone, Indigenous) and subject matter expertise areas (e.g. quality improvement, digital health), and an OHT Application Coordination Team (ACT).

- Working Groups met on a regular basis to develop the content for their assigned sections of the application. A review process was established to ensure that other specific Working Groups and subject matter experts were provided opportunities to review other group's content in order to add their specific lens, check for agreement,

and/or to build upon the ideas. Feedback was consolidated and sent for review to the Steering Committee which represented the consensus body to approve the content put forward. The Steering Committee met on a weekly basis to provide advice, support, guidance and oversight of all application activities. To enable maximum participation in all Working Group and Steering Committee meetings, we offered both an in-person and Zoom meeting option.

- Kids Come First is committed to ensuring full transparency and availability of information to all of our partners. A Google Drive was used to organize and track all of the documentation related to the development of the Full Application which included all of the working documents and meeting materials pertaining to the Steering Committee, 13 Working Groups and the OHT ACT. Access to the Google Drive was provided to all OHT partners and they were invited to review and comment on documents at any point during the process, ensuring full transparency and maximizing engagement.

- An OHT Application Coordination Team (ACT), comprised of nine individuals from six different organizations, supported the Steering Committee and 13 Working Groups. The ACT huddled on a daily basis to provide progress updates and prioritize tasks. The ACT developed common project management worktools, provided project management and logistical support to all of the Working Groups, participated in Working Group meetings, prepared meeting materials and ensured that the Working Groups were on track to meet their deliverables. The ACT provided weekly updates to the Steering Committee.

- The content of the application was fully developed by representatives from the team members and family and youth partners and was finalized by the ACT.

- A foundational principle for our team is “Nothing about us without us", and youth and family partnership was foundational to our Full Application project structure. Thirteen youth and family partners were co-leads and/or representatives on our various Working Groups. The Steering Committee was co-chaired by a youth partner. Each Working Group was led by two or three co- leads, with family partners as co-leads of the Mental Health and Addictions Working Group, the Complex Care Working Group, and the Governance Working Group. Family and youth partners were also representatives on other Working Groups. The Steering Committee was comprised of all of the co-leads from each Working Group.

- Core to our commitment to partner with children, youth and families every step of the way in our team development, we wanted children and youth to help us name our team. We launched a #NameOurOHT naming contest for youth under the age age of 21 through social media channels across our partner organizations and in local schools. There was tremendous interest and we received over 100 entries! We then asked youth

BEFORE and AFTER

Laila is a 15-year-old youth with mental health and addictions needs

Right Now: Laila is a 15-year-old youth who has struggled with anxiety for the past two years. Over the last few months, Laila's mom has noticed that Laila is more withdrawn, spending more time in her room at home and missing school. Laila's math teacher just called home to say that Laila failed a math test. Laila's mom asks Laila about the failed test and Laila shares that her anxiety has been getting worse and to try and cope, she has been smoking marijuana. She is also self-harming and has scratches and cuts over her forearms. Laila's mom, feeling overwhelmed, concerned and scared, brings Laila to see her pediatrician. The pediatrician gives Laila and her mom a list of organizations who provide mental health or addiction services. Laila and her mom leave the pediatrician's office confused about where to go for help

Kids Come First: At the doctor's appointment, Laila's pediatrician sends an e-referral to the Coordinated Access and Navigation service. The next day, Melissa, a clinician with the Coordinated Access and Navigation service, contacts Laila and together they co-assess her needs and come to a shared understanding of what the Laila is concerned about. They discuss different options about what to do next and when Laila has decided, Melissa makes an appointment for Laila to see a clinician with the right skills to meet Melissa's needs. Laila's mom receives a phone call from a family support navigator, a parent whose child has also accessed mental health and addiction services, to answer any questions and to offer support. Laila and her mom feel listened to, supported and hopeful about the future.

Drawn by: Aryin age 13

to narrow down the list and the top 3 names were put forward for a public vote to decide the final name.

- A youth and family panel was hosted for partners and their respective Boards of Directors, to hear firsthand about their experiences and how our Kids Come First team can be the difference maker for children, youth, families and providers across our region.

- A Francophone Working Group was established, consisting of eight Francophone service provider agencies from across the region, along with agencies who serve Francophone children and youth. The Francophone Working Group reviewed and consulted on application content from other Working Groups with a view to ensuring equity would be achieved in the region for Francophone communities, children, youth and families. The co-leads for the Francophone Working Group were also members of the Steering Committee.

- An Indigenous Working Group was established, consisting of three community based Indigenous organizations. The co-leads for the Indigenous Working Group were also members of the Steering Committee. The Indigenous Working Group reviewed and consulted on application content from other Working Groups with a view to ensuring recognition of the team value and our commitment to Indigenous organizations, that our Kids Come First team recognizes the explicit need to address racism within our current health system through education, and a commitment to improve care transitions as well as communication with Indigenous organizations.

- A Community Pediatrician Working Group of 25 pediatricians met four times to discuss challenges and possible ways the OHT could improve their work. One member led this group and participated on the Steering Committee, a second participated on the Governance Working Group.

- Family Physicians/Primary Care Providers formed a second working group, which met four times. Two members served as leads and participated on the Steering Committee. Information was presented to a broader group of family physicians, and a bilingual survey was distributed to physicians, nurse practitioners and others seeking additional perspectives on the challenges and solutions the OHT could address. Further presentations are planned across the region (i.e., urban and rural, different practice models, etc.) to engage physicians, nurse practitioners, community dentists and pharmacists as part of the pediatric health system strengthened by our OHT.

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How Will You Transform Care?

Transforming Care

In this section, you are asked to propose what your team will do differently. By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experience;provider experience; and value. By working together as an integrated team, Ontario Health Teams are also expected to help improve performance on a number of important health system measures,

3.1 What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity?

Considering the measures listed above and the health status of your Year 1 and maturity populations, please identify and provide rationale for what your team considers to be your most important (e.g., top three to five) performance improvement opportunities both for Year 1 and longer term. In your response, consider your team's assets, the services you intend to provide, and the features of your Year 1 and attributed populations. Explain how you identified these priority improvement opportunities and any relevant baseline performance data you have for your Year 1 and/or attributed populations.

Our team's objectives are to:

1. Improve access to quality child and youth health services.

2. Ensure the success of Ontario's new OHT system by equipping providers across the continuum with the supports they need to care for their youngest clients and patients.

- In Year 1 we will be launching innovative new first-in-Ontario care coordination models for children and youth with mental health and addictions and those who are medically complex, that will scale up existing partnerships and build upon expertise we've developed in this region through previous partnership models.

- In Year 1, we will empower parents in their children's immunization process and improve preventative health care for individual children and youth. It will increase the efficiency of surveillance for vaccine preventable diseases, and through timely notifications for at risk children and youth will assist in preventing vaccine preventable diseases, and decrease costly infectious disease outbreaks.

- We will deliver both the new care models and our digital health immunization strategy in ways designed to make them replicable across Ontario so lifespan OHT's can be supported to care for their youngest patients.

Children and Youth with Mental Health and Addictions

- In today's system, one of the most frustrating realities for young people, their parents/caregivers and primary care physicians is that they need have to act as care coordinators or navigators for children and youth because organizations are not connected. Kids Come First will work together to remove this burden and take care of the coordination for them by making the work of our agencies interoperable. We will re-imagine care for children and youth with mental health and addictions so that physicians will have one central resource to access through one number to call or one link to click.

- Children, youth, and their families/caregivers in the Champlain region will receive consistent, equitable and timely access to efficient, effective, integrated and culturally-safe mental health and addictions services. They will receive their care at the right time (minimal waiting), with the right people (appropriate clinical skills), doing the right thing (evidence based therapeutic interventions), in the right place (closest to home) in the official language of their choice.

- The current health care system is not meeting the needs of children and youth with complex mental health and/or addiction needs who are often either at severe or imminent risk of suicide, self-harm or harm to others. The system's current failures result in children and youth having to access services repeatedly often with poor outcomes, and due to insufficient supports being in place in the community, they are seeking help by visiting emergency departments which compounds the pressures associated with high occupancy and longer wait times.

- In Year 1, will we transform care for these children, youth and their families/caregivers by better connecting specialized child and youth mental health and addictions services. Across our region, we have existing resources and expertise that we will build upon to develop a regional, bilingual, Coordinated Access and Navigation Service. Our team will leverage technology to ensure that information is exchanged seamlessly both within our partners, and with community physicians and other OHTs in the official language of the child, youth and families/caregivers choice. Communication within team members and across other OHT partners is essential to support informed decisions about the child or youth's health care and this will be achieved in alignment with privacy and confidentiality requirements. We have heard from families/caregivers that they need increased supports and we will work with them to provide what they need. Children and youth will access services in their official language of choice and we will improve relationships with Indigenous community organizations, with collaborative, coordinated care as the foundation throughout all stages of children and youth's health care journeys, with "culture as treatment" embedded into careplans to support children, youth and families in building resiliency.

Children and Youth with Medically Complex Needs

- Children and youth may have needs that are complex. That doesn't mean the system that cares for them should be complex too. Five hundred medically complex children in the Champlain region attend five or more specialty clinics which means that their families must access programs and services in multiple settings, requiring them to repeat their stories and navigate the complexity of working with many providers. Informed by recommendations outlined in the THRIVE report as well as the lived experiences of experts and family partners, our goal in Year 1 is to lift the burden on families/caregivers, family physicians and community pediatricians by implementing a regional, integrated home care strategy that will be grounded in the use of standardized tools and processes across the members of our collaborative. This new model will integrate services provided by home care providers, specialty child and youth acute, developmental and rehabilitation organizations under the umbrella of Kids Come First. By building upon the successful school-based rehabilitation transition of services in January 2019, the integrated home and community care strategy would achieve positive and evaluable outcomes. Our strategy will include **single-point story-telling** for children, youth, and families, continuity of care along the spectrum of health care services, including care transitions within the team and to adult services, and will deliver **minimally disruptive health care** that will focus on the family as a unit.

- **In Year 1, our OHT will improve our evaluation capacity and adopt a data-driven** approach to decision-making to inform care delivery. Data will be collected for planning, program evaluation, performance measurement and outcome monitoring, which will enable our team to understand the capacity of the system so that we can respond to the needs of children, youth and families/caregivers. Data specific to services provided to Francophone children, youth and families/caregivers, as well as linguistic variable, will be collected and analyzed to determine system capacity and opportunities. We will work together to scan and identify evaluation tools that measure quality of life for the children, youth, and families within our target populations to ensure that we have a consistent approach to evaluation throughout the team.

Population Health

- Canada has an immunization coverage rate of 84% which lags behind those of the United Kingdom (96%), United States (93%) and Australia (93%). This is an issue of both immunization uptake and documentation. Recognizing that immunizations are a key tool in keeping all kids healthy, our team in partnership with Ottawa Public Health and PANORAMA, will support population health by focusing on strategies to drive both vaccine uptake and real-time documentation submission.

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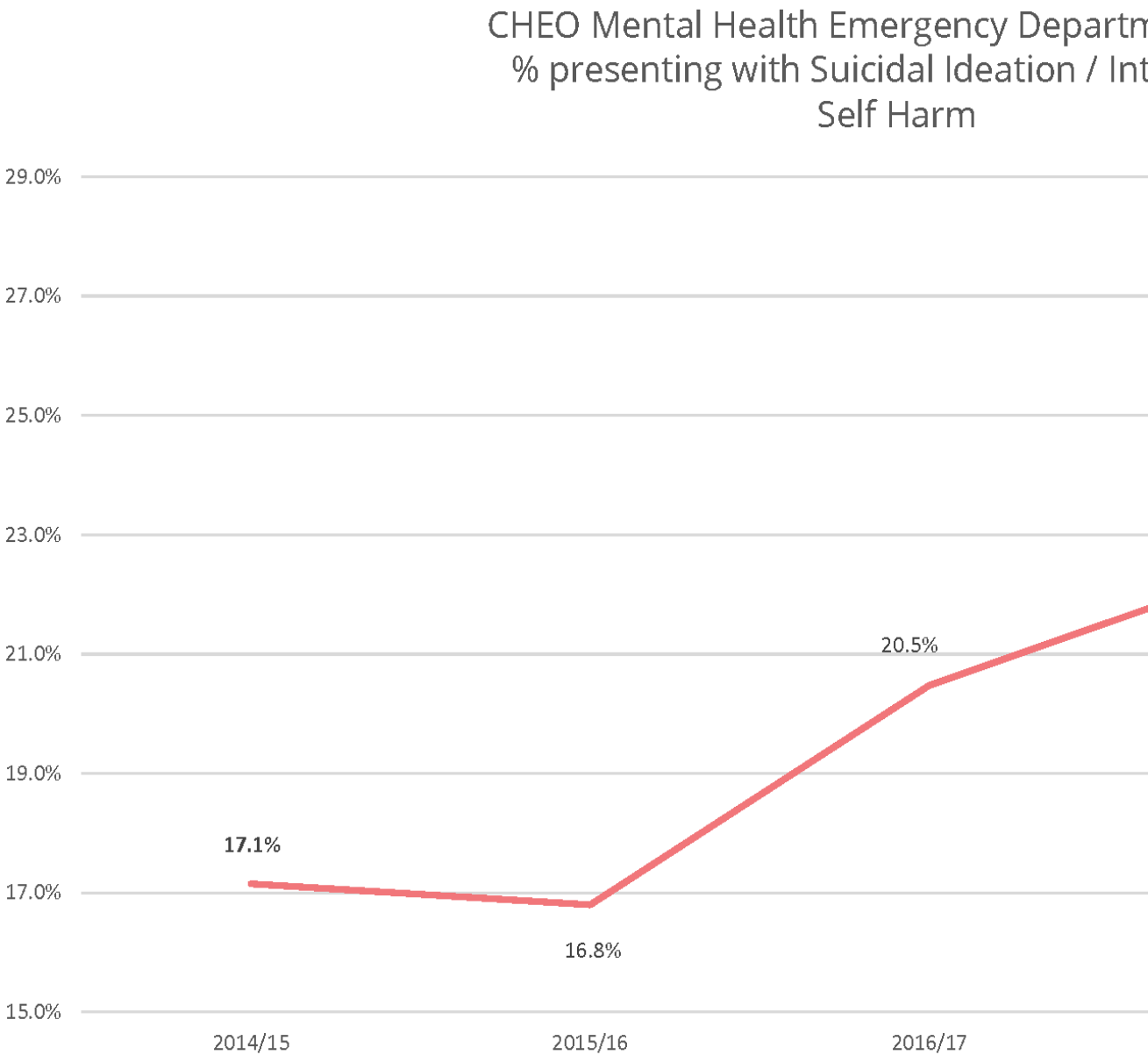
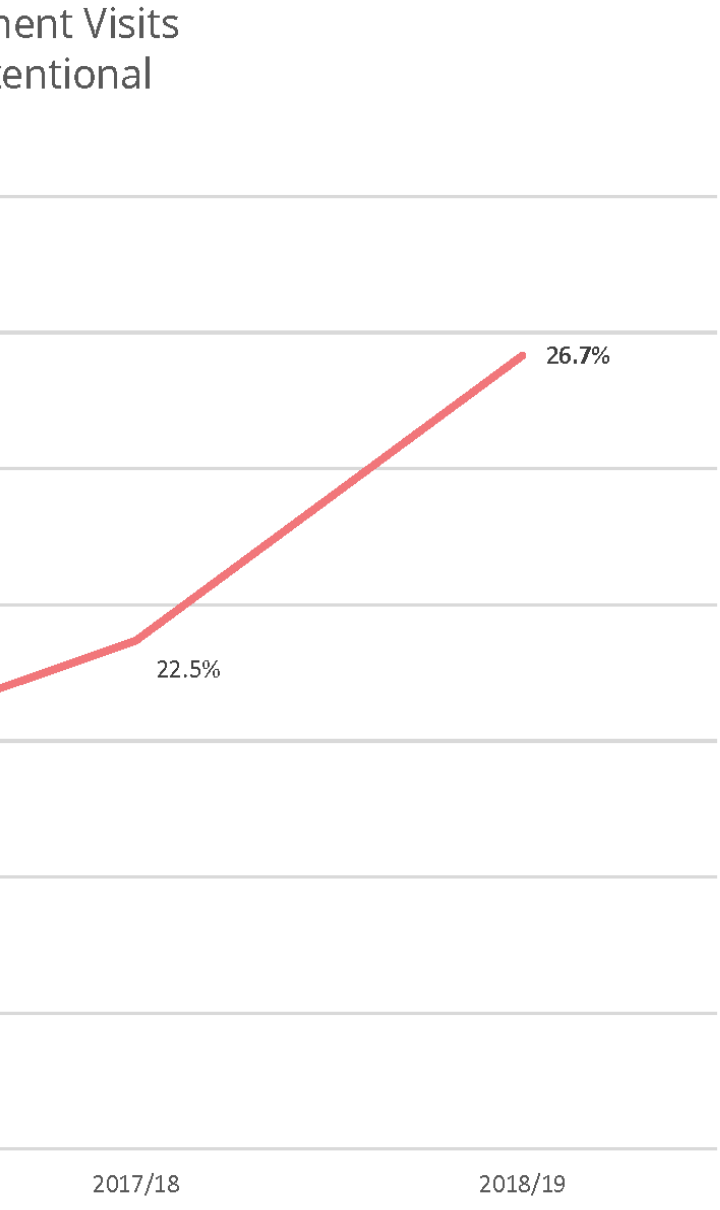
Changing Needs





Demand for mental health emergency services has increased substantially across the Kids Come First region. From 2014/15 to 2018/19, child and youth emergency department visits for mental health problems increased by almost 10% percent. We also see wide variation in the use of emergency department visits for mental health and behavioural problems. In the exhibit below, we show the percentage of children presenting with suicidal ideation / intentional self harm to CHEO's Emergency Department.

In the exhibit below, we show actual and expected emergency department visits by sub-region, where the expected is the provincial average age-standardized visit rate. There were 48% more visits by western Champlain's children than expected (which is congruent with the findings above with respect to the reliance on the ED in general in the sub region) and 15% fewer visits by Eastern Ottawa's children (which may reflect the fact that services are more readily accessible and available to children and youth in this sub region).

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- Kids Come First includes over sixty organizations and hundreds of physicians, until now untapped resources, that will work together with CANImmunize to impact immunization uptake and documentation.

- CANImmunize is a mobile-first platform designed to empower Canadians to manage immunization information. The platform enables individuals to track their vaccinations by providing customized schedules based on their age and province/territory of residence. The app also provides recall/reminders and outbreak alerts for Vaccine-Preventable Diseases (VPD) in their local areas using data provided by Healthmap. CANImmunize also provides users with reliable, easy-to-understand information on vaccines and the diseases they protect against. CANImmunize can hold as many records as needed by an individual or whole family. The individual can then document their immunizations against their custom schedule, and CANImmunize will send reminders via email, SMS or push notifications when it's time to receive their next immunization. CANImmunize generates a digital yellow card that is available, even if the user is outside of Internet connectivity (offline). CANImmunize is also built as a communication tool; we work with Pan-Canadian experts and recognized associations such as the Canadian Pediatrics Society, the Society for Obstetricians and Gynecologists of Canada and others to provide timely, accurate information on vaccination. We also collaborate with public health at the local, provincial/territorial and national level to send targeted messaging directly to the home screens of people using the app in their jurisdictions.

- By providing parents/caregivers with an integrated digital immunization record, we can achieve two things in Year 1. First, we can empower parents/caregivers and improve the experience of immunizing their children. Parents of newborns can use CANImmunize to receive recall reminders when their vaccination appointments are approaching or overdue, which is a proven strategy to improve on-time vaccination rates. By linking the parental record with local public health through CANImmunize, we will improve surveillance of immunization rates for children 0- 4 years old (prior to school entry) which is key to preventing costly disease outbreaks. Second, for parents/caregivers of school-aged children, access to their official immunization record in CANImmunize helps improve awareness of their childs' status against the Immunization of School Pupils Act (ISPA) ahead of suspension season. This will allow them time to receive the necessary immunizations to attend school. Ultimately, this will reduce the burden of notifying parents/caregivers of incomplete records by the local public health units. This digital solution will result in clinicians no longer incurring the administrative burden of in-person appointments to assess and retrieve immunization records and clinician time can be redirected towards care. CANImmunize has the potential to save thousands of visits to primary care and other health practitioners annually.

- As the first consumer health platform to connect to the Digital Health Immunization Repository (DHIR), lessons from the implementation will provide a framework to evaluate indicators of health system performance for future integrations. At maturity, we will provide leadership to other OHTs for the adoption of similar innovations which improve the health of children and youth.

Children and Youth with Mental Health and Addictions:

Performance improvement opportunities:

- % of children and youth who report agreeing or strongly agreeing with their care experience in seven key areas (access / entry to service; services provided; participation/ rights; therapists, staff support workers; environment; discharge, program completion, treatment and overall experience (OPOC-MHA)
- % of children and youth accessing mental health and addiction services who have a primary care provider
- % of children and youth visiting the ED 4+ times per year for mental health and addictions needs
- % of children/ youth who identify themselves as Francophone
- % of children/ youth whose mother tongue is French and request service delivery in French
- % of children and youth who have digitally access to their health information

Families/Caregivers of Children and Youth with Mental Health and Addictions:

- % of families/caregivers who report agreeing or strongly agreeing with the care experience for their child or youth in six key areas (access/entry to service; services provided; participation/rights; therapists/support workers/ staff; environment; overall experience) (OPOC-MHA)
- % caregivers seeking mental health and addiction support for their children that are connected to caregiver peer support services (that wish to be connected)
- % of families/caregivers who report a high level of caregiver distress
- % of family/caregiver who report having skills and ability to support their child / youth

with mental health or addictions needs

- % of families/ caregivers who have digital access to the health information of their children and youth.

Providers and Other OHTs:

- % of family physicians, community pediatricians and other primary care providers who report supporting children and youth with mental health and/or addictions needs
- % of family physicians, community pediatricians and other primary care providers who report being somewhat or very comfortable having the knowledge to address mental health and/or addictions issues
- % of family physicians, community pediatricians and other primary care providers who report being somewhat or very comfortable with their level of knowledge to address mental health and addictions issues
- % of service providers, including primary care, who reported a clear feedback loop between themselves and mental health and/or addiction services
- % of service providers, including primary care, who reported that access to mental health and addiction services is "quick and immediate"
- % of service providers who have digitally accessed to the health information of the children and youth in their care

3.2. How do you plan to redesign care and change practice?

Members of an Ontario Health Team are expected to actively work together to improve care for their patients. Please describe how you will work together to redesign care and change current practices in your first 12 months of operations to address the performance improvement opportunities you identified in section 3.1.

In your response, please consider what specific outcomes you're aiming to achieve, as measured by one or more of the indicators listed above (or others, as relevant), and what targets, if any, you have set from baseline.

Note that detailed commentary on how you propose to provide care coordination and system navigation services, virtual care, and patient self-management are requested in subsequent sections.

- Kids Come First partners have spent years understanding the needs of the children and youth that they care for. We will scale up successful existing programs and projects to launch innovative care models that shift the burden from families and physicians to the system where it belongs. Through our collaboration we have developed a comprehensive strategy for closing the gaps.

Mental Health and Addictions: How we will make care better for children, youth and families

- Children and youth will experience seamless and efficient transitions into, through and between treatment services, supported by the Coordinated Access and Navigation Service, with the appropriate intensity and complexity to meet their needs. When children and youths' needs change, or they require new services or are transitioning to adult services, they will be supported.

- Children and youth will have consistent and timely access to the right mix of supports, receive care from multi-disciplinary teams of professionals including family physicians and community pediatricians, will receive coordination across health and other human services regardless of their community, and in the official language of their choice.

- Children, youth and families/ caregivers will report being able to easily access information on available mental health and addictions services in English and French, and they will be fully informed on how to access services and how long it will take before they get those services. We will provide children and their families/caregivers and youth with digital access to their health information, in the official language of their choice, which will support them in making informed decisions about their health care and ensure that relevant and up to date information is shared with their health care team members.

- Children, youth and/or their families will experience improved outcomes, increased capacity to thrive and families will experience reduced stress.

How we will make Ontario's new OHT system successful:

- Family physicians, community pediatricians and other OHTs will be able to easily access information on available Mental Health and Addiction services and will be able to easily refer children and youth to appropriate services both online through one link to click and through their electronic medical record (EMR). Through the seamless, digital exchange of information, these providers will be up to date and have real time knowledge that they need to support children, youth and families in making shared, informed health care decisions and they will be able to follow the recovery journey of the children and

youth in their care.

- In Year 1, Kids Come First will work in partnership with youth and families/caregivers, other OHTs and will leverage current services and resources such as Parents Lifeline of Eastern Ontario and Services Access to Recovery in order to realign resources to develop a multifaceted coordinated access and navigation service. This service will be available in both official languages, and will simplify and improve equitable access to culturally safe mental health and addiction services. Here are the ways we will redesign care and change practice.

Easy, 24/7 access to up to date information about available services

- Children, youth and families/caregivers, service providers, family physicians and community pediatricians, will be able to obtain information about available services through a toll-free staffed regional phone number/one click.

Expansion of Family Peer Support and Navigation

- Our team understands how important it is to families to have communities and community peers that they can connect with for support, so we will expand our existing family peer support and navigation services.

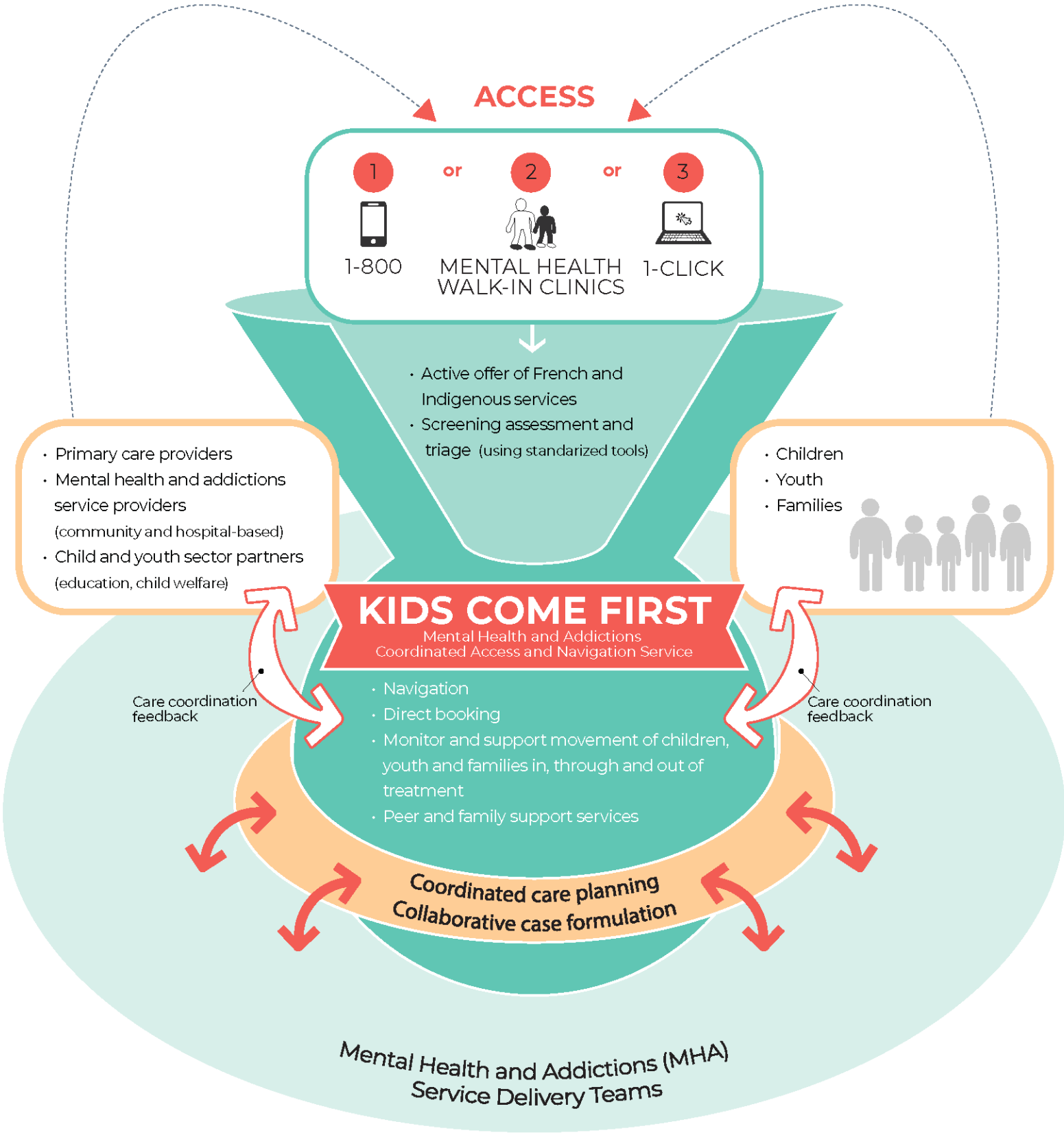
Increase low threshold access and make it easier to refer to services

- Children, and youth will be able to access care through walk-in, chat/text, and outreach services, and along with their parents/caregivers and providers, will be able to submit referrals online for new services as well as additional services when care needs have changed.

Better linkages to primary care and for physicians and other primary care providers

- We will support children and youth in accessing primary care for those who do not have a family physician. Through e-referral integration with electronic medical records we will be able to provide direct links between primary care and the coordinated access and navigation service

Improved treatment matching, including stepped care and integration of mental health and addiction services:



Dear Government:
How health care is imortant to kids
vimeo.com/336195857

THRIVE:
The future of integrated health service planning for children & youth.
ww.cheo.on.ca/uploads/AboutUs/Files/THRIVE%20Report@202017.pdf

COMPLEX CARE

Champlain Complex Care Program

Since March 2010, the Champlain Complex Care Program has been collaboratively working with hospital and community partners to keep children in their community. If children with complex conditions coming through the ED are dealt with faster through an organized system, then you increase the ability to see other/more kids in the ED quicker.

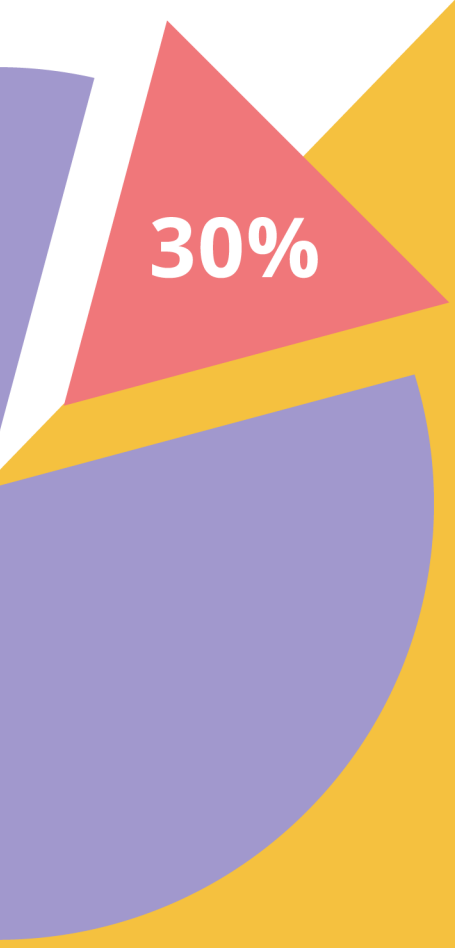
We want to bring care closer to home. We want to build capacity in the system, health care providers, children and families. We want to provide resources to children and families so that they are accessing care sooner and not waiting until the last minute to bring their child to hospital and then being admitted straight to ICU because they are so sick.

↓23%	↓50%	↓50%	↓75%
Visits to ED	**Days in ICU**	**Days in OR**	**Days in Hospital**

SAVINGS OF $3.5 MILLION

When comparing 2 years pre vs. 2 years post intervention (n=49)
Source CHEO Decision Support Data

1% off Children



Our interdisciplinary team provides care coordination for the medical needs of children, youth and families by:

- Identifying the team members required for the care of a child/youth.
- Proactively coordinating the child/youth's medical needs.
- Helping navigate the health care system and improve access to care.
- Providing comphrehensive medical care.
- Monitoring the progress of the child/youth's medical condition.
- Foster team work by bringing community together through Family Focused Team Meetings.
- Ensuring that 100% of families have a Medical Care Plan to help summarize important medical information.

- Through the use of common, standardized tools, involvement of multidisciplinary teams, direct referrals, and assessment and treatment matching, and clear and consistent clinical pathways for services in both official languages, children and youth will transition seamlessly in and out of services as their needs change and ensure they are supported through the next steps in the recovery process.

Increased care coordination and creation of formalized feedback loops

- Coordinated care plans and common discharge planning processes and tools, will enable seamless transitions. We will examine technology/database solutions to support continuous communication between children, youth, families/caregivers and service providers, including family physicians and pediatricians, and ensure they have easy access to health information in the official language of their choice in order to assist in making informed decisions about their health care.

Standardized waitlist management

- In order to ensure equity to children, youth and their parents/caregivers when waiting for care, service providers will report into a centralized waitlist that will be monitored for English and French services.

- Children, youth and their families will have expanded and consistent access to peer support and family support while waiting for services and we will expand access to technology based solutions e.g. Ontario structured psychotherapy program, Big White Wall and Bounce Back.

Children and Youth with Medically Complex Needs

- Families and health care providers in the Champlain region have many ideas about how to improve home and community care services for children and youth. But structures in place until now have limited our ability to innovate together to improve access and quality of these services. Families, clinicians, service provider organizations and health care entities are excited to work together to co-design services that we will provide through an integrated home and community care strategy. This will include:

Single-point story-telling

- It is exhausting for parents/caregivers of children and youth with medical complexities to have to repeatedly share their child's health care stories to the numerous care providers across the spectrum of care — hospital, hospice, home, community, and school. They worry about keeping information updated, and aren't confident that their child's health

information is shared across providers, knowing that the risk of error is higher as a result; they want to know what story is being told and have the opportunity to update it, anywhere, anytime. Kids Come First will change this by implementing The Single Point of Care (SPOC).

- SPOC is a tool developed, tested and iterated by families and the Champlain Complex Care Program over the past decade. It allows collaboration amongst all care providers to develop a single plan of care that includes information about a child's medical history, interventions, community providers, specialists, medications, and technology supports.

Continuity of Care

- For children and youth with medically complex needs, ensuring continuity of care and 24/7 support is essential. We will break down inter-organizational barriers to create new transition standards and to align roles, responsibilities, and language across organizations.

- Sometimes there are too many individual frontline providers caring for these children and youth. We will review existing roles and wherever possible, establish smaller teams of providers which will foster greater trust, reduce the number of handoffs, and assist in building therapeutic relationships. When there has been a significant change in the health care status and/or needs of medically complex childrven and youth, they and their parents/caregivers will meet their home and community care providers before they leave hospital, hospice or transitional care setting. Through proactive anticipation of needs, we will improve communication and transfers between facilities and the home setting which will reduce stress for children, youth and their families. We will build upon our existing relationships to strengthen the communication and connection between services and organizations for the most medically complex child (eg: Champlain Complex Care Program, CHEO Palliative Care, and Roger Neilson House).

- Beyond Year 1, we will build upon the success of the Champlain LHIN Rapid Response Nurse program and the CHEO Palliative Team to provide additional support available 24/7 to the most medically complex children and their families. We can help to alleviate significant stress on families and community care providers by ensuring that there is always a healthcare provider available who has access to the child's chart and medical history.

- We will ensure that family physicians are up to date on the medically complex children and youth under their care, by offering virtual care visits with hospitals so that they are aware of treatment plans. This will help to establish connections with other members of the care team, and build the conditions for a truly integrated system where all care providers will have a better understanding and appreciation for the roles of fellow providers within the team.

Minimally disruptive health care

- The care needs of medically complex children are so significant that parents don't have much time to just be parents or for siblings to just be siblings. the Kids Come First health team will deliver minimally disruptive health care that will allow kids to be kids and to meet them and their families where they are at in their care journeys. We want to focus on providing health care, not illness care, thereby ensuring children, youth, and families feel supported in all aspects of life.

- Families and children want to receive care in settings that they are most comfortable with and that do not impose challenges or burdens, such as transportation needs/costs, and triggers of past trauma. We want families to access health care where they already are, and we will use technological solutions to decrease the number of challenges they face. By leveraging technology and building upon existing successes of key worker-supported satellite clinics, we can increase the amount of support offered to these families and children in underserved areas without significant disruption to their lives. By providing health care in different settings, we will be able to positively impact the entire family.

- The lived experiences of clinical care providers and family partners were explored throughout the process and identified gaps that were previously reported in the THRIVE report and family feedback from the Navigator Program, Roger Neilson House, Rotary Home, and the Champlain Complex Care Program.

Alignment of resources and services

- In Year 1, we will work together to define and align our terminology, resources, services, and goals and to understand how we can best meet the needs of our target population, as many of the required services such as respite and specialized pain and symptom services are not available outside of the pediatric realm.

Build on successes of current partnerships

- Through the success of a pilot partner project between Roger Neilson House, the CHEO Palliative Care Team and the CHEO Oncology Team, each child with a new oncological diagnosis receives a referral to the team for pain and symptom assessment and treatment, as well as relationship building earlier in the trajectory. This results in health care providers, children, youth, and families having access to more resources and supports to ensure the best possible outcome. We want to encourage and expand upon these relationships and partnerships, ensuring that we are all working together to develop innovative services that are current and relevant

to our target population and optimize opportunities for early needs identification.
- Coordinated Services Planning (CSP) has cross-sectoral partnerships that are working together to provide seamless child, youth, and family-centred service experiences. Children, youth and their families will benefit from the enhanced collaboration and communication among all care providers and partners working to support the CSP model of care.

- Kids Come First believes Indigenous organizations are best positioned to provide culturally-based care to Indigenous children, youth and families/caregivers and will proactively offer Indigenous children, youth and families/caregivers services that are offered at Indigenous agencies. If an Indigenous child or youth chooses to access care at non-Indigenous agency, our team members will work closely with Indigenous organizations to incorporate culture as part of treatment. Our team will implement a comprehensive training plan for our partners with the aim to reduce Indigenous specific racism and understand historical context in order to provide kind and competent care to the Indigenous community.

Focus on Population Health through Digital Immunization Surveillance

- Through CANImmunize, parents, children and youth will be empowered to self-monitor immunization requirements and follow the timelines of required vaccines through the use of digital technology, where the information they need is at their fingertips, anywhere and at any time. Parents will have direct access to reminders so that they can ensure their children's vaccinations are up to date. Recent outbreaks of vaccine preventable diseases such as measles have highlighted the need for individuals to be aware of their vaccination status. By managing their own records, it ensures that immunizations administered by primary care, public health and pharmacists are all captured.

- For family physicians, community pediatricians, and other primary care providers, parental awareness of ISPA status ahead of suspension season will reduce their time spent retrieving records which can be redirected towards providing care rather than administrative tasks. Finally, with a direct channel for public health to reach parents/caregivers, there will be additional opportunities for education and intervention.

- Measurement and evaluation of key indicators will be essential in Year 1 so that our Team can identify what is working well and where there are opportunities for improvement. We will collect baseline data on a number of indicators (listed below) in order to be able to set appropriate targets. For other indicators where we have existing data, we will review historical performance to establish targets.

Performance improvement opportunities:

- Increase in % of children and youth who report agreeing or strongly agreeing with their care experience in seven key areas (access / entry to service; services provided; participation/rights; therapists, staff support workers; environment; discharge, program completion, treatment and overall experience (OPOC-MHA).
- Increase in % of children and youth accessing mental health and addiction services who have a primary care provider
- Decrease in % of children and youth visiting the Emergency Department four or more times per year for mental health and addictions needs
- Increase % of children/ youth whose mother tongue is French and request service delivery in French
- Increase in % of children and youth who have digitally accessed their health information
- Increase in % of children and families with a virtual health care encounter, using a key worker to link technology with specialty knowledge and expertise
- Increase in % of children and families who digitally access their health information
- Increase in % uptake of Single Point of Care document amongst health care provider organizations
- Decreased number of organization-specific documents that need to updated by children, youth, and families
- Decrease in readmission rates and reduced hospital length of stay
- Decrease in avoidable emergency department visits
- Increase in quality of life indicators for children, youth, and families
- Increase in % of families/ caregivers who report agreeing or strongly agreeing favourably with the care experience for their child or youth in six key areas (access/entry to service; services provided; participation/rights; therapists/support workers/ staff; environment; overall experience) (OPOC-MHA)

- Increase in % caregivers seeking mental health and addiction support for their children that are connected to caregiver peer support services (that wish to be connected)
- Decrease in % of families/caregivers who report a high level of caregiver distress
- Increase % of family/caregiver who report having skills and ability to support their child /youth with mental health or addictions needs
- Increase in % of families/ caregivers who have digitally accessed to the health information of their children and youth
- Increase in % of primary care providers who report supporting children and youth with mental health and/or addictions needs
- Increase in % of primary care providers who report being somewhat or very comfortable having the knowledge to address mental health and/or addictions issues
- Increase in % of primary care providers who report being somewhat or very comfortable with their level of knowledge to address mental health and addictions issues.
- Increase in % of service providers, including primary care, who reported a clear feedback loop between themselves and mental health and/or addiction services
- Increase in % of service providers, including primary care, who reported that access to mental health and addiction services is “quick and immediate”
- Increase in % of service providers who have digitally accessed to the health information of the children and youth for whom they are providing care.
- Increase in availability of specialty care providers who provide services in French
- Increase in % of service providers, including primary care, who reported that access to mental health and addiction services is “quick and immediate”
- Increase in % of service providers who have digitally accessed to the health information of the children and youth for whom they are providing care
- Increase in availability of specialty care providers who provide services in French

3.3: How do you propose to provide care coordination and system navigation services?

Seamless and effective transitions, 24/7 access to coordination of care, and system navigation services are key components of the Ontario Health Team model. Care coordination and system navigation are related concepts. Generally, care coordination refers to "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (Care Coordination. Agency for Health care Research and Quality (2018). System navigation activities can include helping people understand where to go for certain types of care and facilitating access to health and social services. Teams are expected to determine how best to implement 24/7 access to coordination of care and system navigation services based on the needs of their patients and which members of the team are best suited to play this role.

3.3.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your Year 1 population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings.

Describe what activities would be in and out of scope for your care coordination service in Year 1. Describe which patients will have access to care coordination services, how they will access the service, and whether care coordination resources will be organized

differently from how they are currently deployed in order to better serve your population. Indicate whether your team will coordinate any care beyond the in-scope services provided by your immediate team.

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.
Describe how you will determine whether your care coordination is successful.

List of any of the members of your team have experience coordinating care across multiple

providers and care settings. Describe in and out of scope activities. Describe what type of staff would provide coordination, how many existing FTEs.

- Kids Come First has deep and extensive experience in care coordination for children, youth and families. Currently however this work is done largely within specific programs or funding silos. As a team, we are going to optimize our resources by sharing common tools, data, and information and leverage our extensive expertise to alleviate the burden from family physicians, pediatricians and families who end up needing to act as care coordinators for children and youth. We have a complete inventory of our resources and will review these to determine how to leverage them appropriately.

- Families and primary care physicians and community pediatricians report how daunting they find the complexity of the child and youth health system for many kids. That's the problem we're setting out to solve — so families have a better experience of the health care system and that other providers, particularly primary care physicians, find it easier to secure the care they need for their youngest patients. Our team is well-positioned to enhance the specific expertise needed to deliver complex pediatric home care and to support this vulnerable population in a meaningful way.

- Kids Come First members have extensive experience working together across multiple providers and care settings to coordinate care, including the Integrated Plan of Care Process, Choice and Partnership Approach (CAPA), Coordinated Service Planning (KidsInclusive and CHEO), Bridges, Vanier Social Pediatric Hub, multi-service agencies which are single access point for a wide variety of services (e.g. Valoris), Ottawa Coordinated Access and Referral, Lanark County Situation Table.

- Many team members have experience coordinating care across multiple providers and care settings, including care coordinators for 6200 children and families annually, 700 of whom have medically complex needs and require services at home and/or school.

- The Champlain Complex Care team provides care coordination to 162 children and families with medical fragility and technology dependence and the CHEO Palliative Care Team and Roger Neilson House provide 24/7 care coordination in hospital, community, school and home to 125 children who have complex medical needs and a life-limiting illness.

- Rotary Home provides care coordination to 110-130 children and families annually.

- Coordinated Services Planning provides care coordination for over 86 families, activating a coordinated service plan. The Patient Navigator program provides care coordination

and system navigation for children and families at CHEO.

- Dedicated resources for care coordination mechanisms currently exist across mental health and addictions systems though the processes to access these mechanisms are independent of each other and often limited geographically by community.

- In Year 1, our team would examine how to streamline and standardize care coordination through the Coordinated Access and Navigation service for the entire Champlain region in a way that is culturally safe and available in English and French. Further work would need to be completed to determine if there is sufficient capacity within the current resources to meet the anticipated need for care coordination under the Coordinated Access and Navigation service.

- Care coordination and navigation will be used judiciously and depend on many child and family factors. Care coordination will look differently depending on where the child and family are in their trajectory and based on their individual needs. Care coordination will fluctuate because the child and family's needs change. Through coaching and access to information, children, youth, and families become more familiar with their condition, interventions, responses, system, and where to go to get further information.

- Currently there are several key workers in multiple organizations that provide this service and we would need to maintain the current level of funding to continue to provide these services. If current funding levels drop, we will not have sufficient capacity to meet the coordination needs of our Year 1 population.

  Current key workers exist within:

  - The Community Discharge Team (LHIN + CHEO)
  - CHEO Complex Care Team
  - CHEO Palliative Care Team
  - Roger Neilson House
  - Rotary Home
  - Parent Navigator Program
  - Coordinated Services Planning

List activities that would be in and out of scope for your care coordination service in Year

- In Year 1, Kids Come First will work in partnership with children, youth and families/ caregivers and other OHTs to co-design a coordinated access and navigation service that will coordinate the care of children, youth and their families with mental health and/

or addictions issues in the Champlain region.

- Care coordination will be proactively offered in either official language through an active offer. Resources within the Team will be shared across the region and organized to ensure that we can respond most effectively to the needs of the child, youth and their families/caregivers.

- Kids Come First members will include and support Indigenous specific service alternatives for mental health and addictions care by actively offering and valuing the services provided by Indigenous community partners. Where there is capacity, coordinated care planning will be led by Indigenous organizations.

Children and Youth with Mental Health and Addictions:

- In Year 1, all addictions and child and youth mental health services within the Champlain region as well as current processes and mechanisms to support coordinated care would be in scope. The focus of care coordination will be on children and youth with complex mental health and/or addiction needs who are often either at severe or imminent risk and whose needs are not being met by the current system. Care coordination services will be accessed through the Coordinated Access and Navigation service and our partners will implement a unique identifier (e.g. health card number).

- Out of scope would include youth justice addictions and mental health services, services for mental health and addictions needs of parents, private mental health and addiction services and services that respond to social determinants of health (e.g. housing), with the understanding that there needs to be appropriate referrals and linkages and follow up to these services based on the needs of the child or youth.

Mental Health and Addictions Care Coordination:

- Care coordination will be delivered by a multi-disciplinary team of professionals with the skills and expertise appropriate to the functions and activities they are required to perform, and in particular, with a high level of clinical training among those performing screening and assessment functions.

- A clear process for seamlessly transitioning care coordination to another OHT will be developed for youth when their needs would be better met in adult mental health and addictions services.

- Standardized screening, assessment and triage to determine child/youth's needs for

mental health and/or addictions.

- Ongoing collaborative case formulation (co-assessment and shared understanding of the problem) between children, youth, families/caregivers and service providers.

- Co-development of a coordinated care plan, based on consideration of all treatment options available that would best meet their treatment needs, goals and preference of child, youth and families/caregivers.

- Direct booking for children and youth into services as determined by coordinated care plan.

- Seamless clinical pathways to move through/between care with access to multi-disciplinary teams of professionals to meet their needs.

- Stepped care approach — ability for children and youth to transition in and out of services with appropriate intensity and complexity as their needs change.

- Clear pathways to Indigenous organizations to provide culturally based care to Indigenous children, youth and families/caregivers .

Care coordination for Children and Youth with Medically Complex Needs will include:

- Activities that are within the scope for care coordination services in Year 1 include:

- Enhancing relationships with schools because that is where kids spend much of their time. CHEO is the designated organization to lead Coordinated Services Planning in Ottawa, Prescott, Russell, Stormont, Dundas, and Glengarry region. There is a formal agreement already in place with seven school boards, the LHIN, and other partners to participate in coordinated services planning so that meetings can be held in school to coordinate care and support families with their goals.

- Collaborating within the Kids Come First team to develop a one-story template that is recognized and utilized across teams and organizations as a tool to enhance care coordination services. Complex Care for Kids Ontario now has a standardized Medical Care Plan for the province and this could serve as the foundation.

- Focus on a proactive prevention approach by organizing care activities and sharing information and resources, ensuring that care providers have access to what they need to do their work until other resources are available (after hours) .

- Reviewing titles and roles of key workers, such as nurse navigator, care coordinator and seeking out opportunities to align the language and expectations across organizations.

- Implementing one number to call/one link to click so that families can access information when they want, where they want.

- Recognizing that nothing is out of scope for the most medically complex children with life-limiting conditions and followed by the CHEO Palliative Care Team.

- Coordinated Services Planning will continue to integrate services for Inuit, Metis, First Nations, and Francophone organizations and hard to serve populations (such as those that are supported by Community Health Centres).

3.3.2 How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services the need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

Describe how the system navigation service will be deployed and resourced, and whether your team has sufficient existing capacity to meet the anticipated navigation needs of you Year 1 population.

Describe how you will determine whether your system navigation service is successful.

- Throughout the Champlain region, dedicated resources and processes for system navigation services currently exist across mental health and addictions systems. In Year 1, the focus of system navigation services will be for children and youth with complex mental health and/or addiction needs who are often either at severe or imminent risk and whose needs are not being met by the current system. We will look to coordinate and bring these services together in a new way to maximize their reach and create more intentional clinical pathways for children and youth. We will align the amount of coordination/navigation based on the needs of the family so that the input into the system brings the most value. Navigation will also be easier by using common titles,

roles and descriptions. We will collaborate to provide education for staff across our partners to understand the value and role which Indigenous organizations provide to children, youth, families during navigation.

- Navigation should start early in the care journey so that children, youth and families don't ever feel like they don't know where to go. We understand that navigation is itself an intervention, not not a precursor, and that meaningful navigation positively impacts the entire care trajectory for a patient and family. The bilingual Coordinated Access and Navigation Service will create system navigation services that are driven by the needs of children, youth and families as close to home as possible to access the best treatment. This will be accomplished by:

    - **Direct booking for children and** youth into services providing the best treatment option as determined by screening, assessment, triage, evidence, collaborative case formulation and goals and preferences of child, youth and families/caregivers

    - Coordinated access and navigation staff who **stay involved** with children, youth and families/caregivers.

    - **Facilitating navigation to adult services** as appropriate and thereby supporting other OHTs and youth in understanding the care journey and what the goals of care are.

    - **Combining peer navigation with clinical navigation** by having a team of peer and family staff that possess clinical capacity and expertise and as well as individuals with lived experience.

    - The navigator program is an inventory of resources, we will build upon what already exists and the 211 Community Information Centre of Ottawa

    - **Provide a toll free staffed regional number and web option** so that children, youth, families, service providers, primary care and pediatricians have easy access to information about available services. **Increasing the spread of mobile and digital tools** to alleviate the challenges and barriers to accessing treatment for children, youth and families.

    - **E-referrals, assessment and triaging, accessing and sharing health information electronically, and direct booking** will ensure that all children and youth are navigated to the right service more efficiently.

BEFORE and AFTER

Roxanne is the mother of a 13-year-old youth with mental health needs

Right Now: : Roxanne is the mother of 13 year-old Lucas, who is struggling so much he barely makes it to school, or even out of his room. Lucas's doctor referred him to a psychiatrist, but they are still waiting for an appointment. Roxanne brought him to hospital emergency last night after finding a suicide note – the second time this month she's been afraid for his safety and didn't know where else to turn. Lucas is getting worse, and Roxanne is terrified, exhausted, and now struggling herself– no one seems to understand what she's going through or how serious this is.

Kids Come First: Roxanne is the mother of 12 year-old Lucas, who is starting to show signs that he is struggling. His doctor connects Roxanne to a Family Peer Supporter - a parent who has been through similar challenges and understands what she's experiencing. Together they put together a plan that includes his school, doctor, a social worker, and Roxanne – all on the same team, and with support from the Kids Come First experts. Every step of the way, each provider on the team is working with the same story and current information – both Lucas and Roxanne feel heard and understood. While Lucas gets help, so does Roxanne. She feels supported and prepared. She knows what to watch for, and who will catch them if things start to escalate. When the Family Peer Supporter calls to check in, she shares that she's feeling optimistic that her now 13-year old is back in school, and on the right path.

Drawn by: Aryin age 13

    - **Implementing defined pathways to Indigenous organizations** to provide culturally -based care to Indigenous children, youth and families/caregivers and where there is capacity, navigation services should be led by Indigenous organizations.

- We have heard directly from parents and caregivers that one of their chief concerns is the frustration of having to interact with so many different organizations, each with their own policies, operational procedures and practices which makes it hard for families to navigate and requires that they have to adapt to each organization's approach. The families with the greatest care needs face the greatest burden.

- With the alignment of home and community care with other child and youth health services, we will reduce the number of organizations that children, youth and their parents interact with, resulting in streamlined communication, reduced miscommunication and errors, and increased efficiency and safety.

How we will make care better for children, youth and families:

- They will understand the treatment options available to them or their child/youth based on their assessed needs, goals and preferences and are supported to access the treatment option of their choosing. Children, youth and families/caregivers will understand what the available services are and how to access them, and how long it will take to receive these services.

- When current services are not meeting children and youth's needs, they will be supported to seamlessly transition to different treatment services, including adult services when appropriate.

How we'll make Ontario's' new OHT system successful;

- Family physicians and community pediatricians will no longer spend hours trying to figure out what services are available, where and for whom. They will be able to easily access information on available mental health and addiction services for the children and youth in their care and won't have to spend precious time on sifting through information. They will be able to easily refer children and youth to the Coordinated Access and Referral service, including online and through their EMR, to access mental health and addictions services.

- The following are potential Mental Health and Addictions indicators for determining whether the Kids Come First's system navigation service is successful:

    - The number of navigator/coordinator connections that have been made for the family

- The number of organizations/agencies using SPOC document as primary source of information
- Increased number of peer support/peer navigator connections
- Using the tracking tool in EPIC for those with access, to demonstrate how early we are transitioning youth/children
- Track how many youth have made it to follow-up appointments
- Family experience feedback

- The following are potential Complex Care indicators for determining whether Kids Come First's system navigation service is successful:
  - Decreased length of hospital stay over two years
  - Avoidable ED visits
  - Number of monthly symptom assessment admissions and as needed assessments conducted at Roger Neilson House
  - Experience of home care service provider organization frontline workers in accessing resources
  - Collecting data on the linguistic variable to inform whether we are successful at coordinating services in language of choice

3.3.3 How will you improve care transitions?

Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population.

Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

- With many transitions between providers, the complexity of the system and challenges of transitioning to adult services, parents/caregivers spend a great deal of time advocating for their children's needs, repeating their stories and coordinating care. The purpose of Kids Come First is to address this problem, improve the patient/family experience and increase access to quality services.

- In Year 1, members of our team will work in partnership with children, youth and families/ caregivers and other OHTs to develop transition services to and among mental health and addiction services for children and youth, between primary care and mental health and addiction services and from our team to other OHTs in the Champlain region. We will prioritize working with other OHTs to develop clear clinical pathways between services of other OHTs that are needed for children, youth and their families/ caregivers. Transition services will be proactively offered in both official languages. For children and youth with complex medical needs, our goal is that we will collectively – through Kids Come First – have oversight and coordination of care for children and youth. This will streamline hospital to home transitions as well as those between community-based providers. Staff, frontline staff from service provider organizations, patients and families will benefit from our Team's strong pediatric professional practice infrastructure. We will work with our partners, children and families to identify and co-design the coordination functions that are most helpful to inform movement forward and how we will support family physicians and community pediatricians in maintaining closer connections to the children and youth in their care.

- Through improved integration of mental health and addiction services, children and youth will experience fewer transitions. Kids Come First will ensure there is flexibility around age and admission criteria as well as no refusals of access to treatment. Children and youth will have access to multi-disciplinary teams, and support will be provided to access primary care for those who do not have a family physician. Children and

youth will be involved in shared decision making, experience standardized discharge planning processes and plans that include system navigation support, and for youth that are transitioning back to school, they will be offered programming to support social connection and to reduce loneliness and social isolation. Longer term care planning will be established, including clear care pathways with other OHTs for adult services. Across all transitions, our team will ensure that there is a feedback loop between providers to ensure the transition was the 'right' one.

- In Year 1, we will collaborate to provide education across the Kids Come First partners to recognize that Indigenous children and youth are extremely vulnerable during care transitions, and to understand the value and support which Indigenous organizations provide to children, families and OHT partners during care transitions.

- Our team currently participates in initiatives to improve transitions for children and youth with mental health and addictions. The strengths and challenges of each of the following transition initiatives would be considered in the co-development of the Coordinated Access and Navigation service and built on wherever possible.

    - Choice and Partnership Approach (CAPA)

    - Coordinated Access for Mental Health and Substance Use/ Addictions Services in Champlain LHIN

    - Lanark County Situation Table Project

- For children and youth with medically complex needs, there are a number of programs and resources in place to support transitions including:

The transition to adult care program "on my way" which follows 7 key principles for effective transitions

- Prepare youth at 14 -years-of age and their families to foster healthy development in all domains
- Involve child/youth and families in transition planning starting at 14-years-of age and at each appointment
- Use of a planned and coordinated approach
- Ensure progressive movement towards active participation in health management
- Ensure excellent information transfer
- Re-frame "leaving pediatrics" as an achievement
- Continually evaluate programs/services

Transition to Adult Care Tool Kit

- My Health 3-sentence summary
- Birth to 18 Years Skills List
- Transition Readiness Checklist for Parents
- Transition Readiness Checklist for Teens
- Develop your own Health Passport (SickKids)
- Suggested Stages of Transition
- MyTransition App - created by CanChild at McMaster University

Complex Special Needs transition to Adult Care Tool Kit

- My Health 3-sentence summary
- Transition Readiness Checklist for Parents of Youth with Complex Special Needs
- Transition Readiness Checklist for Teens with Complex Special Needs
- Complex Special Needs Transition Resource Guide
- Transition Timelines for Children and Youth with Complex Special Needs
- Develop your own Health Passport (SickKids)
- Secure/Build a relationship with primary care provider/family physician
- Portal on LHIN website

3.4 How will your team provide virtual care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

Please refer to Appendix B – Digital Health to provide your proposed plan for offering virtual care options to your patients.

CONTENT IS PROVIDED IN APPENDIX B – DIGITAL HEALTH

3.5.1 How will you improve patient self-management and health literacy?

Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team's existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

- Children, youth and their families/caregivers will receive timely and relevant support and tools to help them with their mental health and/or addictions concern, supporting their resilience, wellness and recovery. Following Year 1, all children and youth with a mental health or addictions concern and their families/caregivers will have access to culturally safe self-management and health literacy supports in the official language of their choice, including tools to support mental wellness and mental health promotion, through a central repository connected to our coordinated access and navigation service.

- Kids Come First will provide culturally-safe education series and workshops for families/caregivers co-designed and co-delivered by families/caregivers in English and in French (in-person and online eg: OTN, Zoom) and we will provide skill and capacity building training in both official languages for families/caregivers for common mental health disorders. Since stigma is still a barrier for accessing resources, we will leverage connections with schools and other community-based services to promote access to these resources. Families have told us that medication management is a current gap in our system so we will explore youth and family co-designed tools to support medication management (e.g. building off the former Med Ed resource for youth aged 12-24 years and their care partners).

- We will build off our existing infrastructure in Year 1, by integrating our existing programming into our coordinated access and navigation service and by curating our existing information and self-management resources into a central repository, promoted through our coordinated access and navigation service's toll free staffed regional number/website.

- In Year 1, our team will expand on the following existing tools and programs within our region in both official languages to our target population of children and youth with complex mental health and addictions needs and their families/caregivers:

    - Family peer support and peer family navigation
    - Youth peer support and peer-led wellness services integrated for mental health and addiction.

- Youth-led mental health literacy programs
- Psychoeducational groups and sessions through hospitals and community-based mental health and addiction services
- Vetted online self-management tools for youth and families/caregivers
- Ementalhealth.ca repository of tools and information

- Health literacy involves more than access to information; it encompasses an understanding of how to use available information. We will build literacy and capacity as we develop the single-point story-telling platform through key workers in each organization, peer support programs, and child, youth, and family partnerships. We will develop strategies to align language and terminology across all care providers to enhance health literacy so that families are not struggling to understand what different words mean in different organizations.

- Children, youth, and families will co-create a single-point story-telling document, providing opportunities to enhance health literacy. The document promotes self-management and self-advocacy and every organization and care provider has access to the same information. Feedback from families is that a document such as this also provides them with credibility amongst healthcare providers they are unfamiliar with, providing additional support regardless of time, date, or location.

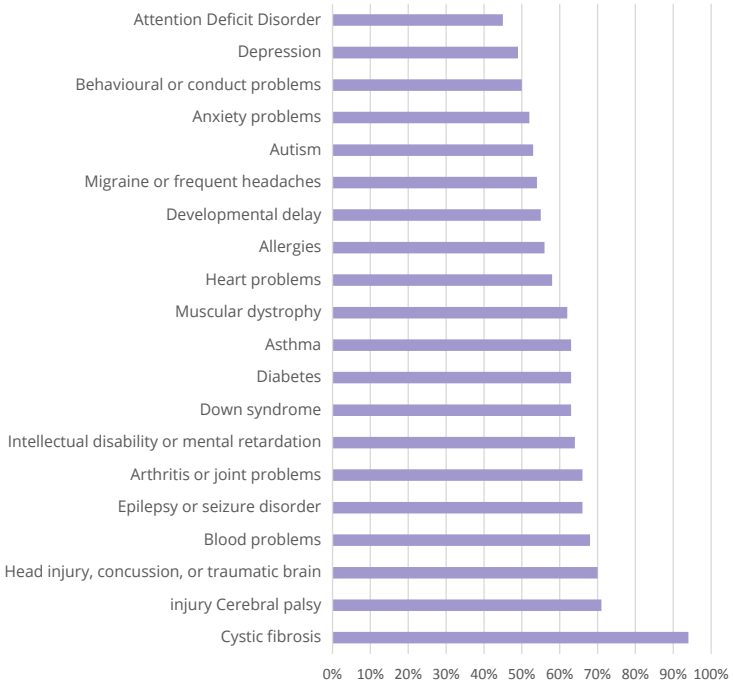
- Evidence-based information on immunization is available through CANImmunize, children, youth and caregivers will have digital access to their official immunization record and vaccination status compared to the provincial schedule. Timely, accurate information on vaccination will be provided. Push messaging will be sent directly to users, tailored to the age of the child on additional health information such as breastfeeding, healthy development milestones, car seat safety, sun protection, etc., and recalls/reminders and outbreak alerts in their local areas will be issued.

- With CANImmunize, children, youth and parents/caregivers will have digital access to their official immunization record and be able to see their vaccination status compared to the provincial schedule. Through the CANImmunize Knowledge Centre, they will have access to information on immunization, supporting improved health literacy and awareness of local outbreaks of vaccine preventable diseases.

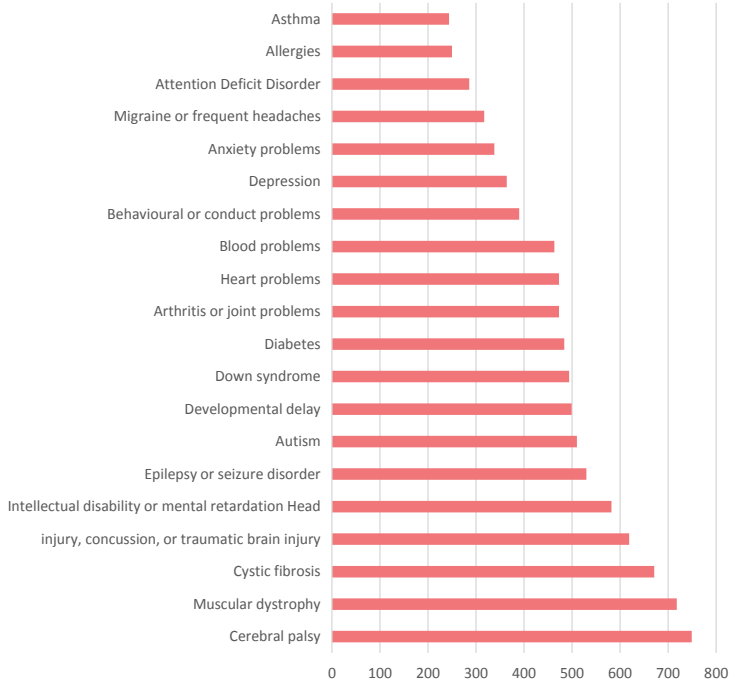
- For children and youth with complex medical needs, Kids Come First uses numerous self-management and health literacy tools. In Year 1, we will build upon the following:

    - The tell-back/teach-back model used in family and community-based practice for medical care;

Likelihood of Receiving Family Provided Care at Home



Average Annual Family Care Hours per Recipient



Likelihood and Intensity of Family Provided Care by Child's Diagnosis

Families are the backbone of the child and youth health system. Families provide more health care services to the LHIN's children and youth than any group of health care professionals. Families make two major contributions to the health system. First, they meet their children's need for services. Second, they help make best use of system resources by avoiding formal service use, including hospital and home care services. The following table shows the findings of family provided care for children and youth with special needs.

Source: THRIVE - The future of integrated health service planning for children and youth in the Champlain region. Page 48.

- Self/caregiver-management programs for devices such as IVs; annual meetings between providers, children, youth and families to review care plans and provider learning opportunities for families.

- The simulation program at CHEO provides an opportunity for children and families to learn how to manage airways, catheterize, care for feeding tubes at home prior to discharge. We will explore ways to use this program to promote self-management and health literacy on a broader level.

- The Newcomer Navigation Program and Toolkit provides resources and support for the growing number of children with medical complexities and their families from outside of Canada.

- Changingyourlens.ca is a website that provides health professionals parents and caregivers with resources and tools to better support parents and caregivers of children and youths with medical complexities. The website was developed in partnership with Pinecrest-Queensway Community Health Centre, CHEO's Navigator Program/Complex Care Team, Children's Healthcare Canada and with input and resources from across Canada

Impact for Providers and other OHTs

CANImmunize will free up clinician time that can be redirected towards patient care by reducing the administrative burden of in-person appointments to assess and retrieve immunization records for parents. Immunizations administered by clinicians, public health and pharmacists can be captured on one record.

3.5.2 How will you support caregivers?

Describe whether your team plans to support caregivers and if so how. In your response, include any known information about caregiver distress within your community or attributed population, and describe how your plan would address this issue.

- Beginning in Year 1, the implementation of the coordinated access and navigation service will improve family/caregiver experience. Specifically, to support families/caregivers of children and youth with mental health and/or addictions concerns, our team will increase access to family peer and child/youth peer support and navigation, building off existing services in the region. Through the enhanced use of telemedicine, eConsult, and eReferal, we will reduce the burden of travel and transportation arrangements by increasing access to care closer to home which will be culturally relevant, specialized services for families living in rural areas as those in urban settings. Our team will provide outreach to families/caregivers, including through partnerships with other community agencies, provide access to much needed respite services, and offer supports if/when children and youth are waiting for services.

- Through our redesigned mental health and addictions services and a range of culturally safe family/caregiver supports in English and French, families/caregivers will be better able to cope and care for themselves and they will have improved experiences accessing and receiving services. Research demonstrates that children and youth with mental health illness who have strong family support have better outcomes. By supporting families/caregivers through Kids Come First, we expect the effectiveness of providers' interventions will be enhanced.

- We will continue to use an interdisciplinary team model approach and expand this to include multiple services and organizations when possible to ensure a holistic perspective of caregiver needs and issues.

- Key workers within organizations and primary care providers will provide a contact point for caregivers and provide resources, support and guidance on a regular basis. We recognize that caregiver distress is not always visible, tangible, and measurable so we will provide a proactive approach that includes health literacy and self-management tools in promoting caregiver wellness. Peer support in terms of navigators, intake providers, and matching programs have proven immensely valuable and we will look for opportunities to expand upon these programs, roles, and functions.

- Educational tools such as Changingyourlens.ca is helping to educate and build capacity on how to support the emotional, social and financial impact on families.

- A recent survey by Parents Lifeline of Eastern Ontario of families/caregivers of children and youth aged with mental health and/or addictions issues found that over 70% of respondents find it very or extremely challenging to cope and care for themselves. We will continue collecting data on family/caregiver distress through existing survey mechanisms and through the continued use of the OPOC-MHA Caregiver tool, currently in use by multiple mental health and addiction agencies in the region to track our progress.

- We will work together to develop recognition in health care providers that there may not be visible or measureable signs of distress in caregivers, promoting the need for all workers and organizations to provide clear and concise information on support available to everyone.

- Rotary Home offers a regular respite program which provides families with peace of mind knowing that there are regularly scheduled opportunities to recharge as a family. In addition, 100 nights of emergency respite are available through Rotary Home to accommodate last minute requests that may signify a family is in crisis and needs somewhere to turn.

- Roger Neilson House provides monthly symptom assessment admissions to the most medically complex children to support families increased need for respite, decrease hospitalization rates, and monitor symptoms that are distressing for the child and/or families.

- We know that language barriers can contribute to caregiver distress, so we will seek out opportunities to increase the number of bilingual care providers, build upon translations services, provide written information in multiple languages, and respond to the needs of the community (ex: providing French support groups if needed).

- With CANImmunize, families' entire immunization records are together, in one secure place. This will make it easier for caregivers to manage the process of immunization for those that the care for, as well as themselves.

BEFORE and AFTER

James is a 17-year-old with health and mental health needs

Right Now: : James is a 17 year old living near Chalk River. Lately he has been feeling sad and not interested in school or his friends. He's had severe depression in the past. James is worried that his depression is coming back. His family doctor retired a year ago and he has been on a waitlist for a family doctor since then. His parents aren't sure what to do.

Kids Come First: James took a look at the Kids Come First mobile resource. He used this in the past to find apps and self-help resources. He had an on-line chat with a youth mental health worker who scheduled an urgent virtual teleconference with him the next day. A care coordinator was notified and she scheduled an appointment for him to meet his new family doctor. He and his parents were shown how to use the electronic shared chart. His parents were reassured to learn about the care plan and that James will have the help he needs.

Drawn by: Caleb age 10

3.5.3 How will you provide patients with digital access to their own health information?

Providing and expanding patients' digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity.

Please refer to Appendix B – Digital Health to provide your proposed plan for providing patients with digital access to their health information.

CONTENT IS PROVIDED IN APPENDIX B – DIGITAL HEALTH

3.6 How will you identify and follow your patients throughout their care journey?

The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers, implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.

Describe the mechanisms, processes, and/or tools that your team proposes to use to collectively identify, track, and follow up with Year 1 patients.

- Kids Come First is going to chart a new course that will change the way we have traditionally understood our patients' care journeys. We will identify, track and follow children and youth by implementing three key elements:

1. **A common unique identifier for each individual** (e.g., OHIP number) to appreciate each child or youth's unique path and needs across different care domains and providers.

2. **Evidence-based, standardized, age-appropriate tools** designed for screening, assessment, risk, and/or progress/outcome measures, relevant to the specific priority population:

- Possible examples for Medically Complex: InterRAI (Pediatric Home Care).
- Possible examples for Mental Health & Addiction: Inter-RAI (Child and Youth Mental Health), Feedback Informed Treatment (FIT), Global Appraisal of Individual Needs (GAIN), Ontario Perception of Care (OPOC), Ontario Common Assessment of Need (OCAN).
- Self-administered tools will be updated to be **linguistically and culturally sensitive**.

- Tools will work together to form a **comprehensive picture and track the progress** of individuals **across multiple domains** and **through transition into adulthood** (e.g., InterRAI suite of tools).

3. Standardized demographics:
- Required and preferred language must be consistently captured
- Cultural factors should be captured with sensitivity that many vulnerable populations, particularly Indigenous people, are reluctant to disclose their information fully due to ongoing mistrust of **health and mental health systems and services**.

- With all three components in place (i.e., unique ID number, common assessment tools, standardized demographics) and consistently collected within each partner's electronic record or database, this data along with service history, client and provider demographics, and costing can be brought together within a **common information platform** (precursor to a full electronic health record) to promote the following benefits:

  - Consistency when determining care needs or service requirements
  - Tracking kid's progress and milestones achieved against common tools, irrespective of the provider
  - Avoiding duplication or over-burden of assessment for kids and families/caregivers who move/transition between services or partners
  - Promoting common and consistent language and care pathways across providers
  - Common performance metrics and accountability to goals
  - Analysis of epidemiological trends and care inequities
  - Benchmarking of best practices and continuous learning
  - Identification of quality improvement opportunities
  - Integrated service delivery planning, including addressing unmet needs related to language or culture
  - Business intelligence to identify savings for reinvestment into areas of need
  - Facilitate movement of skilled providers between geographies/organizations to meet changing demands

- Ultimately, identification, tracking and follow-up will be made that much easier and more robust with the implementation of a common, integrated electronic health record. Such a system will provide additional benefits:

  - Promote consistent data collection across all providers
  - Alleviate kids and families/caregivers from having to retell their story
  - Allow a single access point for kids and families/caregivers to review their own health information

- Streamline analysis for quality improvement, performance management, business intelligence, and future service delivery planning

3.7.1 How will you work with Indigenous populations?

Describe whether the members of your team currently 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?

- In addition to leading the development of our team's strategy to address the health needs of Indigenous people, Indigenous-led organizations also collaborated on numerous working groups and participated in the team's Steering Committee. These stakeholders developed the following commitments for our members to adopt in order to specifically address Indigenous health care needs in Year 1 and in the longer term:

  - **Begin system-wide collaboration:** our commitment is to **connect and strengthen our relationship** with Indigenous-led organizations and engage in proper consultation

  - **Kids Come First will support Indigenous led research, monitoring, and data collection**: In Year 1, we will complete a needs assessment in alignment with the THRIVE report.

  - **Begin system-wide education:** In Year 1, we will collaborate to provide education for staff across our Team on historical context and current practices impacting Indigenous peoples health today to provide culturally sensitive care and recognize the complexity of trauma-informed care

  - **Kids Come First will respect "Culture as Treatment" approach:** Aim to provide kind and competent care and engage Indigenous organizations to provide culturally -safe care

  - **Define roles and responsibilities of OHT members:** non-Indigenous OHT agencies to take a supporting role in providing culturally-based primary care and mental wellness services for Indigenous children and youth which includes access to the culturally based services offered through Indigenous organizations.

- This team will attempt to bring Indigenous-led health and social service organizations into the fold on key initiatives that are in development or proven to work well with the goal of creating either an integrated or parallel process that can be tailored to the needs of Indigenous communities.

- This team is committed to the following relationship building principles: 1) appropriate and meaningful consultation; 2) true and equal partnership; 3) Indigenous right to self-governance; and 4) Indigenous-governed health care services – Indigenous health in Indigenous hands.

- Kids Come First is fully committed to work with Indigenous partners towards fulfilling Ministry's expectations outlined in Bill 74, The People's Health Care Act as it relates to Indigenous health and continue meaningful engagement and consultation with Indigenous-led organizations, health leaders and communities in the region.

- Our team will respect and support Indigenous-led health priorities:

    - As per the United Nations Declaration on the Rights of Indigenous People, Article 23

      "Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions."

    - As per the Canada's Truth and Reconciliation Commission (TRC):

      "There is a need to transform the health system for Indigenous peoples to ensure that the right systems, policies, and legislation contribute to the right care, at the right time, in the right place. This means ensuring that Indigenous peoples can exercise their inherent right to control their own health services.'

3.7.2. How will you work with Francophone populations?

Does your team service a designated area or are any of your team members designated or identified under the French Language Services Act?

Describe whether the members of your team currently engage Francophone populations 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.

- Kids Come First will create opportunities to better understand the needs and preferences of our Year 1 Francophone population of children and youth by conducting a needs assessment of Francophone children and youth to supplement the regional THRIVE plan. In addition, we will intentionally, uniformly and reliably gather data about the linguistic variable, ensure a significant Francophone representation of youth and family partners within our Team, and engage a larger population of children, youth, and caregivers.

- Our team will provide an opportunity to integrate the extensive Francophone capacity that currently exists across our region. We will enable more uniform language-specific data collection, and to better guide children, youth and their families to services offered in their official language of choice.

- Most of the children and youth in our geography live in one of the seven areas designated under the French Languages Services Act (FLSA). These include: the City of Ottawa, County of Dundas (Township of Winchester), County of Glengarry, County of Prescott, County of Renfrew (City of Pembroke, Township of Stafford, Township of Westmeath), County of Russell, and County of Stormont.

- Our team is already rich with organizations that are designated under the FLSA to offer services in French. In addition, some of our organizations that are not designated under the FLSA also deliver services in French to better serve their large Francophone population (e.g. Open Doors in Lanark have French-language capacity for mental health services). Over a dozen organizations within our Team plan, design, and deliver services for our Francophone Year 1 populations and as such they are in an excellent position to identify gaps to better plan an integrated system to serve Francophone children and youth. The Réseau des services de santé en français de l'Est de l'Ontario is the local French services planning organization and it will partner with Kids Come First to plan for the needs of our Francophone children and youth population.

- All of the local children and youth mental health lead agencies already have community engagement committees to help plan service delivery, including in the French language. Through centralized coordinated access, we will develop clear service pathways for access to French-language services to children and youth who request it. The Ontario Telemedicine Network (OTN) will enable Francophone children and youth to access some Francophone professional resources from outside the Champlain area.

- One of the issues being addressed is the availability of qualified staff to serve our Year 1 population in both official languages. Providers highlight the need to provide work environments where French-speaking professionals are given "French-friendly" work environments (i.e. with enough French tools available, the ability to document their work in French, etc.) to help with the recruitment and retention of top talent.

- Through a partnership with children, youth and their families, Kids Come First will help them to access a wider range of professionals capable of serving them in French. Our team presents a great opportunity to expand capacity to address the needs of Francophone children and youth by reducing service barriers and allowing flexibility between organizations.

3.7.3. 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.

- Within our team, there are innovative and impactful programs and services that are available to some of our most vulnerable children, youth and families. In Year 1 and beyond, we will look to further the impact of the following programs:

- **Wraparound Ottawa** (a partnership between the Youth Services Bureau, Crossroads Children's Centre and Coordinated Access) works with existing supports and services to help families, children and youth with complex needs (including a large portion of Francophone families) find solutions and work towards a better life. Teams made up of family members, friends, professionals, and others with a strong commitment to the family's well-being come together to "wrap" individual families in community supports. Together they create and implement an action plan that builds on the family's strengths, provides services to meet their needs, and guides them towards achieving their goals.

- **The Vanier Social Pediatric Hub** offers services in English and French to children and youth of Vanier, an underserved and high needs neighborhood, home to many vulnerable families including Francophones, newcomers, Indigenous and low-income. It is a collaboration between the Vanier CSC, CHEO, Montfort Hospital, Sandy Hill CHC and other providers. It provides welcoming child and youth centered, coordinated, comprehensive and integrated, interdisciplinary and inter-sectoral, holistic health and social care to the neighborhood's children and youth with support to their families and with respect and promotion of their rights in accordance with the UN Convention on the Rights of the Child. The Vanier Social Pediatric Hub **is the first in Ontario** to use this model and it presently offers services by referral to children and youth with complex psychosocial needs living or going to school in the Vanier area.

- **Infant mental health programs for children 0-6 years of age** and their parents and caregivers are delivered by Centre Psychosocial. In partnership with the Youville Centre, the infant mental health program is deployed within the Young Mothers programs (Programme jeunes parents) for women 14 to 25 years of age who are pregnant or have a child or children and who wish to complete their High School studies. The Programme

jeunes parents includes complementary psychosocial and educational components within a single program. The infant mental health program strives to promote mental health and wellbeing for children of these vulnerable mothers. The infant mental health programme is offered by several early childhood care centres operated by the Centre Psychosocial as well as other centers that are located in underprivileged neighbourhoods and whose childcare spaces are largely or totally subsidized by the City of Ottawa.

- CANImmunize has partnered with the First Nations and Inuit Health Branch (FNIHB) of the Federal Government to include the "Don't Wait, Vaccinate" materials in CANImmunize's Knowledge Centre. These materials are tailored for both First Nations and Inuit populations across Canada. CANImmunize has also worked with the Ottawa Newcomer Clinic and Government Assisted Refugees to produce a section for Newcomers to Canada, tackling topics such as "Where can I get immunized?" and "I have been vaccinated before. Do I still need to get vaccinated?". CANImmunize will continue to examine how to best address issues of diversity related to additional language requirements, Indigenous populations, medically complex individuals, and those who are vaccinating on modified schedules such as catch-up schedules.

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

D escribe 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.

- This proposal has been developed with the participation of young people, their parents and caregivers at every level — from the original THRIVE pediatric capacity plan to the identification of priorities for the new team. From the development of this Full Application to the naming of our team and with seats around every single decision-making table. This reflects our vision for the future: engagement with children, youth, and families will be replaced with partnership and co-design.

- A foundational principle for Kids Come First is "Nothing about us without us'. As partners in our future team, families/caregivers and youth will jointly determine the appropriate roles and mechanisms for this partnership to be effective, such as through representation in governance, advisory committees, implementation teams, and evaluation teams.

- In Year 1, we will establish a youth and family partner infrastructure which will be led by a youth or family partner. This collective of partners will include a diversity of individuals from across our region with varying care needs and experiences, as well as Francophone

and Indigenous partners to ensure our work will be inclusive and truly representative.

- Our team's youth and family partners will co-create our partnership framework building upon existing resources such as Health Quality Ontario's Patient Engagement Framework and CHEO's Partners in Health Toolkit. We will expand upon the successes, our participating organizations' many, long-established youth and family advisory committees. Our youth and family partners will provide guidance and direction in identifying opportunities to canvass broader groups of people, while appreciating the time and resource limitations that exist within our target population and their families.

- One of the reasons a child and youth-specific OHT is needed is to ensure the voices of children, youth and families are heard in the delivery of health and social services. Children and youth constitute a very small proportion of the overall users of the health care system. An overwhelming majority of children live with parents or caregivers, most go to school and many are involved in systems like child welfare, child care or youth justice. The health issues they face are substantively different from those that adults and seniors experience. The reality of kids' lives and their health challenges are rarely heard in health services planning and development. Our robust child, youth and family engagement structures will both shape our services and be a resource for all other OHT's in our region.

- We will incorporate a multi-faceted approach to involving children, youth and families in care redesign and will extend to partnering with caregivers beyond parents and guardians including siblings, grandparents, and extended family members and friends that are part of the child or youth's care circle. This will span the continuum of partnership approaches from sharing, to consulting, to deliberating and to collaborating through co-design and co-creation, across key domains of personal care and health decisions, program and service design, and policy, strategy and governance. We will adopt various methods including: co-designed youth and family experience surveys, story-telling, focus groups, ad hoc youth and family advisors with specific lived experience to inform key policy and/or processes, and experience based co-design including emotional mapping. Examples of key care redesign opportunities include: youth and family/caregiver partners co-designing the care pathways to other OHTs; ensuring our programs are seamless, appropriate, culturally safe and in the official language of their choice; and implementing fully-operational coordinated access and navigation service for integrated mental health and addictions service delivery. All of these will be the result of active partnership and co-design with diverse youth and families/caregivers, and with Francophone services specifically co-designed in partnership with Francophone youth and families/caregivers.

- With CANImmunize, user engagement is a key part of the development process. Voluntary beta testers to gather feedback on every release and we maintain a comprehensive

user support program which combines submitted information with digital analytics to best understand how the platform is utilized and can be improved.

Measuring success of our youth and family partnerships in care redesign

- We have heard from youth and families that there are three key areas to measure to determine whether youth and family partnership is successful in achieving care redesign; these align to key tenets of the Quadruple Aim: child, youth and family experience; physician and provider experience; and Improved care outcomes.

- First, we need to understand whether youth and family partners that have been co-creating with our partners, actually feel that they have had meaningful partnership throughout the process. We will do this by regularly measuring and assessing ourselves against established standards for youth and family partnership. The second key area that we need to measure is the extent to which our care re-design efforts positively impact experiences for family physicians, community pediatricians, and frontline providers and we will regularly seek their feedback through informal and formal means. Lastly, key outcome measures will demonstrate whether we are achieving improvement through our redesign efforts, that are consistent across the region as we reduce gaps and inequities in service delivery.

HOW WILL YOUR TEAM WORK TOGETHER?

4.1 Does your team share common goals, values, and practices?

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates. Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

- Our OHT Full Application signatories have identified the following principles which we share and which are aligned with the Ontario Health Team model:

    - Child, youth and family partnership in the co-design and ongoing leadership at all levels of operations within the team
    - Collaboration to better connect care for patients and families in pursuit of the quadruple aims
    - Clear and timely communication between members and within governance
    - Inclusive and transparent Evidence based decision-making
    - Prudent stewardship
    - Commitment to health equity
    - No single sector or organization to exercise control or dominance.
    - Balance of rural and urban priorities
    - Any bureaucracy must be aid of nimble decision-making or to be avoided.
    - Clinician autonomy is to be protected
    - Flexibility for organizations/clinicians to work with other OHTs and outside of the MoH environment
    - Lastly, all of our full application signatories strongly align with the value of the following statement “Nothing about us without us” where decisions must be co-lead by children, youth and families at all levels of governance and within all working groups or action teams

- Our full application signatories have identified the following goals and opportunities which are aligned with the Ontario Health Team model:

    - To make patient experience more consistent across providers
    - Ensure comparative outcome measurement and more efficient and effective sharing of best practices

- Leverage the influence which 60+ partners can have to secure public, private and philanthropic investment that would not be attainable by any one partner on their own
- Provide training and align professional development across members
- Pursue opportunities to shared infrastructure (i.e. digital health)
- Better support families with a spectrum of services available
- Managing transitions – between providers, through age milestones
- Creating capacity through collaboration
- Identification of gaps in service
- Data collection and analysis
- Make seamless patient experience across providers
- Efficiency around shared services and resources – (i.e. training, payroll, hr systems)
- Ensure better use of existing capacity, resources, and expertise, specifically to meet fluctuating demands

4.2. What are the proposed governance and leadership structures for your team?

Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework. Please describe below the governance and operational leadership structures for your team in Year 1 and, if known, longer-term. In your response, please consider the following:

- *How will your team be governed or make shared decisions? Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?*

- *How will your team be managed? Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines..*

- *What is your plan for incorporating patients, families and caregivers in the proposed*

leadership and/or governance structure(s)?

- *What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)? For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?*

The Kids Come First team is ready to establish an inclusive and comprehensive OHT governance model which will allow for operational, clinical and transformational benefits across our 60+ providers.

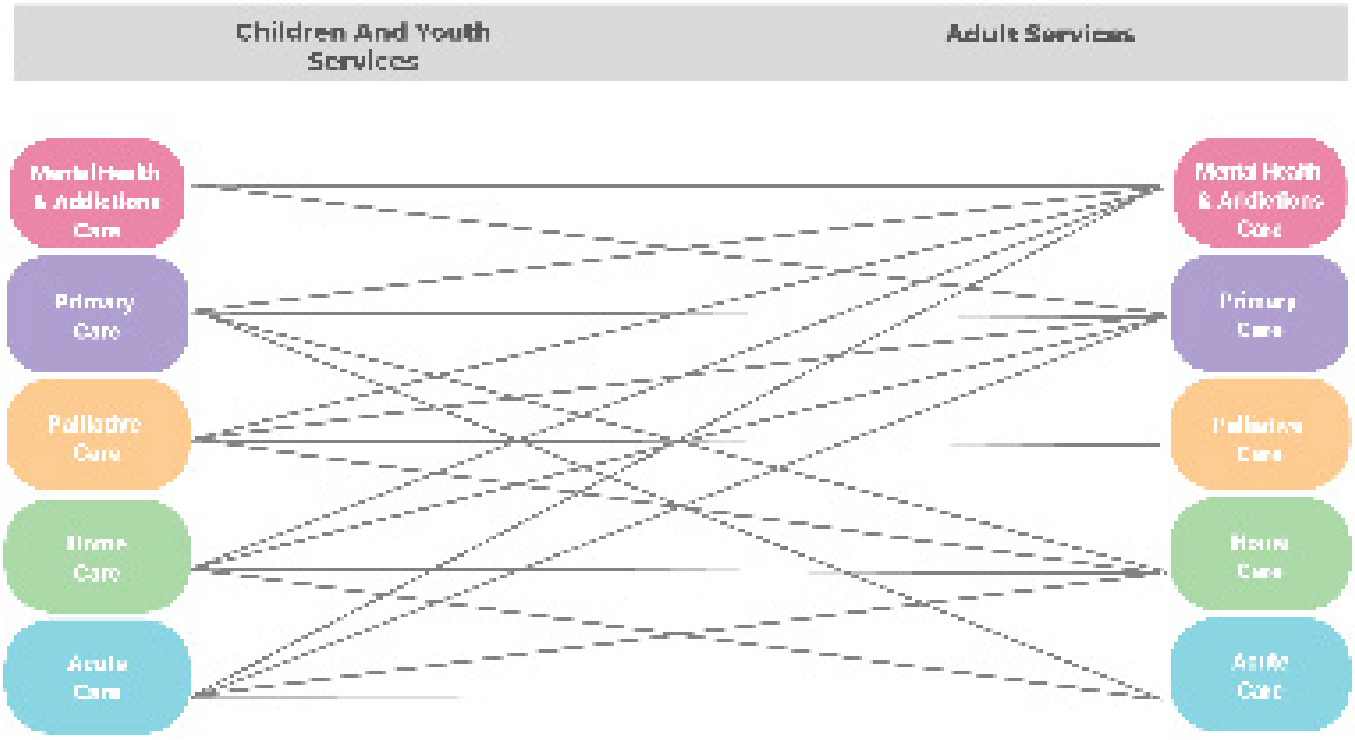
- Within our governance model we will bring together groups from multiple sectors to work toward a joint outcome with the focus being on action.

- Within all levels of governance — including in all action teams — decisions must be co-lead by children, youth or family members.

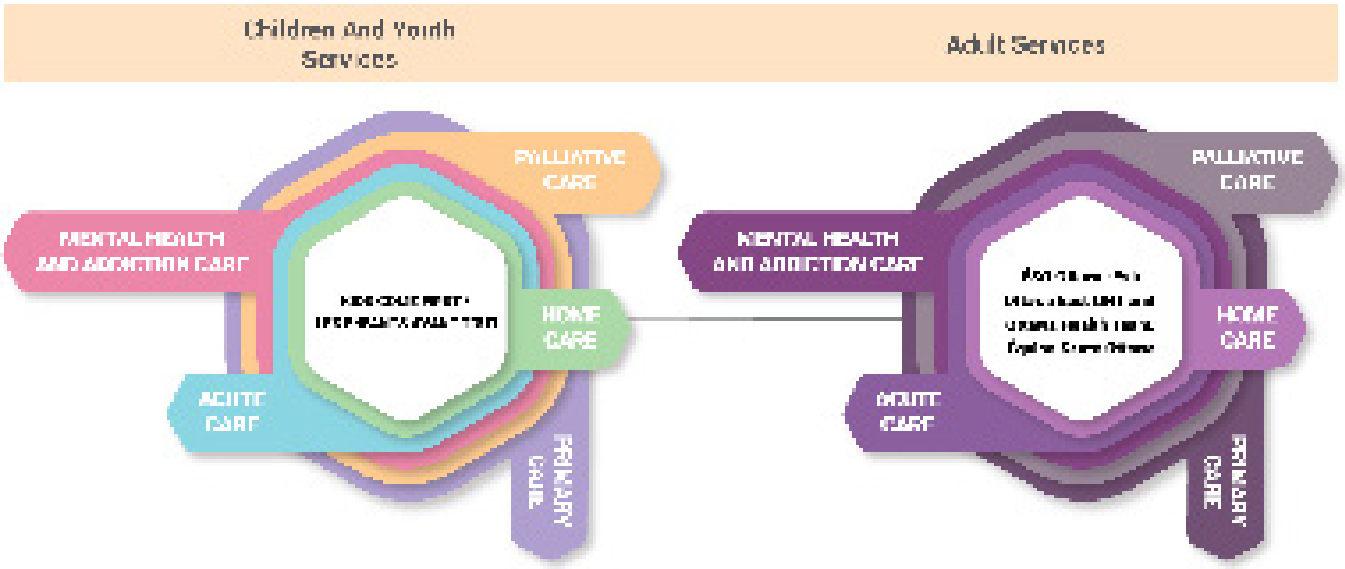
- Additional members may join our inclusive child and youth focused team easily as it is anticipated that as Kids Come First matures we will adjust our priorities to deliver upon the policy direction set by the Ministry.

Transition of youth to adult health services

Without OHT'S



With OHT'S



BEFORE and AFTER

Martine is an 18-year-old with medical complexity

Right Now: Martine has medically complex needs and has grown up in the child and youth medical system. She's worried that now she is 18 years old, she will be meeting many new health professionals for adult medical care. Martine has not been sleeping well and for her this means she's anxious about the upcoming appointments she has with these new providers. At her first appointment, the provider didn't have all of her medical history and health information, and was not aware of her recent housing concern. Martine was given a phone number to call for help. She left feeling discouraged, alone, and worried that the rest of her appointments would end the same way.

Kids Come First: Martine has medically complex needs and has grown up in the child and youth medical system. Now that she is 18 years old, she feels ready to move on to adult services. For the last 2 years, the Kids Come First team and the adult care team in the OHT where Martine lives, have been working together to ensure her transition from youth to adult services is continuous. At her first appointment in the adult OHT, the provider had access to all of Martine's medical history and health information and connected her with a social worker to speak with about her housing concern. She left feeling confident that a plan was in place and that her new care team understood her needs.

Drawn by: Aryin age 13

Member Organizations and Constituent Groups

- These entities are the participating clinical and key community members who make up the Kids Come First partnership.

- Constituent groups of these members, such as mental health service providers and community pediatricians, will be grouped together for common interest. Constituent groups will identify a senior representative(s), preferably the CEO or ED, to be part of the Steering Committee. Such representative(s) must be able to provide input and make decisions on behalf of the group.

- Member organizations are expected to mobilize their resources in support of the functioning of the Steering Committee and in support of the agreed upon priorities and strategies of the team, such mobilization and operationalization to be within the power and jurisdiction of each individual organization.

- The member organizations will be party to a joint venture agreement which will set out the roles and responsibilities of the parties.

- The structure will ensure representation by families, and specific populations (such as Francophone and Indigenous) in multiple ways throughout the governance and operation of the team. The process will seek design focus from families and specific populations in order to ensure outcomes which work for those groups.

- Physicians are part of the membership group and will be represented in the Steering Committee structure. It is important to confirm that physician compensation is not part of the mandate, responsibility or oversight of the team or Steering Committee.

- NOTE: Members may have functions which are not part of the mandate of this team. Nothing in the functioning of this team limits the ability of members to carry out their other mandates or liaise with other groups in pursuit of their mandate.

Steering Committee

- The Steering Committee is the coordinating body for the Kids Come First and is comprised of representatives of the full active members of the team. Its function is to (i) plan, (ii) establish strategy and priorities, and (iii) coordinate system metrics, reporting and accountabilities for the delivery of the services to the our populations. The Steering Committee will also have a primary role in liaising with the Ministry of Health and other government groups for both planning, implementation and reporting.

- The Steering Committee will oversee joint assets and resources and will coordinate the efforts to obtain joint or augmented funding and resource opportunities in the name of Kids Come First.

- This committee will oversee and plan for the evolution of team

- The Steering Committee will be comprised of between 12-20 representatives whose role, while being a representative of a specific entity or group, is primarily to act in the interest of the greater team. In addition, spaces on the Steering Committee will be dedicated to specific populations and families, being an essential element to the functioning of the Kids Come First.

Action Teams

- The action teams fall into various categories, each to liaise with one another and with the Steering Committee. While the different types of action teams are set out below, they are not mutually exclusive in that individuals from, for example, a Specific Populations (Francophone, Indigenous,etc.) Team, may also be direct participants in a Collaborative Service Delivery Team so as to ensure a direct link to the perspectives and functions involved. The teams, however, may also function separately in order to ensure they have the opportunity to work amongst themselves.

Participants in Action teams

- **Members:** These are individual from entities who make up the team partnership

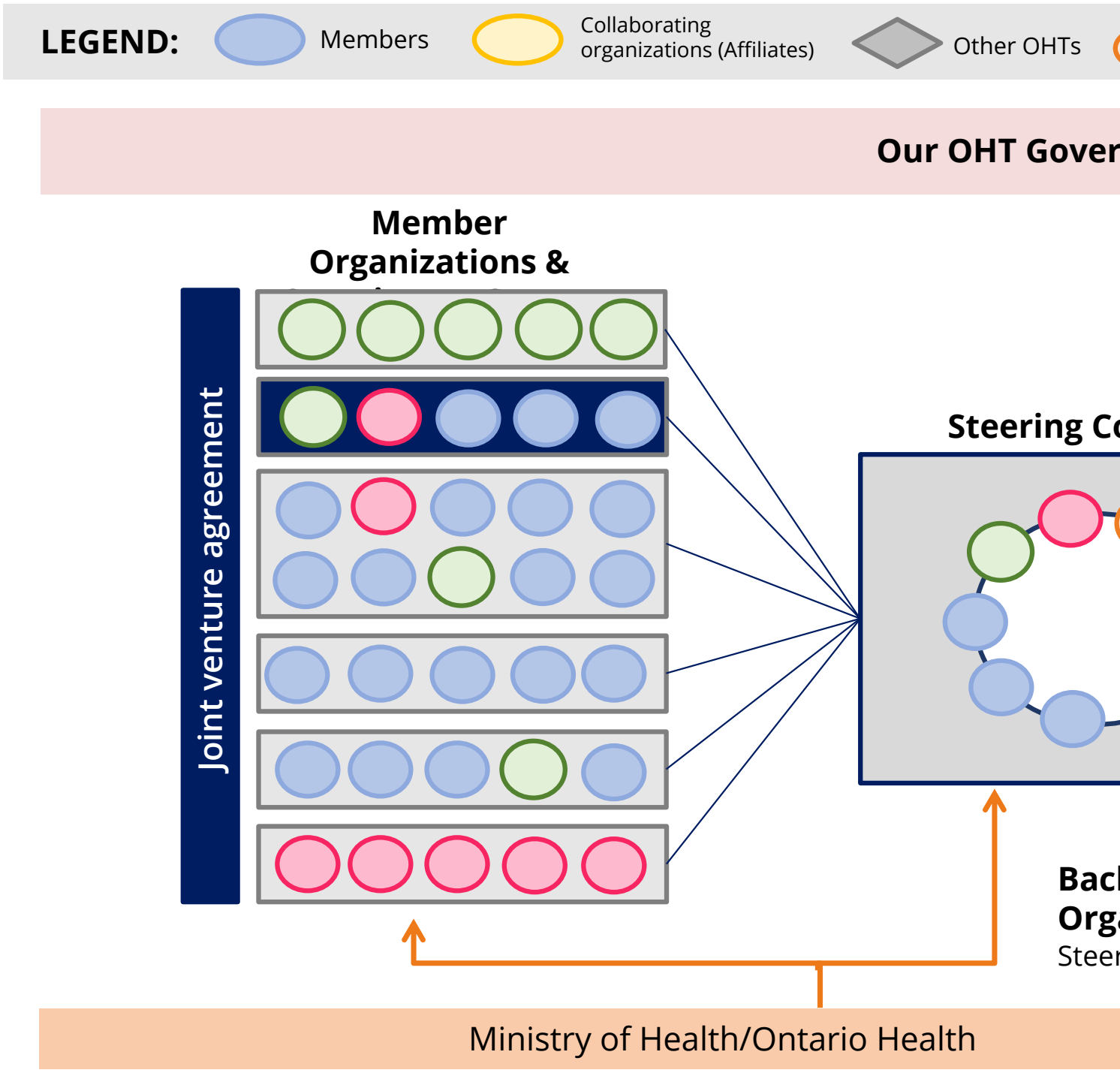
- **Collaborating organizations (Affiliates):** Represent non-member organizations who advise and endorse action team work

- Our team will refine the concept of full membership and affiliate member status to allow diverse engagement while maintaining a core group of members

- **Children, Youth & Family:** The governance structure will seek representation of families, and specific populations on all levels of governance in co-leadership roles

- **Specific Populations:** The governance structure will include representation of specific populations such as Francophone and Indigenous in multiple ways throughout the governance and operation of the team

- **Other OHTs**: As a team focused on children and youth, it is essential that Kids Come First



MEMBERS

- Individual Organization Autonomy
- Collectively select Steering
- Support Teams strategic plan
- System metrics/Outcomes
- Mobilize and support Action Teams

STEERING

- Strategic pl
- Coordinati
- Advocacy
- Scorecard

Physicians & Clinical Leaders

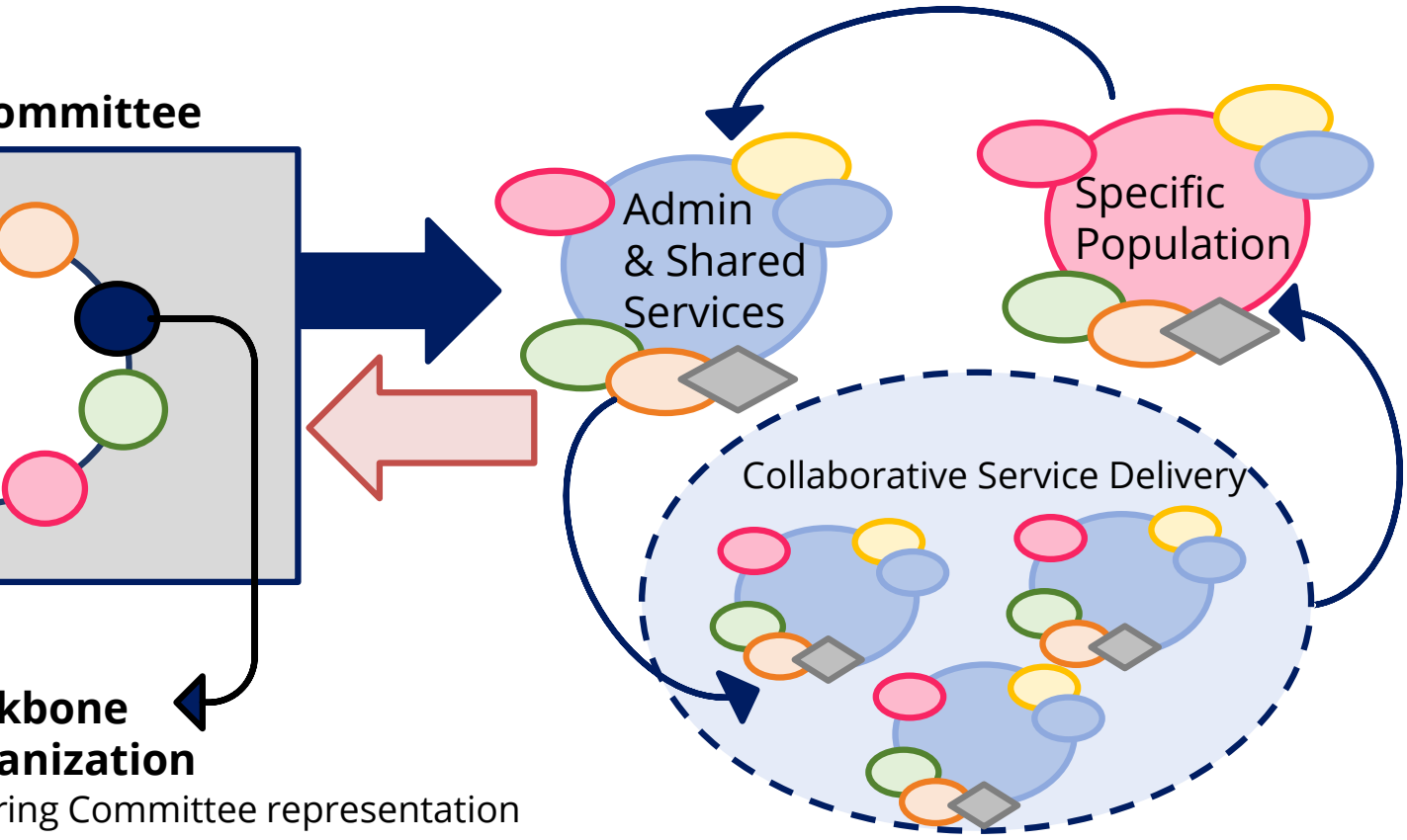
Children, Youth & Family

Specific Populations (Francophone, Indigenous,etc.)

nance Structure

ACTION TEAMS

(i) Collaborative Service Delivery, (ii) Specific Populations,
(ii) Administrative and Shared Services



ommittee

kbone anization

ring Committee representation

anning
on

- Independent dollars
- Empower Action Teams
- System needs (Common Data)

ACTION TEAMS

- Collaborative service delivery
- Mobilize to meet system outcomes
- Collaborate/Communicate

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How health care is imortant to kids
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THRIVE:
The future of integrated health service planning for children & youth.
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as a whole, and individual action teams as appropriate, liaise and function in support of other OHTs providing a continuum of care in the region and beyond.

Types of Action Teams

Collaborative Service Delivery:

These groups will implement and be responsible for the delivery of direct clinical and health services. This will be in accordance with their mandates and skill sets. Strategies, priorities, metrics and reporting will be coordinated through the Steering Committee in which members have had a role through their Steering Committee representatives.

Specific Populations (Francophone, Indigenous,etc.):

These teams will partner with the Steering Committee, the other action teams and the Team as a whole on matters such as language and cultural issues, Indigenous matters and other issues which may arise. This is a crucial function and is to be visible and meaningful.

Administrative and Shared Services:

These teams may include such matters as shared infrastructure or support services where opportunities arise and can be beneficial. This may also include common data collection and reporting. Importantly, this also includes digital health and the evolution of health systems into a more integrated digital environment, such being an expectation of the government.

Conflict resolution

- Our team has determined that the following progressive conflict resolution process be adopted by OHT members and affiliates:

1. Steps to minimize conflict and seek a consensus decision
2. Referral of issues to the Steering Committee
3. Referral to board chairs (if an organization has no board, the process moves to the next step)
4. Referral to 3rd party mediation through the Steering Committee
5. Option to exit the team on notice

4.3. How will you share patient information within your team?

At maturity, Ontario Health Team will have the ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team?

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

- Our youth and family partners have highlighted the importance of appropriately protecting personal health information while also ensuring that their information is available when and where it's needed. Kids Come First will establish policies and processes to safeguard personal health information as well as data sharing arrangements and, if appropriate, health information network provider agreements. The magnitude and significance of the information and data flows will determine the nature of the safeguards to be established with and among individual organizations. Having a variety of safeguard tools will allow our team to enhance protections quickly as data flows change and new clinical service activities develop among the team's partners. Updates to PHIPA based on the needs of current digital realities will support the vision of Kids Come First and will ensure that the expectations of children, youth and families/caregivers are met.

4.3.2 How will you digitally enable information sharing across the members of your team?

Please refer to Appendix B – Digital Health to propose your plan for digital enablement of health information sharing.

- Please see Appendix B - analysis of the solution being recommended.

How Will Your Team Learn & Improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any?

Identify whether any of your team members have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

Where there are issues, describe whether there is a plan in place to address them. Indicate whether participation on the team will help and why. Indicate whether there will be any formal accountability structures in place between individual team members and the team as a whole for ensuring that individual performance or compliance issues are addressed.

- All Kids Come First partners are in **good standing** regarding governance, financial management, and compliance with contractual performance obligations, applicable legislation or regulation.

- Care organizations and facilities periodically undergo **voluntary external review or accreditation** from relevant standards bodies, such as:

  - Accreditation Canada
  - Canadian Accreditation Council (CAC)
  - ISO
  - Commission on Accreditation of Rehabilitation Facilities (CARF)

- Some organizations (e.g., home care service providers) are obligated to undergo appropriate accreditation and financial review to be eligible for government contracts.

- Organizations **learn and improve** from external review/accreditation activities through the knowledge and experience of the surveyors.

- Physicians and other independent professionals are compliant with their relevant **regulatory colleges,** such as:

  - College of Physicians and Surgeons of Ontario (CPSO)
  - College of Psychologists of Ontario (CPO)
  - College of Registered Psychotherapists of Ontario (CRPO)
  - College of Nurses of Ontario (CNO)

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All partners view collaborating in the Kids Come First model with the perspective of *Stronger Together.*

- Collaboration, sharing of ideas, and learning from each other will ensure that all organizations meet and exceed minimum standards, but also achieve the **Quadruple Aim.**

- Newer standards focusing on **integrated care** models and **partnerships,** along with increasing emphasis on **client and family-centred care,** will be achieved by learning from each other and leveraging existing partnered frameworks.

- Common external review or accreditation processes may yield efficiencies or savings.

All Kids Come First members will be accountable through a formal Joint Venture Agreement.

- This agreement between the members will be established **prior to implementation.**

- This agreement will clarify responsibility issues between and among the members as well responsibilities for joint or team owned resources and deliverables, including:

    - Clear and timely evidence-based decision-making processes
    - Conflict resolution
    - Performance management and a commitment to system metrics
    - Data collection, information sharing and resource allocation

Quality and performance improvement and continuous learning are supported by strong accountability.

- Effective **accountability structures** come from the development of **shared vision, values, and targets** for key performance indicators (KPIs) that all partners are contributing towards.

- KPIs may include **process, outcome and balancing measures** as part of well-rounded **evaluation framework** that considers the child or youth along with the family/ caregivers, the care providers, and the system – delivering on the **Quadruple Aim.**

- Quality improvement efforts map **shared processes,** identify and **remove barriers**

and inefficiencies, and yield the best way to complete a task. Expectations that partners complete tasks in the prescribed way becomes a key accountability outlined in the **accountability agreement.**

- Outcome measures reflect what is most important to the kids and families/caregivers, as well as the outcomes clinical experts and the system will drive to and celebrate, such as:

  - Increased vaccine uptake rate
  - Decreased attempted and completed suicide rates
  - Increased school readiness and high school completion rates

- **Achievable Benchmarks of Care (ABCs)** can be used to identify organizations or providers able to achieve the highest quality outcomes to facilitate learning and improvement of others towards these high outcomes.

- **Balancing measures** are important for monitoring and mitigating **risk**, especially during times of **change and disruption.**

5.2. What is your team's approach to quality and performance improvement and continuous learning?

Ontario Health Teams are expected to pursue shared quality improvement initiatives that help to improve integrated patient care and system performance

5.2.1. What previous experience does your team have with quality and performance improvement and continuous.

Describe what experience each of the members of your team have had with quality and performance improvement, including participating in improvement activities or collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).

Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.

Describe your members' approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.

Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all memberorganizations/providers

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Kids Come First partners are dedicated to quality improvement and achieving the Quadruple Aim, in partnership with children, youth and families.

- Improvement within an integrated health delivery model will occur through a combination of **significant *disruptions* and iterative *optimizations.***
- Partners are coming together to collaboratively increase **quality improvement (QI) capacity and culture** and deliver **improved service quality and outcomes.**
- Partners will develop a **shared quality framework** and **performance metrics** relevant to the focused areas of improvement.
- Effective quality improvement requires skills and competencies for staff to not only do their work, but to also improve their work.
- Most partners use **Lean** as their QI approach; others use Health Quality Ontario's IDEAS program or Institute for Healthcare Improvement's Model for Improvement.
    - All methods share **common tools and language** around clear problem and goal definition, prioritization and focus, stakeholder engagement, being data-driven, and iterative small tests of change (i.e., Plan-Do-Study-Act or PDSA cycle).
    - **QI huddles** promote staff engagement, problem-solving and alignment of initiatives to **strategic goals.**
    - Common QI tools and training will be **adapted** to be **linguistically and culturally appropriate** for our partners and stakeholders.

- **Coaching** to expand QI **capacity** is within the mandate of many partners:
    - Larger organizations have multiple staff members with yellow, green or black belt **Lean certification** spreading this knowledge internally.
    - Smaller organizations **pool resources** to share QI experts, which aligns data collection, process improvements, and outcomes across partners.
    - The mandate of **Ontario Centre of Excellence for Child and Youth Mental Health** includes developing QI capacity within the sector and driving **performance standards** contained in a sector-wide **quality framework.**
    - **Ottawa Public Health** participates in the Ontario Locally Driven Collaborative Projects program, "Strengthening continuous quality improvement in Ontario's public health units" to build common QI capacity across public health units.

Quality improvement, program evaluation, and performance management activities rely on robust data and analytical capacity

- **Data** for QI is collected through provision and documentation of care, process audits, satisfaction surveys, outcome measures and feedback:
    - LHIN Care Coordinators use InterRAI Pediatric Home Care and Child and Youth Mental Health tools to determine home care service requirements; mined data supports QI to identify community needs, strengths and preferences.
    - The Champlain Continuous Quality Improvement Committee, combining over 20 mental health and addiction agencies with patient and family reps, analyzes Ontario Perception of Care (OPOC) data to identify shared priority improvement initiatives.
    - School-based development and rehabilitation services (Physical therapy, occupational therapy, speech-language pathology) are reviewed annually through surveys of school partners and families.

- Our team **leverage IT platforms and digital tools** to collect, combine, analyse, and report data from **different systems** for **performance management** across partners and care domains.
    - **Epic**, CHEO's integrated electronic health record, includes **EpicCare Link** to share patient information with partners (e.g., Royal Ottawa Mental Health Centre, Ottawa Public Health) and a robust patient portal **(MyChart)** where patient surveys and patient reported outcome measures (PROMs) can be collected.
    - Epic also supports **data warehousing** (including external data sources), **business intelligence** and **advanced analytics.**
    - **Greenspace,** a digital data platform amalgamating and analyzing numerous

measures, promotes improved access, treatment outcomes, and sharing of best practices across several MHA agencies.
- CHEO's QI Team includes industrial engineers with simulation/modeling experience and software to model different patient pathways to optimize quality, efficiency, and cost.

Collaborative, cross-sectoral or multi-organizational Quality Improvement successes can be learned from, leveraged and expanded in our region and beyond

- **Choice and Partnership Approach (CAPA)** - this lean-based approach to care navigation, care consistency, and wait-time management includes shared decision-making with clients and families. It was implemented by CHEO outpatient Mental Health services, and has subsequently been implemented across all regional Child and Youth Mental Health agencies with a common evaluation framework.

- **Champlain Complex Care Program** - collaborative multidisciplinary care model involving both hospital and community services provides families with care coordination and navigation to reduce ED and inpatient utilization.

- CHEO is a designated Best Practice Spotlight Organization (BPSO) by the Registered Nurses Association of Ontario (RNAO) for its' focus on the implementation of best practice guidelines with respect to breastfeeding, asthma symptom control, family centered care, management of venous access devices and assessment and management of pain. CHEO joins over 550 hospitals internationally who have implemented these practices.

- **Bridges -** collaboration between CHEO, the Royal Ottawa Mental Health Centre, Youth Services Bureau and Ottawa Public Health to provide supportive group therapy for youth and their families between crisis admissions and the availability of individual treatment.

- **Ottawa Public Health Healthy Babies, Healthy Children (HBHC) initiatives** - in partnership with local hospital birthing units and NICU's, public health nurses establish bedside contact with babies and new parents to facilitate screening, assessment, home visits and referrals to community services to support complex medical and social needs.

- **Rideauwood/CHC collaboration** - provides rapid access to opioid treatment programs for patients cared for at the community health centres (CHC).

- **CHEO-Roger Neilson House Partnership** - children receiving respite and palliative care services at RNH will soon be documented within Epic, CHEO's integrated electronic health record, improving care integration and safety between the two organizations, and expanding the personal health information available through the MyChart portal

- **Cornwall Community Hospital Child and Youth Mental Health Services "Situation Table"** - brings together multiple cross-sector stakeholders (police, youth justice, education, municipality, health, child welfare, addiction, mental health, etc.) to address situations involving acutely elevated risk. This model has been adopted in other community mental health agencies.

- **Vanier Social Pediatric Hub** - collaboration between CHEO, Montfort Hospital, Centre des services communautaires Vanier, Sandy Hill CHC, and multiple community partners to deliver culturally sensitive, trauma informed, comprehensive and integrated multi-sectoral, health and social care to the neighborhood's children, youth and their families.

- **Planet Youth Lanark County** - leveraging the social ecological approach to youth substance abuse prevention developed in Iceland, multiple organizations (child and youth mental health, public health, municipalities, concerned citizens, the United Way) make changes to the community environment to change the social context that youth at high-risk for addiction are parented, nurtured and socialized.

- **Section 23 Day Treatment Classrooms** - Child and youth mental health providers collaborate with school boards in the region to combine treatment and educational goals through specialized day treatment classrooms, offered both in French and English.

- **TIMELY Project with Parents' Lifeline of Eastern Ontario (PLEO)** - patients and families presenting to the Pembroke, Winchester or CHEO Emergency Departments are automatically referred to PLEO for caregiver peer support and mental health service navigation assistance

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

Please refer to Appendix B – Digital Health to provide information on how your team will leverage digital health tools for improvement.

Refer to the Appendix B analysis of the solution being recommended.

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

Do any members of your team have experience working with patients to redesign care pathways?

Identify which of your members have patient relations processes in place and provide examples of how feedback obtained from these processes have been used for quality improvement and practice change. Describe whether any members of the team measure patient experience and whether the resulting data is used to improve.

- Kids Come First is committed to partnering with children, youth and families in designing, delivering, evaluating, and evolving care. The significant involvement of these most important stakeholders in our journey exemplifies how strongly we are committed to working in this way.
    - Parents participated in the Self-Assessment planning and development.
    - Youth and parents have participated in most working groups, and have co-led several of them.
    - The Steering Committee is co-chaired by a youth member.
    - Children and youth submitted over 100 suggestions for our name and there were vote on a short list to select the final name.
- Child/Youth/Family Advisory Councils co-create organizational strategy and partner on operational matters. Council representatives contribute to program and policy review, major organizational initiatives, and senior leader selection committees. Examples include:
    - **Lead Agency Strategic Plan** - Parent Advisory members were equal partners in establishing the strategic objectives for a combined plan covering all Champlain mental health and addiction agencies.
    - **CHEO Master Program/Master Plan** - Youth and Family Partners participated on the Steering Committee and provided advice about engagement opportunities to

obtain opinion on future services and care settings.
  - **CANImmunize** was developed following a mother's feedback that she wanted an easier way to record and track her children's immunizations, instead of the traditional paper-based system.
  - **Living Healthy Champlain** is a regional, patient and caregiver-informed, program promoting self-management supports, programs and resources to those living with chronic conditions.
  - Champlain CQI Committee includes patient and family representatives working with health care providers to analyze Ontario Perception of Care (OPOC) data to identify shared priority improvement opportunities.

- Our partners understand the importance of ensuring that children, youth, and families' voices are heard, including in their own care decisions. All organizations seek and respond to feedback through their respective Patient/Client Relations Offices, surveys and other feedback mechanisms conducted by mail, email, telephone or in-person electronic tools

- **Feedback Informed Treatment (FIT)** is used by several agencies to monitor progress and adjust treatment plans on the basis of sessional client feedback.
  - ***Choice and Partnership Approach (CAPA)*** relies on shared decision-making with children, youth and families to identify the most appropriate next step in their mental health care.
  - **Home and Community Care Patient and Caregiver Satisfaction Survey** tracks performance of the local home care services against provincial counterparts and helps to identify improvement opportunities. We are innovative leaders in child, youth and family partnership.

- We are **innovative leaders** in child, youth and family partnership.

- The Ontario Centre of Excellence for Child and Youth Mental Health created the **Youth Engagement Toolkit** which explains why youth engagement is so important and how to successfully embed it into an organization's operations.

- **CHEO Partners in Health Toolkit** was co-created with children, youth and family partners to help staff identify the level of engagement or partnership needed for specific initiatives and suggest appropriate modalities to reach the target audience.

- **Individualized Health Quality Improvement** is built into youth transition programs and equips kids and families to effectively self-manage chronic diseases and achieve better outcomes through the iterative changes necessary to master progressively independent health management tasks.

BEFORE and AFTER

Sarah is a 13-year-old Indigenous youth with physical and mental health needs

Right Now: Sarah is an Indigenous youth who lived with her mom, grandma and siblings in a First Nation community in northern Ontario. She has a complex history of trauma and self-harming behaviours with no mental health resources in her community to support her; CAS removed Sarah and placed her in a foster care home in Ottawa to help Sarah get better. Sarah was completely removed from all familial connections. In her new group home, non-Indigenous workers who had no understanding of Sarah's history, developed a treatment plan for her. Sarah wasn't thriving; she wasn't going to school, her teeth were decaying yet she wasn't brought to the dentist. Sarah's self-harming behaviours and suicide attempts increased and she was admitted to the Children's Hospital of Eastern Ontario (CHEO).

Kids Come First: Sarah is an Indigenous youth who lived with her mom, grandma and siblings in a First Nation community in northern Ontario. She has a complex history of trauma and self-harming behaviours. With the hopes of finding appropriate treatment options, CAS removed Sarah from her home and her family and placed her in a foster care home in Ottawa. Upon Sarah's arrival she was connected to an Indigenous case manager, community, resources and activities. Sarah, Indigenous community team members, and multiple Kids Come First partners co-created her Integrated Plan of Care, which identified and respected the principle of "culture is treatment" and that Indigenous organizations are best positioned to provide culturally-based care. As a result Sarah was linked to an Indigenous health clinic (e.g., dental care) and mental health supports and began to attend community and culture activities. Sarah received a holistic care where traditional and western approaches are integrated to best support complex needs of the Indigenous youth.

Drawn by: Xavier Age 7

- **Parents' Lifelines of Eastern Ontario** has integrated family peer support and the family voice into the child and youth mental health system across the region at the service delivery level and in system planning. It is a model of family peer support and partnership unique to Ontario, proven to both improve the experience and outcomes for families, and increase capacity of caregivers to participate as partners in the care of their child and in the system.

- CANImmunize collects patient feedback beginning during beta testing and continuing throughout the agile product lifecycle. This agile approach ensures that patient input is central to shaping product improvement.

5.4. How does your team use community input to change practice?

Describe whether the members of your team formally or informally engage with the broader community (including municipalities), and whether the outcome of engagement activities influence the strategic, policy, or operational aspects of your care.

Our partner organizations routinely seek broad community input to inform their strategic plans and operational priorities.

- **Wabano** - and other Indigenous organizations, are governed by community members and have an on-going engagement with community through open forums and other feedback mechanism (e.g., surveys, focus groups, etc.) to determine community needs; this engagement drives our service gap analysis and strategic plan.

- **Youth Services Bureau** - formal broad community consultation as part of strategic planning and implementation of new priority programs.

- **CHEO** - broad community consultation as part of strategic planning, master programming/planning, the new external website, and development of a new patient/family partnership toolkit.

- **Ottawa Public Health** - routinely seeks input from the community, other agencies, law enforcement/justice, education and social services for each major initiative.

- **MH Lead Agency Strategic Planning** - all regional lead agencies coming together and working with community partners, providers, clients and families to develop a common strategic plan.
- **Roger Neilson House** - broad community and partner consultation regarding strategic planning, eHealth rollout, and ongoing operational planning.

Our partner organizations collaborate with the broader community to co-deliver holistic, integrated care.

- **Vanier Social Pediatric Hub** - multiple community partners collaborate to deliver culturally sensitive, trauma informed, comprehensive and integrated multi-sectoral, health and social care to the neighborhood's children, youth and their families.
- **Planet Youth Lanark County** - using a social ecological approach to youth substance

abuse prevention, multiple organizations make changes to the community environment to change the social context that youth at high-risk for addiction are parented, nurtured and socialized.

- **Gender Diversity Planning** - primary health, specialty health, mental health and community service providers have worked with regional trans, two-spirit, intersex and gender diverse populations to develop improved access to culturally appropriate care and services.

- **Bridges** - collaboration between CHEO, the Royal Ottawa Mental Health Centre, Youth Services Bureau and Ottawa Public Health to provide supportive group therapy for youth and their families between crisis admissions and the availability of individual treatment.

Our partner organizations collaborate with the broader community to address the unique needs of Francophone, Indigenous, rural & newcomers.

- **Réseau des services de santé en français de l'est de l'Ontario (RSSFE)** - a Francophone organization that engages the health community to improve active offer and access to a continuum of quality health services in French.

- **Integrated Plans of Care** - connects cross-sectoral service providers, families, and children/youth with complex needs to create coordinated care plans focused on the strengths and needs of the child/youth and their families. For Inuit families, elders participate to ensure that care plans are culturally sensitive.

- **Aboriginal Child Health & Wellness Measure** - this validated tool is used by several agencies to guide local health planning and delivery on the basis of the voice of First Nations children. This tool is to be reviewed by Indigenous advisory committee for feedback and will be an opportunity to jointly develop accountability measures for non-Indigenous organizations who service Indigenous children, youth, and families

- **Children's Mental Health of Leeds Grenville** - health and mental health organizations, youth justice, school boards, police, a youth delegation, and community leaders collaborated to develop a community response to child and youth mental health priorities.

- **Phoenix Centre** - programs and services are adapted to address the needs of rural populations who are Francophone, Indigenous, military, or newcomer.

- **Newcomer Navigator Program** - a CHEO-based program designed to help newcomers navigate the pediatric health care system, a toolkit was developed and shared nationally with other communities. It is now a federally sponsored program to establish formal navigation programs and train navigators.

CANImmunize partners with pan Canadian associations to change practice regarding child and youth immunizations.

- Community input is incredibly important in shaping collaborations between CANImmunize and local public health. In partnership with Ottawa Public Health, and their Parenting in Ottawa community, we are collecting input from parents, healthcare providers and other community leaders. For example, we have been working with one of the Kids Come First partners, the South East Ottawa Community Health Centre, to best understand how CANImmunize can be incorporated into outreach programs for high risk, new mothers. Through Kids Come First, we will scale up initiatives like this across our collective.

- CANImmunize has been accredited by the Health Standards Organization as a leading practice. Working with the Canadian Medical Association's Joule, it is an included digital resource for Joule app store and My Virtual Care, a telemedicine hub provided by the Ontario Telemedicine Network (OTN). The Canadian Pediatric Society, The Society of Obstetricians and Gynecologists of Canada, the Federation of Medical Women in Canada and the Canadian Immunization Research Network are all partners in the CANImmunize project. Additionally, CANImmunize is endorsed by Immunize Canada, iBoost Immunity, Kids Boost Immunity and Vaccines 411.

- As the opportunity for comprehensive primary care management evolves, community partners such as Ontario MD will be important to work with. For example, as EMR integration with the DHIR comes to fruition, collaborating with primary care clinicians and their technology vendors will be crucial to ensure the technology is leveraged to its full extent.

5.5. What is your team's capacity to manage cross-provider funding and understand health care spending?

Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever pooled financial resources to advance integrated care (e.g., jointly resourcing FTEs to support care coordination)? Does your team have any experience tracking patient costs or health care spending across different sectors?

Kids Come First will collaboratively develop programs that: leverage lower-cost community and primary care; address rural health needs; reduce duplication through common intake processes and single patient care plans; integrate and co-locate complementary services to streamline care; and work with other sectors (e.g., public health, education, social welfare, justice) to promote health as the backbone to societal inclusion and economic success. Our team will leverage the relationships that the public health service providers have with these other sectors.

How we will make care better for children, youth and families:

- Kids Come First will provide support to families through family peer support offered by a number of organizations, including the Parents Lifeline of Eastern Ontario stepped care model of Family Peer Support and navigation-unique to our region, already integrated with mental health providers, and proven effective.
- Connect and co-locate complementary services to streamline care.
- Reinvested savings to expand service offerings and/or capacity.

How we will make Ontario's' new OHT system successful:

- Reduce duplication through common intake processes and single patient-care plans.
- Our team will build on numerous successful integrated care delivery models for kids and families that have increased patient/client satisfaction, examples include:
- **The Champlain Complex Care Program** is an outstanding example of successful collaboration among five of our partner organizations. As a result of the program, there has been a 50% reduction in emergency department visits and an 80% reduction in hospital length of stay.

- The **Mental Health Bridges Program** illustrates the positive impact of integrated care across four of our partners resulting in a 72% decrease in the hospital readmission rate for children and youth with mental health issues.

- **Integrated Plans of Care** connect cross-sectoral service providers, families, and children and youth with complex needs to create coordinated care plans that focus on the strengths and needs of children, youth, and their families. For Inuit families, elders participate to ensure that care plans are culturally sensitive.

- Centre Psychosocial partners with the Youville Centre to offer the **Infant Mental Health Program** which is provided within the **Young Mothers programs (Programme jeunes parents)** for women 14 to 25 years of age who are pregnant or have a child or children and who wish to complete their high school studies.

- **Roger Neilson House** and **CHEO** work together to deliver seamless care to palliative children and youth.

- In addition, our team includes unique regional and provincial child and youth health assets with the expertise to drive high quality, integrated care; establish common outcome measures, evidence-informed care practices, and patient/family engagement tools; and deliver mentorship, partnership, learning collaboratives and quality improvement toolkits.

- **Better Outcomes Registry and Network (BORN)** facilitates and improves care for mothers, children and youth by linking information and providers to address care gaps spanning the spectrum from normal to high acuity and rare conditions and is an authoritative source of accurate, trusted and timely information to monitor, evaluate and plan for the best possible beginnings for life-long health.

- **Champlain Maternal Newborn Regional Program (CMNRP)** is composed of a network of perinatal healthcare providers from hospitals, public health units, community health centres, a birth centre and other community agencies. With families' voices at the center of what we do, CMNRP's goal is to ensure high quality integrated services and care at the right time, at the right place, by the right provider along the continuum from pregnancy through the postnatal period.

- **Ottawa Public Health** collects and analyzes population-level data with a health equity lens, which enables responsive planning of programs and services to address gaps in access and health outcomes.

- Key linguistic variables will be included in our measurement and evaluation approaches

to ensure that the planning, funding and evaluation of French-language services and Indigenous services will be well informed. Indigenous services will be tailored through collaboration with local Indigenous organizations to meet the unique needs of this rapidly growing population of children and youth.

- Kids Come First will collaboratively develop programs that: leverage lower-cost community and primary care; address rural health needs; reduce duplication through common intake processes and single patient care plans; integrate and co-locate complementary services to streamline care; and work with other sectors (e.g., public health, education, social welfare, justice) to promote health as the backbone to societal inclusion and economic success. Our team will leverage the relationships that the public health service providers have with these other sectors.

- In addition to care efficiencies, opportunities to share back office and procurement functions, common staff benefit plans, and EMR/virtual care platforms could yield further savings for reinvestment.

- Kids Come First commits to equitable planning and review of service delivery to ensure a commitment to honour minority populations and their needs as well as our commitment to advocacy on behalf of Indigenous communities for equitable funding and access to health care and other community supports.

- In addition to care efficiencies, opportunities to share back office and procurement functions, common staff benefit plans, and EMR/virtual care platforms could yield further savings for reinvestment.

- All members can demonstrate strong financial management, exemplified by their ability to continuously adapt and expand programming despite rising costs and shrinking resources.

- Members have developed experience robustly estimating and tracking costs per care encounter. We understand the balance between cost savings and creating additional capacity from fixed resources to address access and equity issues.

Implementation Planning & Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones will you us to determine whether your implementation is on track.

- As a collective of providers, we have been working since March on the development of the Kids Come First. In this short period, we have been able to develop a shared and wide-ranging vision for child and youth health because of the long history of collaboration amongst our organizations and providers. This includes projects like THRIVE, Canada's first-ever comprehensive regional capacity plan for child and youth health, and multiple jointly-delivered programs in complex care, mental health and addictions, virtual care and other domains of child and youth health. OHT's will only be successful where there are high levels of trust and a sense of shared purpose amongst the partners. These preconditions exist in our collective.

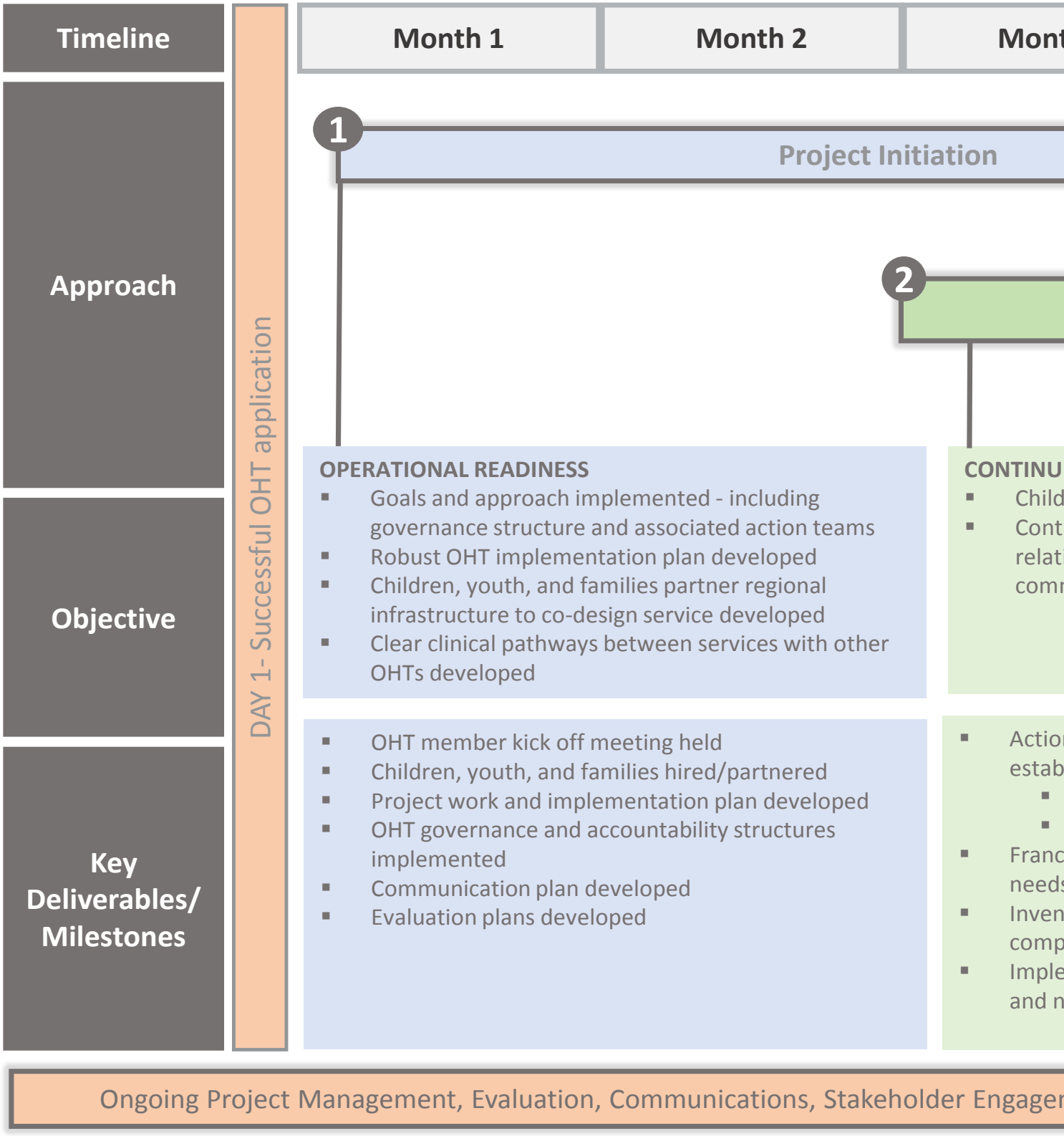
- The following critical path diagram illustrates how our team will successfully operationalize the care redesign identified in Section 3 and drive a successful implementation plan.

    - The critical path includes scheduled milestones, defined objectives, the scope of these goals, and highlights the need to develop evaluation criteria to determine success.

6.2. What is your change management plan?

How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones will you us to determine whether your implementation is on track.

- Critical elements of successful change management include **creating a sense of urgency for change** or **awareness of the need for change**, including a **vision for success**, building **the right team** to achieve the change, and **robust communication.** The Ministry's OHT application process has created the required conditions that are aligned to these fundamentals of change management. For the past six months, our OHT partners have worked collaboratively and tirelessly to move forward in in the development of our Full Application. There is a **collective understanding of, and deep commitment to the need for change**, and the key deadlines associated with the OHT application process has fueled our momentum.


Timeline
Approach
Objective
Key Deliverables/ Milestones
DAY 1- Successful OHT application
Month 1
Month 2
Mont
1
Project Initiation
2
OPERATIONAL READINESS
Goals and approach implemented - including governance structure and associated action teams
Robust OHT implementation plan developed
Children, youth, and families partner regional infrastructure to co-design service developed
Clear clinical pathways between services with other OHTs developed
CONTINU
Child
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relat
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OHT member kick off meeting held
Children, youth, and families hired/partnered
Project work and implementation plan developed
OHT governance and accountability structures implemented
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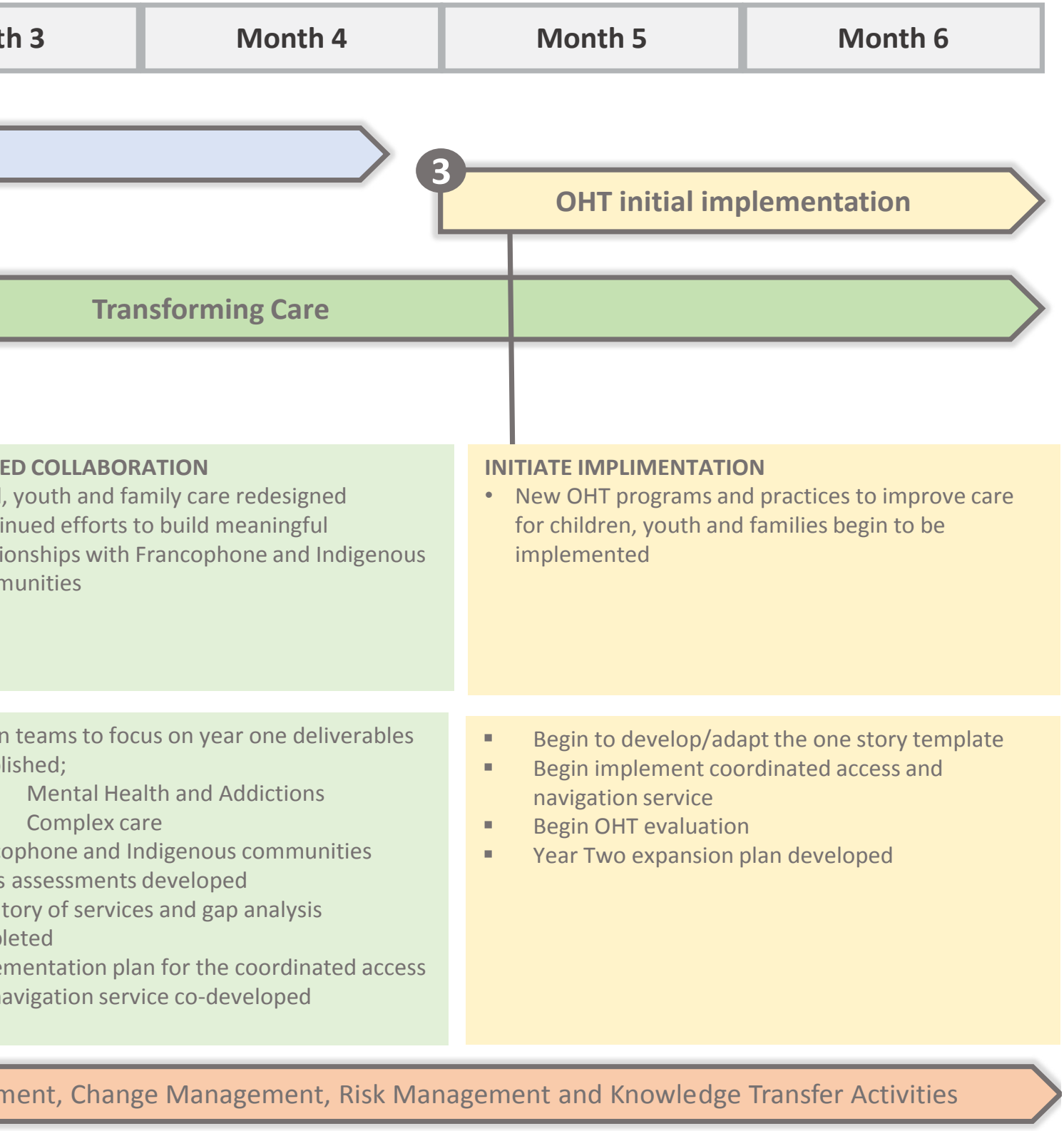

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- Prior to our day 1 as Kids Come First, it will be essential to continue to engage in **regular, transparent communication** with partners, family physicians, community pediatricians, other OHTs, children, youth and families. It will be important to assess the extent to which frontline staff, leadership and physicians across different organizations and practices understand the vision and can clearly see themselves in the new system. To support this effort, a communications plan will be developed with targeted messaging for key audiences including: frontline staff, physicians, other OHTs, leadership, executives, Boards of Directors, children, youth and families. We will communicate regularly using multiple channels (e.g. virtual town halls; email; website; social media; feedback/Q&A channel etc.) to ensure that all stakeholders understand the need for change and how our OHT will improve care for children, youth and their families as well as the benefits to physicians and to other OHTs.

- With any significant transformation or innovation, **training is critical.** Our OHT will develop and implement a training plan to ensure that all providers and staff are well prepared to fully engage in the change and our new, innovative ways of working together. Providers, staff, leadership, and youth and family partners will have the knowledge and skills necessary to achieve success in their respective roles. Training will include key areas such as: new processes and workflows; use of new technology; capacity building and competency development to achieve full youth and family partnership; and education for staff across our team on historical context and current practices impacting Indigenous peoples health today to provide culturally-sensitive care and recognize the complexity of trauma-informed care.

- As with any significant change, even with those that are clearly improvements over current practice, there can be resistance to the change among some individuals. Given the importance of having alignment across our partners, our team will develop a **resistance management plan** that can be implemented as needed.

- A key component of successful change management is to **deliberately and continuously recognize achievements**, **efforts, and successes** of not only our team as a collective, but also of our individual organizations, and our frontline staff that care for children, youth and their families. Kids Come First will work collectively to ensure that we celebrate successes and recognize individual contributions.

- Through establishing and measuring our team's performance on key metrics, we will be able to continue to reinforce the need for change through our vision and recognize our achievements. We recognize that the elements of our change management plan will be iterative, cyclical, and not always sequential.

6.3. How will you maintain care levels of care for patients who are not part of your Year 1 population?

Indicate how you will ensure continuity of care and maintain access and high-quality care for both your Year 1 patients and those patients who seek or receive care from members of your team but who may not be part of your Year 1 target population.

- All children, youth and their families across our region will continue to receive the care and services that they need. The prioritization of our Year 1 populations in no way will negatively impact care delivery to other children and youth. In fact, we expect that through our system level improvements of one number to call/one link to click, our regional, bilingual, Coordinated Access and Navigation Service, our fully-integrated pediatric home care program, and leveraging digital health solutions to support the spread of virtual visits, that children, youth and families who may need care will experience improved access to and quality of care.

- Kids Come First will create opportunities to better understand the needs and preferences of our Francophone population of children and youth by conducting a needs assessment of Francophone children and youth to supplement the regional THRIVE plan. In addition, we will intentionally, uniformly and reliably gather data about the linguistic variable, ensure a significant Francophone representation of youth and family partners within the team, and engage a larger population of children, youth, and caregivers.

- We will provide an opportunity to leverage the significant Francophone capacity to serve more childre, youth and families across our region. The team will enable more uniform language-specific data collection, and to better guide children, youth and their families to services offered in their official language of choice.

- Through our team's commitment to connect and strengthen our relationship with Indigenous-led organizations, to engage in proper consultation, to respect "Culture as Treatment" approach, and to implement system-wide education to provide culturally -sensitive care and recognize the complexity of trauma-informed care, we will be well positioned to ensuring that Indigenous children, youth, and families receive the levels of care that they need.

6.4. Have you identified any systemic barriers or facilitators to change?

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.

- With our extensive experience working together and many existing joint programs, Kids ComeFirst is well positioned for success. Our team can achieve faster progress to achieving our shared goals if the following systemic barriers are addressed:

    - Revisions to current privacy legislation would help us to achieve the goal of seamless sharing of health information across all partners.

    - As with any new intervention, the introduction of digital technology which facilitates patient access and control of health information faces several challenges. First, the laws and regulations which govern the privacy of health information in Ontario do not adequately address the role of consumer health technologies and should be updated to do so. Second, the lack of a coordinated digital identity for Ontarians limits use of these technologies. For example, while individuals can access the Digital Immunization Health Repository (DIHR) with their OHIP card, for those who don't have an OHIP card, Public Health Units currently provide the Ontario Immunization Identification and PIN. This technology is not supported in the CANImmunize integration, due to resource constraints at the MOH which limits access to those who have OHIP cards. This affects newcomers, refugees, out of province students.

    - Amongst our partners, there is tremendous support for an integrated pediatric home care program. The home and community care sector however, is experiencing significant health human resources challenges. Service Provider Organizations are experiencing recruitment and retention challenges across the province. Despite investments in home and community care, we have not seen an equivalent increase in the number of frontline providers to deliver care. Systemic changes are required to create working conditions that will attract and retain frontline providers to home and community care. This includes but is not limited to establishing wage parity for frontline home care providers, implementing neighborhood care models or geographical alignment to minimize the amount of travel for frontline providers, and implementing client-partnered scheduling (windows of time) approaches to create greater capacity for frontline staff. In addition, there are existing restrictions and limitations regarding procurement of home care service provider organizations (e.g.

the inability to enter into new contracts), as well as the limitations of current home care contracts (e.g. the lack of appropriate performance metrics to measure quality of care). A facilitator to change would be a review of the home care procurement process and modernization of home care contracts.

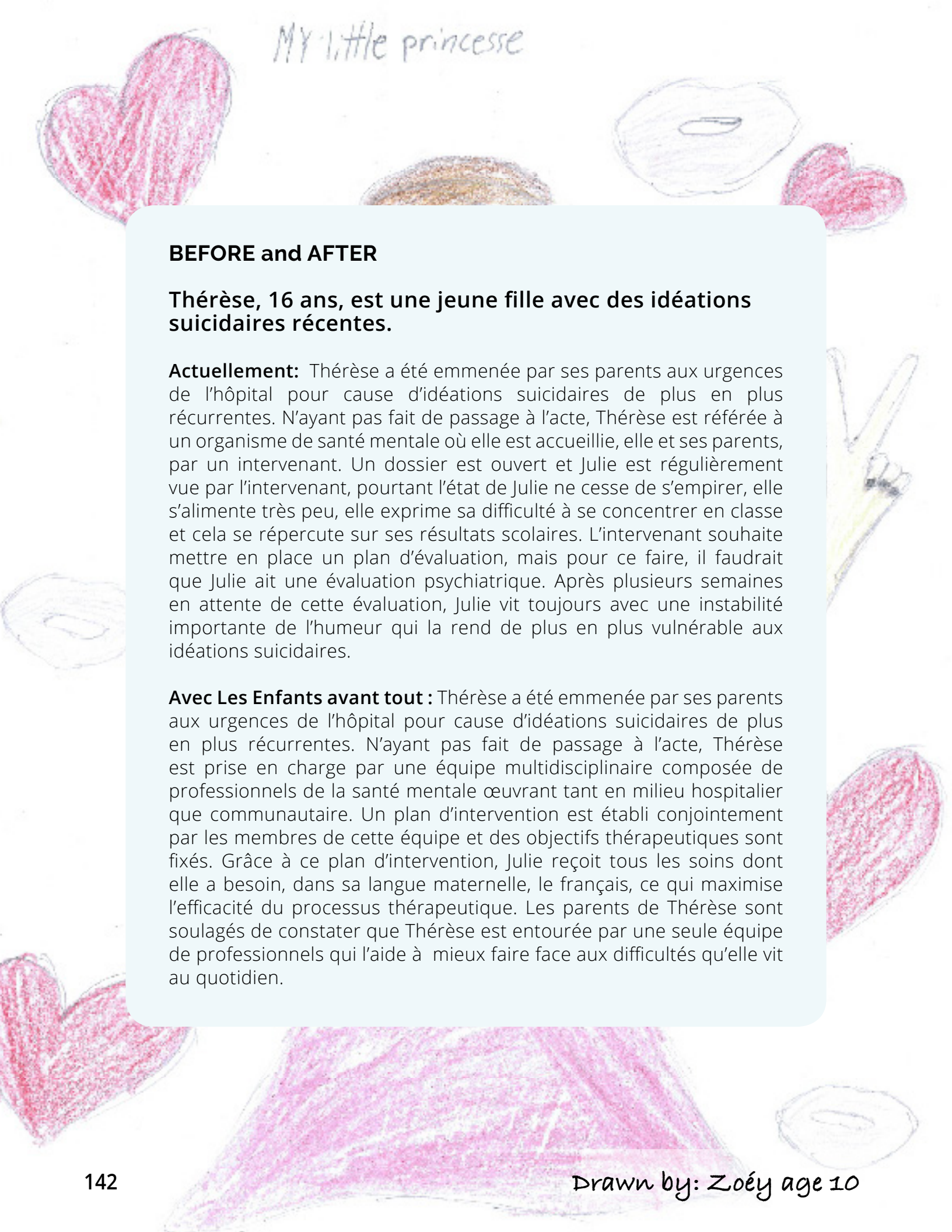
6.5. What non-financial resources or supports would your team find most helpful?

Please identify what centralized resources or supports would most help your team deliver on its Year 1 implementation plan and meet the Year 1 expectations set out in the Guidance Document. This response is intended as information for the Ministry and is not evaluated.

- Children and youth are not tiny adults! They are a population with unique needs that require a tailored approach to their care. Innovative models like ours need to be supported in order to ensure that the needs of children, youth and their families are met.

- Our team would benefit from non-financial resources and supports that would enable us to more quickly achieve our goals. These include but are not limited to:

    - Quality improvement, program evaluation, and performance management activities rely on robust data and analytical capacity. A common data warehouse and business intelligence support, either locally or provincially, would enable robust performance monitoring within the team as well as peer benchmarking.
    - We know that the interoperability of multiple EMRs is problematic so provincial expansion (data collection and access) of ConnectingOntario ClinicalViewer as a platform for providers to access health information would help to ease the burden on physicians and other providers. Similarly, integration of OLIS data in Epic and community EMRs will support care closer to home as important information is tracked across all providers. Finally, OTN is recognized as a key tool in our virtual care strategy, so ensuring that all Kids Come First partners have OTN access, as well as prioritizing the CHEO Epic MyChart project, will be needed in order to meet our Year 1 virtual care targets.
    - Working with the MOH to develop support guides and FAQs for Public Health Units to communicate back to parents involved in projects such as the Digital Health Immunization Repository(DHIR) integration would be helpful. From a change management perspective, supports to promote and communicate these services across diverse populations would be valuable; for example, translation, and plain and inclusive language, etc.



BEFORE and AFTER

Thérèse, 16 ans, est une jeune fille avec des idéations suicidaires récentes.

Actuellement: Thérèse a été emmenée par ses parents aux urgences de l'hôpital pour cause d'idéations suicidaires de plus en plus récurrentes. N'ayant pas fait de passage à l'acte, Thérèse est référée à un organisme de santé mentale où elle est accueillie, elle et ses parents, par un intervenant. Un dossier est ouvert et Julie est régulièrement vue par l'intervenant, pourtant l'état de Julie ne cesse de s'empirer, elle s'alimente très peu, elle exprime sa difficulté à se concentrer en classe et cela se répercute sur ses résultats scolaires. L'intervenant souhaite mettre en place un plan d'évaluation, mais pour ce faire, il faudrait que Julie ait une évaluation psychiatrique. Après plusieurs semaines en attente de cette évaluation, Julie vit toujours avec une instabilité importante de l'humeur qui la rend de plus en plus vulnérable aux idéations suicidaires.

Avec Les Enfants avant tout : Thérèse a été emmenée par ses parents aux urgences de l'hôpital pour cause d'idéations suicidaires de plus en plus récurrentes. N'ayant pas fait de passage à l'acte, Thérèse est prise en charge par une équipe multidisciplinaire composée de professionnels de la santé mentale œuvrant tant en milieu hospitalier que communautaire. Un plan d'intervention est établi conjointement par les membres de cette équipe et des objectifs thérapeutiques sont fixés. Grâce à ce plan d'intervention, Julie reçoit tous les soins dont elle a besoin, dans sa langue maternelle, le français, ce qui maximise l'efficacité du processus thérapeutique. Les parents de Thérèse sont soulagés de constater que Thérèse est entourée par une seule équipe de professionnels qui l'aide à mieux faire face aux difficultés qu'elle vit au quotidien.

Drawn by: Zoéy age 10

- Access to the Client Health and Related Information System (CHRIS) that is currently used in home and community care across the province.
- Support in co-creating a pediatric survey with youth and their families that could be used provincially to measure quality and experience with care.

6.6. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting any of the Year 1 Expectations for Ontario Health Team Candidates set out in the Guidance Document. Please describe any mitigation strategies you plan to put in place to address identified risks.

As part of your response, please categorize the risks you've identified according to the following model of risk categories and sub-categories:

- Please see Appendix C - Additional Supplementary Documentation or Supplementary Excel Spreadsheet

Membership Approval

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ww.cheo.on.ca/uploads/AboutUs/Files/THRIVE%20Report@202017.pdf

7. 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	Kirk Boyd
Position	President
Organization (where applicable)	CAO
Signature	
Date	Sept. 25/19

Team Member	
Name	Cindy Harrison
Position	President and CEO
Organization (where applicable)	CommuniCare Therapy
Signature	
Date	September 23, 2019

Team Member	
Name	CHRIS HUGHES
Position	CHAIR OF THE BOARD
Organization (where applicable)	SMH St. Mary's Home
Signature	
Date	09/23/2019

Team Member	
Name	Mike Villeneuve
Position	Chair, Board of Directors
Organization (where applicable)	Winchester District Memorial Hospital
Signature	
Date	September 26, 2019

Team Member	
Name	Keanan Stone
Position	Board Chair
Organization (where applicable)	Renfrew Victoria Hospital
Signature	
Date	September 26, 2019

Team Member	
Name	Linda Geisel
Position	Board President
Organization (where applicable)	Seaway Valley Community Health Centre
Signature	Linda Geisel
Date	September 26th, 2019

Team Member	
Name	Peter Currie
Position	Board Vice-Chair
Organization (where applicable)	Kemptville District Hospital
Signature	
Date	September 26, 2019

Team Member	
Name	Fay Bennett
Position	Chair
Organization (where applicable)	Lanark Renfrew Health & Community Services
Signature	Fay E Bennett
Date	September 24, 2019

Team Member	
Name	Natasha Tatartcheff-Quesnel
Position	Manager
Organization (where applicable)	Ottawa Children's Coordinated Access and Referral to Services (housed in the Youth Services Bureau of Ottawa)
Signature	Natasha Tatartcheff-Quesnel
Date	September 30th 2019

Team Member	
Name	Gerry Harrington
Position	President, Board of Directors
Organization (where applicable)	Pinecrest-Queensway Community Health Centre
Signature	
Date	September 30th, 2019

Team Member	
Name	GAYE E. MOFFETT
Position	Founder, President + CEO
Organization (where applicable)	GEM Healthcare Services (2011) Inc.
Signature	
Date	Sept 30, 2019

Team Member	
Name	Garry Yaraskavitch
Position	Board Chair
Organization (where applicable)	Pembroke Regional Hospital
Signature	
Date	September 25, 2019

Team Member	
Name	Gilles Clavelle
Position	Board Chair
Organization (where applicable)	Valoris for Children and Adults of Prescott-Russell
Signature	
Date	October 1, 2019

Team Member	
Name	Andrée Métivier
Position	BOARD CHAIR
Organization (where applicable)	Orléans-Cumberland CCM. Res. Centre
Signature	
Date	September 30th, 2019

Team Member	
Name	Kecia Podetz
Position	Board President
Organization (where applicable)	Crossroads Children's Mental Health Centre
Signature	
Date	September 30, 2019

Team Member	
Name	Purnima Sundar
Position	Acting Executive Director
Organization (where applicable)	Ontario Centre of Excellence for Child and Youth Mental Health (CHEO)
Signature	
Date	October 1, 2019

Team Member	
Name	Marc Bisson
Position	Directeur général
Organization (where applicable)	Centre de santé communautaire de l'Estrie
Signature	
Date	1er octobre 2019

Team Member	
Name	Anthony Esposti
Position	Board Chair
Organization (where applicable)	Family Services Ottawa
Signature	
Date	01/10/19.

Team Member	
Name	Mr. Ralph Heintzman
Position	Board Chair
Organization (where applicable)	Children's Aid Society Ottawa
Signature	
Date	1 October 2019

Team Member	
Name	Joanne King
Position	Board Chair
Organization (where applicable)	Rainbow Valley DHC RVCHC / SFMH
Signature	
Date	Oct. 1 2019

Team Member	
Name	Bruno Carchidi
Position	Board Chair
Organization (where applicable)	Rideauwood Addiction and Family Services
Signature	
Date	Oct 1/2019

Team Member	
Name	Linda Savoie
Position	Board Chair
Organization (where applicable)	Carlington Community Health Centre
Signature	
Date	October 1, 2019

Team Member	
Name	Mary Wattie
Position	Chairperson, Board of Directors
Organization (where applicable)	The Ottawa Rotary Home
Signature	
Date	October 1 2019

Team Member	
Name	Joanne King
Position	Board Chair St. Francis Memorial Hospital
Organization (where applicable)	RVCHC / SFMH
Signature	
Date	Oct. 1, 2019

Team Member	
Name	Stuart Cottrelle
Position	President
Organization (where applicable)	Bayshore HealthCare Ltd.
Signature	
Date	20191010 2

Team Member	
Name	Barbara Darlow
Position	Chair, Board of Directors
Organization (where applicable)	Arnprior Regional Health
Signature	
Date	October 2, 2019

Team Member	
Name	Debora M. Daigle
Position	Board Chair
Organization (where applicable)	Cornwall Community Hospital/ Hôpital Communautaire de Cornwall
Signature	
Date	2019-10-02

Team Member	
Name	Noela Fowler
Position	President, Board of Directors
Organization (where applicable)	The Safe haven Project for Community Living
Signature	
Date	October 2, 2019

Team Member	
Name	Kumanan Wilson
Position	CEO
Organization (where applicable)	CANImmunize Inc.
Signature	
Date	October 2, 2019

Team Member	
Name	Mike D'Amico, on behalf of James Malizia (Board Chair)
Position	Secretary-Treasurer, Board of Directors
Organization (where applicable)	Youth Services Bureau of Ottawa
Signature	
Date	October 2, 2019

Team Member	
Name	SHAILJA VERMA
Position	PRESIDENT
Organization (where applicable)	YOUVILLE CENTRE
Signature	
Date	October 2, 2019

Team Member	
Name	Serge Quinty
Position	Président du conseil d'administration
Organization (where applicable)	Centre Psychosocial
Signature	
Date	2 octobre 2019

Team Member	
Name	Michael Guerriere
Position	President and Chief Executive Officer
Organization (where applicable)	Extendicare (Canada) Inc.
Signature	
Date	October 3, 2019

Team Member	
Name	Randy Larkin
Position	Board Chair
Organization (where applicable)	Almonte General Hospital/Fairview Manor
Signature	
Date	October 3, 2019

Team Member	
Name	David Kinsman
Position	Board Chair
Organization (where applicable)	Dave Smith Youth Treatment Centre (DSYTC)
Signature	
Date	1 Oct 2019

Team Member	
Name	Abby Armstrong
Position	Chair
Organization (where applicable)	Open Doors 2SLGBTQ+
Signature	
Date	Oct - 3/19

Team Member	
Name	Simon Brazier
Position	Board Chair
Organization (where applicable)	Roberts/Smart Centre
Signature	
Date	October 3, 2019

Team Member	
Name	MICHAEL LUPIANO
Position	BOARD CHAIR
Organization (where applicable)	ROGER NEILSON HOUSE
Signature	
Date	Oct. 3, 2019

Team Member	
Name	Shirlee Sharkey
Position	Director
Organization (where applicable)	SE Health
Signature	
Date	October 1st, 2019

Team Member	
Name	Michel Gervais
Position	Directeur général
Organization (where applicable)	Centre des services Communautaires Vanier (CSC Vanier)
Signature	M. Mc Gillon - président
Date	3-10-19

Team Member	
Name	Brian Pelletier
Position	President
Organization (where applicable)	Wabano Centre for Aboriginal Health
Signature	
Date	5-10-19

Team Member:	
Name	Cathy Munroe
Position	Board President
Organization (where applicable)	South East Ottawa Community Health Centre
Signature	
Date	October 4, 2019

Team Member	
Name	DICK RABISHAW
Position	BOARD CHAIR
Organization (where applicable)	DEER RIVER & DISTRICT HOSPITAL
Signature	
Date	19-10-04

Team Member	
Name	Rob Clayton
Position	Board Chair
Organization (where applicable)	Carleton Place & District Memorial Hospital
Signature	
Date	October 3, 2019

Team Member	
Name	Tamara Takpannie
Position	Vice chair
Organization (where applicable)	Inuusuqtigiit Centre for Inuit Children, Youth & Families
Signature	
Date	Oct 4, 2019

Team Member	
Name	Corey Kalsi
Position	Board Chair
Organization (where applicable)	Hôpital Glengarry Memorial Hospital
Signature	
Date	October 4, 2019

Team Member	
Name	Pat Markovich
Position	Board Chair
Organization (where applicable)	Children's Mental Health of Leeds & Grenville
Signature	
Date	Oct 4, 2019

Team Member	
Name	Keith Egli
Position	Ottawa Board of Health Chair
Organization (where applicable)	Ottawa Public Health
Signature	
Date	Oct 4, 2019

Team Member	
Name	Phyllis Grant-Parker
Position	President/Board Chair
Organization (where applicable)	PLEO
Signature	
Date	October 4, 2019

Team Member	
Name	Mathieu Fleury
Position	Chair, Board of Directors
Organization (where applicable)	Ottawa Community Housing Corporation
Signature	
Date	October 4, 2019

Team Member	
Name	Sacha Baharmand
Position	Board Chair
Organization (where applicable)	Centretown Community Health Centre
Signature	
Date	October 4, 2019

Team Member	
Name	Sacha Baharmand
Position	Board Chair
Organization (where applicable)	Centretown Community Health Centre
Signature	
Date	October 4, 2019

Team Member	
Name	Raymond Jacques
Position	Président
Organization (where applicable)	Maison Fraternité
Signature	
Date	4 octobre 2019

Team Member	
Name	Patrick Dion
Position	EORLA Board Chair
Organization (where applicable)	EORLA
Signature	
Date	Thursday October 3, 2019

Team Member	
Name	Dr Nabil Ouatik
Position	Director and board chair
Organization (where applicable)	Pediadent - Specialized Pediatric Dental Centre
Signature	
Date	2019-10-07

Team Member	
Name	DAPHNE FEDORUK
Position	BOARD CHAIR
Organization (where applicable)	CHEO
Signature	D. Fedoruk
Date	October 8, 2019

Team Member	
Name	FRANCOIS Jemaire
Position	Chair of CIMURP V-Pat Services & CNE. PRH
Organization (where applicable)	Champlain Maternal Newborn Regional Program
Signature	
Date	October 8, 2019

Team Member	
Name	Thérèse Narbonne
Position	President, Board of Directors
Organization (where applicable)	The Phoenix Centre for Children and Families
Signature	
Date	Oct. 8/19

Team Member	
Name	Brett Reynolds
Position	Co-Chair
Organization (where applicable)	Ottawa Child and Youth Initiative
Signature	
Date	October 8, 2019

Appendix A: Home Care

Home Care

Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.

In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.

Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team's proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.

Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

A1: What is your long term vision for the design and delivery of home and community care?

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care. Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

- **VISION:** To integrate the provision of health care for children and youth living in the Champlain region by supporting high quality care and simplifying the pediatric health care journey.

- Families and health care providers in the Champlain region have many ideas about how to improve home and community care services for children and youth. But

structures in place until now have limited our ability to innovate together to improve access and quality of these services. Families, clinicians, service provider organizations and health care entities are excited to work together to co-design these services.

- We have heard directly from parents and caregivers that one of their chief concerns is the frustration of having to interact with so many different organizations, each with their own policies, operational procedures and practices which makes it hard for families to navigate and requires that they have to adapt to each organization's approach.

- With many transitions between providers and the complexity of the system, parents spend a lot of time advocating for their children's needs, repeating their stories, and coordinating care. Kids Come First is a solution to this problem.

- Our team is dedicated to helping children and youth live their best lives. A distinct child and youth home and community care program should be developed to ensure adequate child and youth expertise and quality of service by providers. This new model could integrate existing services under the responsibility of the LHIN with those provided by specialty child and youth acute, developmental and rehabilitation organizations. By building upon the successful school-based rehabilitation transition of services in January 2019, the integrated home and community care strategy would achieve positive and evaluable outcomes.

- Integrating pediatric care in the Champlain region leverages the uniqueness of the Champlain LHIN's geographic boundaries that align with our team's catchment area, reflecting the breadth of our programs and services that extend beyond the hospital setting.

- By implementing this innovative strategy, all children and youth requiring home care in Champlain will receive the most integrated care in the province, with improved access to care, smooth transitions, and increased quality of care, while creating system efficiency and sustainability.

- Our team wants to ensure quality care and safe care for chlidren and youth with medically complex needs. Hospitals will serve as a resource to support the development and maintenance of enhanced skills and expertise of home care service provider frontline staff, and this will in turn faciliate improved transitions from hospital to home as home care staff will have the required knowledge and comptencies to care for these children and youth.

- Currently, there are numerous home care service provider organizations that provide care to children and youth, however there is a lack of consolidated pediatric skills and expertise among the frontline home providers. This can result in difficulty ensuring continuity of care and the required specialized knowledge about children's unique medical care needs. Parents sometimes have to teach providers about how to care for their children which deprives them of the respite they desperately need. Kids Come First is proud to include some of Ontario's most innovative, child-focused service provider organizations whose expertise will be crucial to the co-design work.

- Integrating home and community care within the our team will mean less bureaucracy, more service and increased efficiency.

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

Identify your top priorities for home and community care in your first 12 months of operation.

What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.

Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives. Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the optional table below to describe the delivery model.

See supplementary Excel spreadsheet

- Kids Come First will provide minimally disruptive health care that focuses on the family as a unit, not focused on illness. We will achieve continuity of care along the spectrum of health care services provided in hospital, home, community, and school by building upon the case management model of palliative care, complex care, and rapid response nurses and expanding the existing close relationships between complex care and palliative care. Families are clear that they want and need single point story-telling which we will establish through the implementation of a single-story template and leveraging digital health solutions. It is imperative that we break down barriers and maximize scopes of practice; we need to think differently about what frontline providers can do for children, youth and families and remove the constraints that come with differing inter-organizational policies and procedures.

- Ministry approval for our team to be accountable for home care services for children and youth throughout the Champlain region will enable the partnership to enter the next phase of co-design with patients, families, staff, and contracted service provider organizations.

- Based on the work done so far, we are positioned to develop a detailed operational plan for implementation in Year 1 to improve home and community care for the medically complex children and youth receiving home care services throughout the Champlain region.

- With Kids Come First aligning home and community care with other child and youth health services, we will reduce the number of organizations that children, youth and their parents interact with, resulting in streamlined communication, reduced miscommunication and errors, and increased efficiency and safety.

- Our plan would allow us to offer a more fulsome continuum of services under one team consisting of pediatric care, acute care, rehabilitative care, home care service provider organizations, palliative care, and school health care.

- Less than 1% of children and youth with medical complexity (seen by at least five health care services, medically fragile, chronicity, technology dependent, significant challenges to seek appropriate medical services based on rurality or access) make up more than 30% of child health care costs (Cohen et al., 2012)

- There are approximately 6,200 children and youth across the Champlain region that depend upon home and community care services. Of these 6,200 children:

    - 5,500 (88%) of these children receive school based rehabilitation services in a partnership between CHEO and a community-based partner service provider organization.

    - The successful transfer of school based rehabilitation services is a significant first step in creating an integrated care model; there are however, 700 (12%) children and youth with the most medically complex needs that are receiving home care services from service provider organizations under contract with the Champlain LHIN.

    - 100% of these 700 hundred children also receive specialty and rehabilitative services at CHEO.

- Our team will co-design the future model with patients, families, staff, physicians and contracted service provider organizations to ensure the provision of efficient, innovative and child, youth and family partnered home care services across the Champlain region.

- An integrated home and community care model would allow our team to work more closely with contracted service provider organizations who deliver services in the home, and to improve the quality of care delivered by bolstering the knowledge

and skills of their staff. By bringing together providers with pediatric expertise – in hospitals, community, pediatricians, and service provider organizations, we can create a community of practice to support child and youth staff, develop their skills and competencies and build capacity.

- Our Integrated Home and Community Care strategy will build on the successes of the Champlain Complex Care Program which has been collaboratively working with hospital and community partners to provide family-centered care and care coordination to children and youth who are medically complex, fragile and technology dependent.

- Recent evaluations of the Champlain Complex Care program have indicated that this single-point-of-care methodology has resulted in a statistically significant decrease in days in ICU (2.54 to 1.27 days per child or youth) and a statistically significant decrease in days of length of stay in hospital per year (averaging a decrease of 19 days).

- Kids Come First includes partners including hospitals, service provider organizations and others with extensive experience with innovation in digital health platforms. There is great willingness tov use technology to expand access to care.

- Our plan to improve home and community care is designed to deliver outcomes that will benefit children, youth and families, and create efficiencies within the health care system. In order to measure outcomes and identify continuous improvement opportunities, the following indicators will monitored for the pediatric population that requires home and community care. They will be segmented by care pathway in order to identify improvements achieved and opportunities for further efficiencies.

    - Pre- and post-implementation youth and family experience surveys and interviews

    - Length of stay for CHEO inpatients who receive/require home and community care

    - Alternate Level of Care (ALC) status due to lack of appropriate home or community care; ability to transition children home sooner with enriched supports in their home and in the community

    - Better health outcomes and increased quality of life for children, youth and families

    - Emergency department visits and avoided visits for children and youth who receive home and community care

    - Readmission rates for CHEO inpatients who receive/require home and community care

- Percentage of children, youth and families with a virtual health care encounter
- Percentage of children, youth and families who digitally access their health information

- Our team's partnership is well-positioned to enhance the specific expertise needed to deliver complex pediatric home care and support this vulnerable population in a meaningful way.

A3: How do you propose to transition home and community care responsibilities?

Please describe you proposed plan for transiting home and community care resources to your Ontario Health Team in Year 1, such as care coordination resources, digital assets, programs, and local knowledge and expertise.

- In order to establish an integrated home and community care strategy, our team would seek approval to provide community services under the Home and Community Care Services Act 1994 (HCCSA) as an "approved agency." The HCCSA requires MOHTLC approval for "approved agency status" at the recommendation of the LHIN.

- Our goal is that Kids Come First will have oversight and coordination of care for children and youth which will streamline hospital to home transitions. Staff, frontline staff from service provider organizations, patients and families will benefit from our team's strong pediatric professional practice infrastructure. We will work with our partners, children and families to identify and co-design the coordination functions that are most helpful to inform movement forward and how we will support family physicians and community pediatricians in maintaining closer connections to the children and youth in their care.

- Our team will ensure that information related to service provision is reported into Health Shared Services Ontario's Client Health & Related Information System (CHRIS).

A4 Have you identified any barriers to home and community care modernization?

Identify any legislative, regulatory, policy barriers that may impede your team's vision for modernizing home and community care with regards to improving health outcomes, enhancing the patient and provider experience, and ensuring system sustainability. This response is intended as information for the Ministry and is not evaluated.

- The Kids Come First health team will require approval to provide community services under the Home and Community Care Services Act 1994 (HCCSA) as an "approved agency." The HCCSA requires MOHTLC approval for "approved agency status".

- The home and community care sector is experiencing significant human resources challenges. service provider organizations are experiencing recruitment and retention challenges across the province. Despite investments in home and community care, we have not seen an equivalent increase in the number of frontline providers to deliver care. This means that children, youth and their families experience delays in accessing home care services and/or disrupted services when there aren't any available frontline workers to cover absences or to step in when workers leave the sector. Without the ability to reliably and effectively care for children and youth at home, the burden to the acute care sector will grow with increasing ED visits, hospital readmissions and longer length of hospital stays.

- Systemic changes are required to create working conditions that will attract and retain frontline providers to this sector. This includes but is not limited to establishing wage parity for frontline home care providers, implementing neighborhood care models or geographical alignment to minimize the amount of travel for frontline providers, and implementing client-partnered scheduling (windows of time) approaches to create greater capacity for frontline staff.

- Existing provincial contracts with service provider organizations should be modernized. The current performance metrics do not adequately address the quality of care provided.

- While there has been provincial work underway to develop new patient and caregiver experience surveys for home and community care, these are not applicable to pediatric populations and as such, a pediatric survey should be co-created with youth and their families.

- Many of the Kids Come First partners are involved through their provincial associations (e.g. Home Care Ontario, the Ontario Hospital Association and the Ontario Community Support Association) in discussions regarding home and community care service delivery models as part of Ontario Health Teams. We anticipate that this will provide useful structure and information for our work.

Appendix B: Digital Care

Appendix B

Experience from other jurisdictions suggests that digital health is a powerful tool for advancing integrated care, shared accountability, value-based health care, and population health management approaches. In this section your team is asked to assess its current digital health capabilities and propose plans for building off this existing capacity to meet the minimum readiness requirements and Year 1 expectations set out by the Ontario Health Team Guidance Document. Responses provided in this section will be evaluated based on the degree to which your team seeks to integrate already existing infrastructure and improve disparities in digital capacity across the members of your team.

Responses will also help the Ministry understand what supports teams may need in the area of digital health. By completing this section, the members of your team consent that the relevant delivery organizations (i.e., Cancer Care Ontario, Health Shared Services Ontario, Ontario MD, and/or eHealth Ontario) may support the Ministry of Health's (Ministry) validation of claims made in the Current State Assessment by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

MEMBER	HOSPITAL INFORMATION SYSTEM INSTANCES *Identify vendor, version, and presence of clustering*	ELECTRONIC MEDICAL RECORD *Identify vendor and version*	ACCESS TO OTHER CLINICAL INFORMATION SYSTEMS *E.g., Other provincial system such as CHRIS, or other system to digitally store patient information*
The Phoenix Centre		EMHWare, Interai	
Almonte General Hospital		Cerner	Cerner GBIN
Arnprior Regional Health		Meditech - Expanse	CHRIS
Bayshore HealthCare Ltd		Procura V10	CHRIS
Carlington Community Health Centre		Telus PS Suite 5.15.105	CHRIS
Centre Youville Centre		EMHWare	
Centretown Community Health Centre		Telus Practice Solution Suite	CHRIS, DATIS, LHINworks, Working on HRM, OLIS, TOH Epic and IAR
CHEO		EPIC-2018	CHEO/TOH EPIC instance
Children's Mental Health of Leeds & Grenville		EMHWare	
Citizen Advocacy Ottawa-Carleton		N/A	
CommuniCare Therapy			CHRIS
Cornwall Community Hosptial		Cerner, Cerner Millennium 2015, CRMS V2.0	CHRIS
Crossroads Children's Mental Health Centre		EMHWare, autoupdated	
Dave Smith Youth Treatment Centre		BestNotes V1.0	
Deep River and District Hospital		In transition moving to TOH Epic	
Family Services Ottawa		Danic 2009 v3.0	CRMS, OCAN

	ACCESS TO PROVINCIAL CLINICAL VIEWERS *ClinicalConnect or ConnectingOntario*	DO YOU PROVIDE ONLINE APPOINTMENT BOOKING? *Yes/No*	USE OF VIRTUAL CARE *Indicate type of virtual care and rate of use by patients where known*	PATIENT ACCESS CHANNELS *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
		No	OTN 1%	No
	ConnectingOntario & OLIS	No	OTN	No
	ConnectingOntario	No	OTN 2%, Telephone 0%	No
	OLIS		Telephone 100%, Other QoC (hip/knee bundle, MD Matrix/OTN Telemedicine (rheumatoid arthritis), CISCO (carechart@home, oncolocy), Verto (ALC transitional care DX platform)	5% (small pilot project) use AlayaCare
		No		No
		No	n/a	No
	ConnectingOntario	No	OTN ,1%, Telephone 60% (within primary care dept)	No
	OLIS within EPIC			Epic MyChart
		No	OTN 9.6%	Yes
		No	n/a	No
		No		No
		No	OTN 10%	No
		No	Telephone 100%	No
	IAR (Integrated Assessment Record)	No	OTN 40%, Telephone 100% (including texting) Zoom 20%	No
			Unknown	No (planned with Epic)
			OTN 0.5%, Telephone 5%	

GEM HealthCare Services	Software, hfc-201.8 - 84fl32c5	QuickBooks
Hôpital Glengary Memorial Hospital	Meditech - Expanse	Meditech
Inuuqatigiit Centre for Inuit Children, Youth and Families	N/A	N/A
Kemptville District Hospital	Anzer, latest v	CHRIS
Lanark Renfrew Health & Community Services	Telus - PS Suite EMR Version A-5.15.103	CHRIS
Maison Fraternité	DATIS	Integrated Assessment Record, Catalyst
Open Doors for Lanark Children and Youth	EMHWare	
Ottawa Children's Coordinated Access and Referral to Services		
Ottawa Public Health		Meditech (QCH & Montfort), EPIC (TOH), Panorama (DHIR),iPHIS, ISCIS
ParaMed Home Health Service	Complia in development	CHRIS
Parents' Lifelines of Eastern Ontario (P.L.E.O.)	Salesforce	
Pembroke Regional Hospital	Anzer Solutions	CHRIS
Pinecrest-Queensway Community Health Centre	Telus - Nightingale on Demand v9.4.0.8	CHRIS
Rainbow Valley Community Health Centre	Nightingale on Demand	CHRIS
Rideauwood Addiction and Family Services	DATIS	Catalyst
Roberts/Smart Centre	EMHWare R54-1	
Roger Neilson House		CHEO EPIC Instance
Sandy Hill Community Health Centre	Telus Health, Practice Solutions (PS) Suite 09-19 version 5.13/5.14	CHRIS, EPIC TOH for viewing, OLIS (Labs), others for Mental Health Health & Addictions
SE Health	Procura, Procura Clinical	CHRIS
Seaway Valley Community Health	Telus-PS Suite EMR A-	

	No	Telephone	No
ConnectingOntario	No	OTN 10%, Telephone 10%	Patient Portal impl in 2020
N/A	No	N/A	No
ConnectingOntario	No	OTN a few	No
ConnectingOntario	No	OTN 6%, Telephone 25%	No
	No	OTN 10%, Telephone 20%	No
ConnectingOntario	No	OTN 3%	No
	No	OTN 60/email 38/zoom 2	No
ConnectingOntario	No	OTN <1%, Telephone over 40K calls per year	No
	No		No
	No	Telephone 43%	No
ConnectingOntario	No	OTN 5%	No
ConnectingOntario	No	OTN	No
ConnectingOntario	No	OTN 4%, Telephone 5%	No
	No	OTN 2%, Telephone 30%	No
Clinical Connect	No	Currently implementing OTN, telephone 100%, PCVC - 15-20%, Social Media Check-In (RSC Private Learning Academy 25%	No
ConnectingOntario	No	OTN 5%	No
	No	OTN at times/Telephone Telephone <1%, Video <1%	No

Somerset West Community Health Centre	Telus - Nightingale on Demand	CHRIS
St. Francis Memorial Hospital	EPIC Nov 2018	CHRIS
St. Mary's Home	EMHWare	
The Children's Aid Society Ottawa		CPIN (Child Information Protection Network)
The Ottawa Rotary Home	Med-e-care and Customized ShareVision v4.0	
The Safehaven Project for Community Living	N/A	N/A
Valoris for Children & Adults of Prescott-Russell	Vertical Software Inc-Matrix database, CPIN	Matrix-local, CPIN Provincial
Vanier Community Service Centre	EPIC	CHEO EPIC Instance
Wabano Centre for Aboriginal Health	Telus Health PS Suite EMR A-515.103	CHRIS
Winchester District Memorial Hospital	Harris CPR 6.2.2.171	CHEO TOH instance
Youth Services Bureau		CRMS

ConnectingOntario	No	OTN 30%, Telephone 35%	No	
ConnectingOntario	Yes	OTN 30%, Telephone 10%		1%
	No	OTN 10%	No	
	No	No stats on this but do know that youth are accessing various care/support apps	No	
	No		No	
NA	No	Telephone 20%, iPad 1%		
	No	OTN <1%	No	
	No		No	
ConnectingOntario	No	Telephone 20%	No	
	No	OTN 13%	No	
FIT, InterRai	No		No	

B.2 Digital Health Plans

Where gaps are identified through the current state assessment, the plans below should include an approach for addressing these gaps. As you articulate your plans please identify what non-financial support and services you will require from the Ministry or delivery organizations.

- Kids Come First is powered by digital health. A cornerstone of our proposal is to use digital health tools and virtual care to magnify our shared pediatric expertise to support children and youth in our region and across all OHT's; ensuring all providers have access to the tools and experts they need to provide the appropriate care for the children and youth in their care. Young people – and now most of their parents – are digital natives who use technology in every facet of their lives and have high expectations of the health care system in this respect. We will harness those expectations, skills and engagement to advance this important agenda.

- The value of our approach has been seen in many projects across our collective of providers - our region's eConsult program, project ECHO, online access to health records, innovative apps and video visits. Both providers and patients who historically had no direct access to pediatric specialists now have multiple mechanisms to receive the support they need. For example, primary care providers in our region have been supported through technology to increase their capacity to serve young people struggling with mental health and addiction – through training, support for care pathways and virtual consults with specialists. We are eager to scale these successes to support all children, youth and partner OHT's in Eastern Ontario and beyond.

- Our current state survey identified that several Kids Come First Team members are at the leading edge of digital health solutions - in the top 1% of digital healthcare providers in Canada in acute care, home care and the community sector. Some smaller partner organizations, despite their eagerness to advance digital health solutions, have identified a concern about their ability to advance digital health within their present financial constraints. This remains an issue that will need to be addressed, though we believe that pooling our efforts is part of the solution for this challenge. With a fundamental principle of our digital health plan being to expand the use of existing, proven solutions across the team to support children across all regions/OHTs, we will work together to ensure an ecosystem that considers access, affordability and always is centred around patient experience.

- The Kids Come First digital health plan is comprehensive, and was developed in a consultative, thoughtful and analytical way to develop the plan described below. The implementation of our digital health plan, will mean that:

1. Virtual care will overtake traditional office visits as the preferred method for care Youth today have an expectation that they can access what they need, when they need it – their expectation of us includes video visits from their iPhones and secure texting at any hour of the day.

2. Children and youth receiving care at CHEO, Roger Neilson House and other partners will be able to use Epic MyChart to have access to:

a. Their CHEO and Roger Neilson House personal health information in either English or French
b. Secure video visits through MyChart with their providers
c. Secure two-way chat for off-line communication with their providers
d. Update their demographics, medication details and allergies

3. Kids Come First partners will have access to improved patient health information sharing through the use of ConnectingOntario.

4. All of our partners that are planning a digital health investment in the next 18 months, will be supported in evaluating existing regional investments in order to identify which existing instances would be the best fit for their needs.

5. Ideally, our team will have the opportunity to make the CO information available in Epic, and also MyChart to address our patient partners' priority of NOT having silos – not asking them to use multiple patient portals, but rather giving them access to what their providers will have.

- Kids Come First is excited about the improvements that we can achieve through Digital Health. The current state assessment identified a wide array of digital health readiness across our partners and our team structure will ensure that, together, partners are supported in moving towards HIMSS Level 7, we will reduce administrative burdens, standardize care, and benefit from our previous investments. There are a number of barriers that we are working through including privacy and costs to deliver on the shared vision.

B.2.1 Virtual Care

Describe your plan for how you will build off your team's existing digital capabilities to further expand virtual offerings in Year 1. If some or all of the members of your team do not have virtual care capacity, what steps will you take to ensure that by the end of Year 1 your team offers one or more virtual services? Provide an assessment of how difficult it will be for your team to meet the following target: 2-5% of Year 1 patients who received care from your team had a virtual encounter in Year 1.
Describe how you will determine whether your provision of virtual care is successful or not (e.g., measures of efficacy orefficiency).

- Kids Come First partners are national leaders in innovative models of care, often supported through virtual care models to support care closer to home, and in many cases, completely avoid the need for specialist appointments. This is driven by the expectations of our patients, who have grown up with technology meeting their needs in all aspects of their lives. As such, twenty-three of our partners provide virtual care models, including:

- **Fully virtual mental-health supports.** A few of our partners have recognized that often virtual care is the best option. Children & youth get the support they need using the tools they interact with every day.

- **eConsult:** pediatric specialists were early adopters of virtual care delivery through eConsult, with 45 specialists actively participating and providing timely access to 33 different specialties at CHEO for family physicians, general pediatricians, nurse practitioners, and other specialists in the community. Between January 2018 and August 2019, our team of specialists responded to over 3,800 eConsult cases , demonstrating our commitment to improving access to care for the children, youth and families that we serve.

- **CANImmunize:** This is a great example of population-level virtual care. Children, youth and families are empowered to track and submit their own immunization status whilePublic Health and others can issue alerts and push messages to the population at large.

- Building on existing regional and provincial solutions, our team will achieve the target of 2-5% of our Year 1 target populations having a virtual encounter as follows:

    - **Enabling OTN access.** A number of our partners have identified a desire to access OTN to provide services. We will explore how the existing infrastructure within the OHT could be leveraged to support these partners within Year 1.

- **Video Visists via Epic MyChart.** CHEO and OTN are working together on a 'Virtual Visit' project that will allow children, youth and families and their health care providers to connect over Zoom through MyChart. Over 24% of the Complex Care population is already using Epic MyChart, so we can leverage historical investments in EPIC in order to ensure a smooth implementation for this priority population.

- **Regional eReferal pathways.** We are exploring the regional eReferral pathways, leveraging Ocean in conjunction with the provincial System Coordinated Access (SCA) program. The eReferral lead in our region has identified opportunities for our OHT to improve the delivery of care through eReferral channels, determining priority pathways, as well as possibilities for eventual integration into our Epic HIS. Once implemented, the eReferral solution will improve the facilitation of care for children, youth and families, it will enable richer communication channels between referring clinicians, those receiving referrals, and most importantly, children, youth and their families, who will be able to better manage appointment scheduling, and preparing for appointments as needed etc.).

- Our virtual care strategy also extends beyond patients to providers. Pediatric providers are a scarce resource in our healthcare system. Expanding project ECHO, eConsult and virtual consultations we will make pediatric expertise more available to all the children, youth and lifespan providers that need their expert support.

2.2 Digital Access to Health Information

Describe your plan for how you will build off your team's existing digital capabilities to provide patients with at least some digital access to their health information. Provide an assessment of how difficult it will be for your team to meet the following target: 10-15% of Year 1 patients who received care from your team digitally accessed their health information in Year 1.

- Our youth and family partners have told us that having access to their health information is non-negotiable for Kids Come First - which includes eliminating silos of information and instead, consolidating all records. This is their norm in all aspects of their life – school, banking, social- life – they can't understand why it isn't happening for something as fundamental as health.

- Epic MyChart has been available to Eastern Ontario patients for over five years. Currently more than 4,000 children and youth in our region have access to their own health information, are able to update their demographic information, allergies and medications through Epic MyChart and 50% of CHEO outpatient clinics provide secure messaging with children, youth, and families through MyChart. This solution,

in partnership with the broader digital health strategy, will effectively support children and youth with medically complex needs, by ensuring that they have access to their data collected by CHEO and Roger Neilson House. With 24% already enabled, our team is already meeting the 10-15% target for this priority population.

- For children and youth with mental health and addictions, a unique strategy will be developed, one that considers diagnoses and potential triggers as we explore the adoption of a patient portal. For example, a child or youth with an eating disorder may be triggered by seeing their weight included in their health information. Children and youth with mental health and addictions may also have co-morbidities, including eating disorders so even if that was not the primary diagnosis, there could be a therapeutic impact. Our team partners have extensive experience that will inform our approach and we are committed to working together to ensure a thoughtful implementation that will result in our meeting and quickly surpassing the target.

- There are considerations that must be taken into account regarding access to health information when caring for children and youth, such as the age of a child seeking access, proxy access for parents that is no longer applicable as children grow older. An extensive analysis of the appropriate model for implementation has been completed and presented on nationally and Kids Come First will adopt this model as it is currently defined for children and youth with medically complex needs. We will review the model to ensure it appropriateness for children and youth with mental health and addictions. We will be well positioned to share our work and learnings with other OHTs who may also be working to address these types of decisions.

- We have heard from youth and families that multiple patient portals are not acceptable and that a solution that integrates them all is required. Kids Come First recognizes that there is no single EMR/HIS that will meet the needs of all of our partners therefore we will use a two prong approach to build a comprehensive medical record (described in the next section). We will work with ConnectingOntario/clinical document repository (CO/CDR) leadership to identify a model that will allow children, youth and their families to access their health information through Epic MyChart, and access their data in the CDR, thereby ensuring that they have access to their complete record. This will be a stretch goal for Year 1 and full implementation will likely span a three year period.

- CANImmunize enables children, youth and families to be in control of their health information and makes it available to those that need it – including public health – avoiding the dreaded school suspensions and outbreaks.

- Policies and procedures will be developed to ensure that children, youth and families can access their health information in their official language of choice and health

professionals will be able to access health information in their preferred language. Our team will prioritize using child/youth facing digital tools (software, applications) that are available in both official languages.

2.3 Digitally Enabled Information Sharing

Describe your plan for ensuring that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care
anning (e.g., pooling information to understand population health needs and cost drivers, population segmentation, integrated care pathway design).

- Our child, youth and family partners have clearly indicated the need to be able to access their health information in a **single comprehensive record**. Our team's digital health working group highlighted the importance of interoperability as children and youth move across the healthcare system, respect for partners' digital health investments to date and the not-insignificant costs associated with implementing a digital health strategy broadly. As such, Kids Come First will implement a cost-effective, two-prong approach that will meet the expectations of children, youth, and families as well as the family physicians and community pediatricians that care for them.

The following approach was taken to establish the Kids Come First team's Digital Health Plan

- Through consultation with our OHT partners, a review of both the application and the Digital Health Playbook, five functional priorities were identified as follows:

    1. Virtual Care
    2. Children, Youth & Families accessing their records
    3. A comprehensive record
    4. Supporting Transitions/Referrals and Consultations
    5. Quality Improvement & Best Practice implementation

- Using the functional priorities as requirements, the following four architectures were evaluated:
    1. ConnectingOntario
    2. Expand an existing HIS/EMR investment across the OHT
    3. Point-to-point data sharing
    4. OHT specific clinical document repository

- Based on the following analysis, the plan described below was developed.

	Virtual Care	Single Record	Client Access	C/T/R	QI and BP
ConnectingOntario	Project	Time to expand	No known plan	Leverage eReferral and eConsult	Changes required to existing authorities
Expanding existing EMR/HIS	Zoom in Epic MyChart	Cost and time to expand	Epic MyChart	Leverage eReferral and eConsult and EPIC	Strength of the product
Point-to-point Architecture	Project	Cost and time to expand	Local Solutions – no single view	Leverage eReferral and eConsult	Would need to be built into individual systems
OHT-specific CDR	Project	Cost and time to expand	Would need to be created	Leverage eReferral and eConsult	Authority would need to be included in data sharing agreements

The recommendation resulted in a two-prong approach:

1. Leverage the investment in **ConnectingOntario** to ensure a comprehensive record for any/all existing digital health content:
   - One of the key strengths of ConnectingOntario is how it supports transitions between OHT's and between various levels of care. Kids Come First is committed to ensuring our children and youth are supported regardless of where they are seen.
   - If there are challenges addressing the additional functionality needed from ConnectingOntario, the same feed may be also directed to a 'quality improvement and evaluation' repository to keep us on track for our Year 1 deliverables.

2. **Make an existing EMR/HIS solution available** to those of our OHT partners that have not yet made an investment, or are looking for alternatives

1) Clinical Document Repository Analysis

- **ConnectingOntario.** There has been significant investment into the ConnectingOntario solution. In our region 19 hospitals (~20,000 staff), 552 community users and 187 physicians are already onboarded. When our remaining team partners quickly gain access to the solution, they will be able to view CHEO and lab results. Our partner contributions will need to be prioritized to meet the goal of a comprehensive patient record in Year 1. The primary hurdles identified to adopting ConnectingOntario are: The speed at which our partners can contribute and access, the data can only be used in direct care delivery and cannot be used to inform the quality improvement work that the team is expected to engage in. We are not aware of any current plans for patient

access to ConnectingOntario. We will work closely with OntarioHealth to address these needs. One of the key strengths of ConnectingOntario is how it supports transitions between OHT's and between various levels of care. To be Named by Kids is committed to ensuring our children and youth are supported regardless of where they are seen.

- One of the key strengths of ConnectingOntario is how it supports transitions between OHT's and between various levels of care. To be Named by Kids is committed to ensuring our children & youth are supported regardless of where they are seen.

- **OHT-specific CDR.** The working group did discuss the possibility of building a parallel CDR, leveraging local solutions and existing feeds, if patients won't be able to access ConnectingOntario content or that information can't be used for QI/Evaluation on the timelines the OHT project expects.

2) Making an existing EMR/HIS solution available to all OHT partners

- **Epic:** In 1994 CHEO was the first hospital in Canada to adopt Epic and in 2017, became the second hospital in the country to implement Epic hospital-wide. Since then, CHEO has expanded the instance to support the Children's Treatment Centre and in October, it will be implemented in Roger Neilson House. Epic is the most highly rated Hospital Information System in the world, according to KLAS. Examples of how Epic will meet the clinical priorities of our OHT are:

  1. Complex Care tools
  2. Mental Health & Addictions
  3. Clinical pathways
  4. Medication reconciliation
  5. Allergies
  6. Demographics

- **CHRIS:** CHRIS is the Client Health and Related Information System used across LHIN Home and Community Care providers. It is adept at workload management and basic information sharing, and it is used as the repository for Coordinated Care Plans (CCP) for Health Links patients in the region. It is not, however an electronic medical record – it is specifically used for client management.

- **EMRs in the community**, particularly those compatible with Ocean integration – Practice Solutions, Accuro, and versions of OSCAR are compatible with Ocean eReferral solution. These EMRs are used by >80% of all EMR users in our region, and the number is expected to grow further as the rest of the CHCs complete their migration to Telus. The instances of the software are distributed across many practices and

organizations, without a single standardized system that could easily be expanded to others. However, the common integrations with eReferral solutions such as Ocean, and potential integrations in the future with eConsult and Clinical Viewer, do represent opportunities for improved information sharing, collaboration, and care transitions amongst the care team members. Our team is hoping that the MOH and Ontario Health will maintain these integrations as an important priority so that the solutions can be implemented/sustained.

All three options EMR/HIS options were discussed, with recognition that deeper analysis of costs and funding opportunities will need to be done before a final recommendation can be made.

2.4 Digitally Enabled Quality Improvement

Describe how the members of your team currently use digital health tools and information to drive quality and performance improvement. How will your team build off this experience and capability so that it exists at the team-level?

One of our team's guiding principles for QI is for it to be data-informed and data-driven. As such, the digital health plan that will be implemented will include appropriate data sharing to support that principle, while always protecting child, youth and family privacy.

- Kids Come First is keen to pursue the implementation/adoption of **eReferral for priority pathways**, so that we can facilitate better access to referral information for children, youth and families. Enhancing the patient experience with the appointment scheduling, and electronic communication of information that can help in preparing for appointments to make them as effective as possible, are some of the benefits we expect to be able to leverage.

- **CHEO's Quality Improvement Team** includes industrial engineers with simulation/ modeling experience (and now some software) that could be leveraged to model different patient flows or queuing to optimize access, costs, etc.

- **The Champlain Continuous Quality Improvement Committee (CQIC)** brings together mental health and addictions provider organizations and patient and family partners. Committee members sharing OPOC data include Cornwall Community Hospital, Hôpital Montfort Hospital, CMHA Ottawa, Ottawa Salus, Causeway Work Centre, Family Services Ottawa, Dave Smith Youth Treatment Centre, Centretown CHC, Sandy Hill CHCs and Shepherds of Good Hope. OPOC data identified the following three areas for quality improvement related to patient experience with discharge planning: 1) a common understanding of effective transition and discharge planning; 2) training,

capacity building, and/or skill development for staff; and, developing a common tool or toolkit that will help promote sustainable practice change.

- **Greenspace digital platform** Family Services Ottawa is a key member of the Family Services Ontario Steering Committee, which over the last 12 months, has successfully piloted the implementation of Greenspace Platform across 31 of 48 Family Service Ontario agencies and will expand to the remaining 17 agencies in the next 6 months. We will be able to share with the Ministry the lessons learned about how Family Services scaled quickly.

- **CHEO's Complex Care Program** collects a standardized set of data elements to conduct program evaluation and comparison with other programs, demonstrate the benefits of care coordination to reduce ED visits and hospital admissions, and drive further improvement to care plans.

2.5 Other digital health plans

Please describe any additional information on digital health plans that are not captured in the previous sections.

- Our team's core principle is to build out local solutions wherever possible. Additional digitization opportunities will be scoped out in Year 1, as needed.

3.5.3 How will you provide patients with digital access to their own health

Providing and expanding patients' digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity. Please refer to Appendix B – Digital Health to provide your proposed plan for providing patients with digital access to their health information.

- Our youth and family partners have told us that having access to their clinical information is non-negotiable for the Kids Come First team, which includes eliminating silos of information and instead, consolidating all records. Children and youth with medically complex needs will have access to their data collected by CHEO and Roger Neilson House through Epic MyChart. With 24% already enabled, our team is already meeting the 10-15% target for this priority population.

- A task force on how to appropriately roll out the solution to the mental health and addictions priority population will be established with the outputs not only being used in our team – but shared with other OHTs that may be unsure how to proceed with patient access for children and youth. Finally, we will explore the potential of accessing CO/CDR information through MyChart to ensure all relevant data is available to children, youth and their families.

    - Functionality available today and in the next 12 months:
        - Access to lab and imaging results
        - Discharge summaries
        - Clinical letters
        - Clinical notes
        - Educational materials
        - 2-way communications
        - Video visits

- Self-scheduling is an area of improvement for our team as it is not presently offered by our partners, and we know that children, youth and families are requesting it. In Year 1, we will establish a task force which will identify how to enable this important functionality for our priority populations. One potential example is to explore how CAPA could be used to facilitate self-scheduling with functionality being available in our second year. In combination with the Ocean eReferral functionality, children, youth and their families will be supported in seeing their most appropriate provider, in the most appropriate way, according to their own needs.

B.3 Who is the single point of contact for digital health on your team?

Please identify a single point of contact who will be the responsible for leading the implementation of digital health activities for your team.

Name: Mari Teitelbaum
Title & Organization: Chief Innovation Officer, CHEO
Email: mteitelbaum@cheo.on.ca
Phone: 613.737.7600 x2662

Appendix C: Tables

Appendix C:

The following sections are included: Table 2.1.2, 2.3, 2.6.1, 2.8, 6.6

2.1.2. Indicate member organizations (not including physician(s)/ physician groups)

NAME OF ORGANIZATION *Provide the legal name of the member organization*	**TYPE OF ORGANIZATION** *Select type from dropdown list, if 'other' please specify type in column C*	**OTHER ORGANIZATION TYPE**	**LHIN/MINISTRY FUNDING RELATIONSHIP(S)** *Indicate all existing contracts or accountability agreements between the organization and LHINs, MOH, or other ministry. (e.g., MSAA with ESC LHIN, contract with MCYS, etc.)*	**PRIMARY CONTACT** *NAME (Last name, First name)*	**PRIMARY CONTACT** *TITLE (e.g., Director)*
Almonte General Hospital	HOSPITALS		MOH, Champlain LHIN	Wilson Trider, Mary	President & CEO
Arnprior Regional Health	HOSPITALS		MOH, Champlain LHIN	Hanna, Eric	President & CEO
Bayshore HealthCare Ltd	HOME CARE SERVICE PROVIDER ORGANIZATION		All 14 LHINs	Cottrelle, Stuart	President & CEO
CANImmunize	OTHER, PLEASE SPECIFY	Canadian Corporation	Ottawa Public Health	Atkinson, Katherine	Chief Operating Officer
Carleton Place & District Memorial Hospital	HOSPITALS		MOH, Champlain LHIN	Wilson Trider, Mary	President & CEO
Carlington Community Health Centre	COMMUNITY HEALTH CENTRES		MOH, Champlain LHIN, MCCSS	MacLeod, Cameron	Executive Director
Centre de santé communautaire de l'Estrie	COMMUNITY HEALTH CENTRES		Champlain LHIN	Bisson, Marc	Executive Director
Centre des services communautaire Vanier	COMMUNITY SUPPORT SERVICES		MOH, MCCSS	Gervais, Michel	Executive Director
Centre Psychosocial	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		City of Ottawa, MOE (indirectly)	Kosseim, Mylène	Executive Director
Centre Resources communautaire d'Orléans-Cumberland/Orleans-Cumberland Community Resource Centre	COMMUNITY SUPPORT SERVICES		City of Ottawa, Trillium Foundation	Ouellette, Luc	Executive Director
Centre Youville Centre	COMMUNITY SUPPORT SERVICES		MCCSS and MOE	MacKillop, Bev	Executive Director
Centretown Community Health Centre	COMMUNITY HEALTH CENTRES		MOH, Champlain LHIN	Thibault, Simone	Executive Director

PRIMARY CONTACT *Business / Practice Address*	**PRIMARY CONTACT** *City / Community (e.g., Toronto)*	**PRIMARY CONTACT** *Postal Code*	**PRIMARY CONTACT** *EMAIL (e.g., name@email.com)*	**PRIMARY CONTACT** *PHONE (e.g., 416-123-4567)*
75 Spring Street	Almonte	K0A 1A0	mwilsontrider@agh-fvm.com	613-256-2514 x2220
350 John Street	Arnprior	K7S 2P6	eric.hanna@arnpriorhealth.ca	613-623-3166 x220
310 Hunt Club Rd	Ottawa	K1V 1C1	scottrelle@bayshore.ca	613-733-4408
1 Calvert Street	Ottawa	K2G 1M3	katherine@canimmunize.ca	613-294-4672
211 Lake Ave E	Carleton Place	K7C 1J4	mwilsontrider@agh-fvm.com	613-257-2200
900 Merivale Road	Ottawa	K1Z 5Z8	cammacleod@carlington.ochc.org	613-722-4000 x226
841 Sydney Street, Unit 6	Cornwall	K6H 3J7	mbisson@cscestrie.on.ca	613-937-3132 x231
290 Dupuis Street	Vanier	K1L 1A2	mgervais@cscvanier.com	613-744-2892 x1041
150 Montreal Road	Ottawa	KL1 8H2	mkosseim@centrepsychosocial.ca	613-789-2240 X215
240 Centrum Blvd	Orléans	K1E 3J4	louellett@crcoc.ca	613-830-4357
150 Mann Avenue	Ottawa	K1N 8P4	director@youvillecentre.org	613-231-5150 x105
420 Cooper Street	Ottawa	K2P 2N6	sthibault@centretownchc.org	613-233-4443

Champlain Maternal Newborn Regional Program	OTHER, PLEASE SPECIFY	Regional Program	Participating partners, LHIN	Rose, Darlene	Regional Director
Children's Hospital of Eastern Ontario - Ottawa Children's Treatment Centre	HOSPITALS		MOH, Champlain LHIN, City of Ottawa	Munter, Alex	President & CEO
Children's Mental Health of Leeds & Grenville	MENTAL HEALTH AND ADDICTION ORGANIZATIONS			Crosbie, Lorena	Executive Director
Citizen Advocacy Ottawa-Carleton	COMMUNITY SUPPORT SERVICES		MCCSS	Lacey, Heather	Executive Director
CommuniCare Therapy	HOME CARE SERVICE PROVIDER ORGANIZATION		Champlain LHIN, South East LHIN, Government of Canada	Harrison, Cindy	President & CEO
Cornwall Community Hospital	HOSPITALS		MOH, Champlain LHIN, HSAA, MSAA	Despatie, Jeanette	President & C
Crossroads Children's Mental Health Centre	OTHER, PLEASE SPECIFY	Mental Health	MOH, MCCSS	Hone, Michael	Executive Director
Dave Smith Youth Treatment Centre	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Champlain LHIN	Beauchesne, Mike	Executive Director
Deep River & District Hospital	HOSPITALS		MOH, Champlain LHIN, HSAA, LSAA, FHT	Bedard, Richard	President & CEO
EORLA	LABORATORIES		N/A	Dale, Jeffrey	President & CEO
Family Services Ottawa	COMMUNITY SUPPORT SERVICES		MOH, Champlain LHIN, MCCSS TPA, MAG	Speers, Deirdre	Executive Director
GEM HealthCare	HOME CARE SERVICE PROVIDER ORGANIZATION		Health Shared Services Ontario	Moffett, Gaye E.	President & CEO
Hawkesbury & District General Hospital	HOSPITALS		MOH, Champlain LHIN	LeBoutillier, Marc	CEO
Hôpital Glengarry Memorial Hospital	HOSPITALS		MOH, LHIN	Cohen, Michael	CEO
Inuuqatigiit Centre for Inuit Children, Youth and Families (formerly Ottawa Inuit Children's Centre)	ABORIGINAL HEALTH ACCESS CENTRES		MOH, MCCSS, MOE	Adams, Stephanie Mikki	Executive Director
Kemptville District Hospital	HOSPITALS		MOH, Champlain LHIN, HSAA/LSAA	Vassallo, Frank	CEO
Lanark,Renfrew Health & Community Services	COMMUNITY HEALTH CENTRES			Jordan, John	Executive Director

Suite 300A-2305 St. Laurent Bl	Ottawa	K1G 4J8	drose@cmnrp.ca	613-737-2660 x2527
401 Smyth Road Rm W1512	Ottawa	K1H 8L1	amunter@cheo.on.ca	613-737-7600 x2609
212 Vanburen St	Kemptville	K0G 1J0	lcrosbie@cmhlg.ca	613-498-4844 x3021
312 Parkdale Avenue	Ottawa	K1Y 4X5	hlacey@citizenadvocacy.org	613-761-9522 x225
2270 St. Laurent Blvd	Ottawa	K1G 6C4	charrison@communicare.ca	613-738-2871
EO 840 McConnell Ave	Cornwall	K6H 5S5	jeanette.despatie@cornwallhosp.ca	613-938-4240
1755 Courtwood Cr	Ottawa	K2C 3J2	Mhone@crossroadschildren.ca	613-723-1623 x228
112 Willowlea Rd	Carp	K0A 1L0	mike.b@davesmithcentre.org	613-594-8333 x1211
117 Banting Drive	Deep River	K0J 1P0	richard.bedard@drdh.org	*613-584-3333*
501 Smyth Road	Ottawa	K1H 8L6	jedale@eorla.ca	613-739-6804
312 Parkdale Avenue	Ottawa	K1Y 4X5	dspeers@familyservicesottawa.org	613-725-3601 x115
304-383 Parkdale Ave	Ottawa	K1Y 4R4	gaye.moffett@gemhealthcare.com	613-761-7474
1111 Ghislain Street	Hawkesbury	K6A 3G5	mleboutillier@hgh.ca	613-632-1111
20260 County Road 43	Alexandria	K0C 1A0	mcohen@hgmh.on.ca	*613-525-2222 x4104*
230 McArthur Ave	Ottawa	K1L 6P5	executivedirector@inuuqatigiit.ca	613-744-3133
2675 Concession Road	Kemptville	K0J 1G0	fvassallo@kdh.on.ca	613-258-3435
207 Robertson Dr.	Lanark	K0G 1K0	jjordan@lrhcs.ca	613-259-2182

Maison Fraternité	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Champlain LHIN, MSAA, MCCSS	Lemire, Yvon	Executive Director/Directeur général
Ontario Centre for Excellence for Child and Youth Mental Health	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH	Sundar, Purnima	A/Executive Director
Open Doors for Lanark Children & Youth	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH, MCCSS	Clouthier, Kevin	Executive Director
Ottawa Child & Youth Initiative	OTHER, PLEASE SPECIFY	80+ Member organizations in health, recreation, social services and education	United Way	Reynolds, Brett	Co-Chair
Ottawa Children's Coordinated Access and Referral to Services	COMMUNITY SUPPORT SERVICES		MOH, MCCSS	Tatartcheff-Quesnel, Natasha	Manager
Ottawa Community Housing Corporation	COMMUNITY SUPPORT SERVICES		Champlain LHIN	Giguère, Stéphane	CEO
Ottawa Public Health	MUNICIPALITY		MOH, MCCSS, City of Ottawa	Etches, Dr. Vera	Medical Officer of Health
ParaMed (signed by Extendicare)	HOME CARE SERVICE PROVIDER ORGANIZATION		All 14 LHINs	Guerriere, Michael	President & CEO
Pediadent		Specialized Pediatric Dental Care	MOH Healthy Smiles	Ouatik, Dr. Nabil	Director & Board Chair
Pembroke Regional Hospital	HOSPITALS		MOH, Champlain LHIN	Mersmann, Sabine	VP-Patient Services
Pinecrest-Queensway Community Health Centre	COMMUNITY HEALTH CENTRES		MOH, Champlain LHIN, MCCSS, MTCU, Education Council of Ontario	McIntosh, Christopher	CEO
Parents Lifeline of Eastern Ontario (PLEO)	COMMUNITY SUPPORT SERVICES		Champlain LHIN	Schipper, Elyse	Executive Director
Rainbow Valley Community Health Centre	COMMUNITY HEALTH CENTRES		MOH, Champlain LHIN	McLeod, Greg	Executive Director
Renfrew Victoria Hospital	HOSPITALS		MOH, Champlain LHIN	Penney, Randy	President & CEO
Rideauwood Addiction and Family Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH, MCSS, MAG, Champlain LHIN	Levesque, Johanne	Executive Director
Roberts/Smart Centre	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH, MCCSS, MOE	Van Vliet, Catherine	Executive Director

242 Cantin	Ottawa	K1L 7K1	ylemire@maisonfraternite.ca	613-741-2523 x224
695 Industrial Avenue	Ottawa	K1G 0Z1	psundar@cheo.on.ca	613-737-2297 x3769
U10-130 Lansdowne Ave	Carleton Place	K7C 2T7	kclouthier@opendoors.on.ca	613-257-8260 x423
			brett.reynolds@ocdsb.ca	613-721-1820
2675 Queensview Drive	Ottawa	K2B 8K2	natasha@coordinatedaccess.ca	613-729-0577 x1256
39 Auriga Drive	Ottawa	K2E 7Y8	stephane_giguere@och.ca	613-731-1182 x2271
100 Constellation Dr.	Ottawa	K2G 6J8	vera.etches@ottawa.ca	613-580-2424 x23681
3000 Steeles Ave, Suite 103	Markham	L3R 4T9	michael.guerriere@extendicare.com	905-470-1400
318-1929 Russell Road	Ottawa	K1G 4G3	dr.ouatik@pediatdent.ca	613-737-4343
705 Mackay St	Pembroke	K8A 5M8	amendes@rideauwood.org	613-724-4881
200-1365 Richmond Rd	Ottawa	K2B 6R7	c.mcintosh@pqchc.com	613-820-4922 X3375
1755 Courtwood Cr	Ottawa	K2C 3J2	elyse@pleo.on.ca	613-321-3211 x 500
49 Mill Street	Killaloe	K0J 2A0	McLeodG@sfmhosp.com	613-757-0004
499 Raglan Street, North	Renfrew	K7V 1P6	penneyr@renfrewhosp.com	613-432-4851 x260
312 Parkdale Avenue	Ottawa	K1Y 4X5	jlevesque@rideauwood.org	613-724-4881 x201/613-316-9711
1737 Woodward Dr. Suite 104	Ottawa	K2C 0P9	cvanvliet@rcs-crs.com	613-728-1946 x222

Roger Neilson House		Palliative Care	MOH, Champlain LHIN, MCCSS	Wright, Megan E.	Executive Director
Sandy Hill Community Health Centre	COMMUNITY HEALTH CENTRES		MOH, Champlain LHIN, LHIN Type 2 funding	Gibson, David B.	Executive Director
SE Health (Saint Elizabeth)	HOME CARE SERVICE PROVIDER ORGANIZATION		Agreements with 13 of 14 LHINs	Sharkey, Shirley	Director
Seaway Valley Community Health Centre	COMMUNITY HEALTH CENTRES		Champlain LHIN	St John-de Wit, Debbie	Executive Director
Somerset West Community Health Centre	COMMUNITY HEALTH CENTRES		Champlain LHIN, City of Ottawa	Cloutier, Naini	Executive Director
South East Community Health Centre	COMMUNITY HEALTH CENTRES		Champlain LHIN, MSAA for CHC & CSS, MOH for Midwifery	Tonner, Kelli	Executive Director
St. Francis Memorial Hospital	HOSPITALS		MOH, Champlain LHIN	McLeod, Gregory	Executive Director
St. Mary's Home	COMMUNITY SUPPORT SERVICES		MCCSS	Cummings, Kathleen	
The Children's Aid Society Ottawa	OTHER, PLEASE SPECIFY	Child Welfare Organization	MCCSS	Raymond, Kelly	Executive Director
The Ottawa Rotary Home	COMMUNITY SUPPORT SERVICES		MCCSS, Family Managed Care program (3 party agreement with the family and the LHIN)	St. Amour, Gina	
The Phoenix Centre for Children and Families	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH, Champlain LHIN, MCCSS	Lubimiv, Gregory	Executive Director
The Safehaven Project for Community Living	COMMUNITY SUPPORT SERVICES		MOH, MCCSS	Bisaillon, Susan	CEO
Valoris for Children and Adults of Prescott-Russell	COMMUNITY SUPPORT SERVICES		MOH, MCCSS, Ministry of the Attorney General	Fournier, Hélène	Executive Director
Wabano Centre for Aboriginal Health	ABORIGINAL HEALTH ACCESS CENTRES		MOHLTC, MCCSS, Champlain LHIN, Ministry of Tourism, Culture & Sport of Ontario, PHAC, Service Canada, MOE through City of Ottawa, ESDC, City of Ottawa, OFIFC, Ontario Aboriginal Housing Services	Fisher, Allison	Executive Director
Winchester District Memorial Hospital	HOSPITALS		MOH, Champlain LHIN	Boland, Cholly	President & CEO
Youth Services Bureau	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		MOH, MCCSS, City of Ottawa, MTCU	Lowe, Joanne	Executive Director

399 Smyth Road	Ottawa	K1H 8L2	mewright@cheo.on.ca	613-523-6300 x4604
250 Somerset St. East	Ottawa	K1N 6V6	dgibson@sandyhillchc.on.ca	613-789-1500 x2506
90 Allstate Pkwy #300	Markham	L3R 6H3	Shirleesharkey@sehc.com	905-940-9655 x146383
353 Pitt Street	Cornwall	K6J 3R1	dewitd@seawayvalleychc.ca	613-930-4892
55 Eccles Street	Ottawa	K1R 6S3	ncloutier@swchc.on.ca	613-238-8210
1355 Bank Street #600	Ottawa	K1H 8K7	kellit@seochc.on.ca	613-737-5115 x2407
7 St. Francis Memorial Drive	Barry's Bay	K0J 1B0	McLeodG@sfmhosp.com	613-756-3044 X231
780 de l'Église	Ottawa	K1K 3K7	kathleencummings@stmaryshome.com	613-749-2491 x732
1602 Telesat Court	Gloucester	K1B 1B1	kelly.raymond@casott.on.ca	613-747-7800 x2601
823 Rotary Way	Ottawa	K1T 3W6	gina@rotaryhome.ca	613-236-3200
130 Pembroke St. West	Pembroke	K8A 5M8	glubimib@phoenixctr.com	613-735-2374
1173 Bloor Street West	Toronto	M6H 1M9	sbisaillon@safehaven.to	*416-535-8525 X223*
173 Old Hwy 17	Plantagenet	K0B 1L0	hfournier@valorispr.ca	613-673-5148 x2372
299 Montreal Road	Ottawa	K1L 6B8	afisher@wabano.com	613-748-0657
566 Louise Street	Winchester	K0C 2K0	cboland@wdmh.on.ca	*613-774-1049*
2675 Queensview Drive	Ottawa	K2B 8K2	jlowe@ysb.ca	613-857-3024

2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

As an innovative model, we are bringing together specialized child and youth service providers (organizations and physicians), most of whom will only be affiliated with Kids Come First. We also include participants like hospitals, community health centres and family physicians who will be anchored in geographic lifespan OHTs and work with Kids Come First for the delivery of child and youth health services in their practice or community. This is part of our strategy to improve access, quality and transitions for child and youth services and support primary care providers and OHTs to be able to care for their youngest patients.

2.6.1. Collaborating Physicians

NAME OF GROUP *From the dropdown list, select the name of the participating physician group, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column F).*	**PHYSICIAN NAME** *(Last name, First name) If all physicians in group (column A) are included in the application, leave this column blank.*	**PRACTICE MODEL** *Select model type from dropdown list. If 'other' is selected, please specify model type in Other (column F).*	**NUMBER OF PHYSICIANS** *For participating physician groups, please indicate the number of physicians who are part of the group. (e.g., 850)*
FFS - SOLO FEE-FOR-SERVICE	Dr. Jane Liddle, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Sumeet Sadana, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Stephen Grodinsky, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Kathy Keely, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Mark Bialik, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Janina Milanska, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Julie Nault, Chief, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Andrzej Rochowski, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Jane Schuler, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Kristian Goulet, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Hilary Myron, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Sunita Nayar-Kingwell, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Erica Corsi, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Kelley Zwicker, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Aarathi Sambasivan, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Elham Farhadi, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Nicholas Dust, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Corina Francu, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Michael Saginur, Montfort Hospital Pediatric Group	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. William James, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Zave Chad, Community Pediatrician & Allergist	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Judy van Stralen, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Alfred Sisto, Community Pediatrician	FFS - Solo fee-for-service	1

COLLABORATION OBJECTIVES (E.G., EVENTUAL PARTNERSHIP AS PART OF TEAM) AND STATUS OF COLLABORATION (E.G., IN DISCUSSION)
Contributor to OHT Steering Committee; Lead of the Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Participant on OHT Governance and Community Pediatrician Working Groups; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model

FFS - SOLO FEE-FOR-SERVICE	Dr. Fionnaula O'Kelly, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Maheen Ahmed, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Shawn Kelly, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Tobey Audcent, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Mary Ann Beimers, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Leigh Fraser-Roberts, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Mahassen Ghobrial, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Jessica Gammon, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Fatemeh Kojori, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Genevieve Michaud, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Ilana Prehogan, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Tessia Falsetto, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Rob Laberge, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Joanna Jablonska, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Elizabeth Esselmont, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Karen Palayew, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Lauren Segal, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Irfan Moledina, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Fred Lapner, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Uday Chadha, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Anne Gillies	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Therese Hodgson, Community Pediatrician	FFS - Solo fee-for-service	1
FFS - SOLO FEE-FOR-SERVICE	Dr. Aftab Shariff	FFS - Solo fee-for-service	1
OTHER, PLEASE SPECIFY	Dr. Ciaran Duffy, Chair & Chief, Department of Pediatrics, University of Ottawa & CHEO	Other	205
OTHER, PLEASE SPECIFY	Dr. Claire Liddy, Chair, Department of Family Medicine, University of Ottawa	Other	670
	Dr. Alison Eyre, Family Physician, Centretown Community Health Centre	Other	1
	Dr. Jolanda Turley, Family Physician, Bruyere Family Health Team	FHT - Family Health Team	1
	Dr. Lee Donohue, Family Physician, Your Health -Votre Santé	FHO - Family Health Organization	1
OTHER, PLEASE SPECIFY	Dr. Juan Bass, Chief, Department of Surgery, CHEO	Other	65
OTHER, PLEASE SPECIFY	Dr. Kathi Pajer, Chair & Chief, Department of Psychiatry, University of Ottawa & CHEO	Other	33

Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Partipant in Community Pediatrician Working Group; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model; Leads the provision of specialty pediatric services for the Champlain region
Supporter of the Pediatric OHT model
Contributor to OHT Steering Committee; Co-Lead of the Family Physician Working Group; Supporter of the Pediatric OHT model
Contributor to OHT Steering Committee; Co-Lead of the Family Physician Working Group; Supporter of the Pediatric OHT model
Contributor to OHT Steering Committee; Co-Lead of the Complex Care Working Group; Participant on Family Physician and Quality Impro Working Groups; Supporter of the Pediatric OHT model
Supporter of the Pediatric OHT model; Leads the provision of pediatric surgical services for the Champlain region
Supporter of the Pediatric OHT model; Leads the provision of pediatric psychiatric and mental health services for the Champlain region

OTHER, PLEASE SPECIFY	Dr. Elka Miller, Chief, Department of Medical Imaging, CHEO	Other	13	S
OTHER, PLEASE SPECIFY	Dr. John Veinot, Chair & Chief, Department of Lab Medicine, University of Ottaw & CHEO	Other	10	S
OTHER, PLEASE SPECIFY	Dr. Gail Graham, Chief, Department of Genetics, CHEO	Other	15	S
OTHER, PLEASE SPECIFY	Dr. David Rosen Chief, Department of Anesthesiology and Pain Medicine, CHEO	Other	21	S
FFS - SOLO FEE-FOR-SERVICE	Dr. Michael O'Connor, Chief, Department of Ophthalmology, CHEO	FFS - Solo fee-for-service	5	S

Supporter of the Pediatric OHT model; Leads the provision of pediatric radiology services for the Champlain region
Supporter of the Pediatric OHT model; Leads the provision of pediatric laboratory services for the Champlain region
Supporter of the Pediatric OHT model; Leads the provision of genetic services for the Champlain region
Supporter of the Pediatric OHT model; Leads the provision of pediatric anesthesiology and pain medicine services for the Champlain regi
Supporter of the Pediatric OHT model; Leads the provision of pediatric ophthalmologic services for the Champlain region

2.8. What services does your team intend to provide in Year 1?

Provide a description of each service, indicate whether the service would be available to your entire Year 1 population or a subset (with rationale), and indicate which member of your team will provide the service.

SERVICE	PROPOSED FOR YEAR 1 *Select Yes/No from dropdown list*	CAPACITY IN YEAR 1 *How many patients can your team currently serve?*
Interprofessional team-based primary care	Yes	Primary care physicians and community pediatricians in our region have told us that co-ordinating care for children and youth with medically complex needs and those with mental health and addictions is one of the most challenging, time-consuming problems they face. The Kids Come First health team is designed to help solve this problem. During Year 1, we will have the capacity to provide interprofessional team-based care as required to children and youth from our priority populations of those with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.
Physician primary care	Yes	During Year 1, we will have the capacity to support primary care practitioners and community based pediatricians care for their young patients with medically complex/palliative care needs as well as children and youth with mental health and addictions. One of the considerable assets of the Kids Come First health team is the involvement of community pediatricians who are crucial players in primary care and also provide ongoing support as consulting specialists to many primary care physicians.
Acute care – inpatient	Yes	During Year 1, we will have the capacity to provide acute care – inpatient services to our priority populations of those with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.
Acute care – ambulatory	Yes	During Year 1, we will focus on the 50,052 children and youth representing our priority populations of those with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.
Home care	Yes	

PREDICTED DEMAND IN YEAR 1 *Of year 1 population, how many patients are predicted to need this service?*	**DESCRIPTION** *Indicate which team member(s) will provide the service. If a proposed service differs from your existing scope, explain how you will resource the new service. If there is a gap between capacity and demand, identify plans for closing the gap.*
We estimate that between 40-60% children and youth representing our Year 1 populations will require Inter-professional team-based care. Note: No systematic data are available for non-physician primary care services.	• The Kids Come First health team includes every single Community Health Centre in our region, including family physicians and primary care providers, as well as all 12 rural hospitals, which are highly-aligned with family doctors in their communities.
Kids Comes First will ensure that we support the 1,400 primary care physicians and community pediatricians by providing them with streamlined access to mental health services, addictions services and home care services for our Year 1 populations.	Please refer to table 2.6.1 in Appendix C
We estimate that there will be between 4,500-5,000 acute inpatient admissions for children and youth representing our Year 1 populations.	• Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre
We estimate that there will be between 110,000 – 150,000 acute ambulatory care visits for our Year 1 populations. Note: The LHIN's hospitals do not centrally report comprehensive ambulatory clinic data that separately counts child and youth visits.	• Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • The Kids Come First Health Team will explore opportunities for satellite clinics at partner hospitals in Year 2 and beyond
The estimated demand in Year 1 for Home care services is 700 children and youth.	• Bayshore Healthcare • Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • CommuniCare Therapy • GEM Healthcare • ParaMed • SE Health

Community support services	Yes	During Year 1, we will have the capacity to provide home care to our Year 1 priority population of children and youth with medically complex/palliative care needs.
Mental health and addictions	Yes	During Year 1, we will have the capacity to provide community support services to the 50,052 children and youth representing our priority populations of those with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.
Long-term care homes	No	Not applicable
Other residential care	No	Not applicable
Hospital-based rehabilitation and complex care	Yes	During Year 1, we will have the capacity to provide hospital-based rehabilitation and complex care to our priority population of children and youth with medically complex needs.
Community-based rehabilitation	Yes	During Year 1, we will have the capacity to provide community-based rehabilitation to our priority population of children and youth with medically complex needs.

In Year 1, we estimate that 100% of children and youth with medically complex needs and an unknown proportion of children and youth with mental health and addictions will require Community support services.	• Ottawa Rotary Home • Champlain Maternal Newborn Regional Program • Citizen Advocacy Ottawa • Family Services Ottawa • Orléans-Cumberland Community Resource Centre • Ottawa Children's Coordinated Access and Referral to Services • Ottawa Community Housing Corporation • Roger Neilson House • St. Mary's Home • The Safehaven Project for Community Living
We estimate that close to 100% of the youth with complex mental health and/or addiction needs will require mental health and addictions care in Year 1.	• Centre Psychosocial • Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • Children's Mental Health of Leeds & Grenville • Cornwall Community Hospital • Crossroads Children's Mental Health Centre • Dave Smith Youth Treatment Centre • Maison Fraternité • Open Doors for Lanark Children and Youth • Rideauwood Addictions and Family Services • Roberts Smart Centre • The Phoenix Centre for Children and Families • Valoris for Children and Adults of Prescott-Russell • Wabano Aboriginal Health Access Centre • Youth Services Bureau • Centre of Excellence for Child and Youth Mental Health (CECYM)
Not applicable	Not applicable
Not applicable	Not applicable
In Year 1, we estimate that up to 700 children and youth with medically complex needs will need hospital-based rehabilitation and complex are.	• Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre
In Year 1, we estimate that approximately 700 children and youth with medically complex needs will need community-based rehabilitation.	• Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • CommuniCare Therapy

Short-term transitional care	Yes	During Year 1, short term transitional care would be available to a subset of our priority population of children and youth with medically complex needs.
Palliative care (including hospice)	Yes	During Year 1, we will have the capacity to provide palliative care to our priority population of children and youth with medically complex needs/palliative care needs.
Emergency health services (including paramedic)	Yes	During Year 1, we will have capacity across our team partners to provide emergency health services to the 50,042 children and youth with medically complex needs, and those with mental health and addictions.
Laboratory and diagnostic services	Yes	During Year 1, we will have the capacity to provide laboratory and diagnostic services to our Year 1 priority populations of children and youth with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.
Midwifery services	No	
Health promotion and disease prevention	Yes	During Year 1, we will partner with CANImmunize, Ottawa Public Health, PANORAMA, and the 1,400 primary care physicians and community pediatricians in our region to support population health by focusing on strategies to drive both vaccine uptake and real-time documentation submission.

In Year 1, we estimate that approximately 75-100 children and youth will need short-term transitional care.	• Bayshore Healthcare • CommuniCare Therapy • GEM Healthcare • Roger Neilson House • SE HEalth • The Ottawa Rotary Home
In Year 1, we estimate that approximately 250 children and youth with medically complex needs will need palliative care services.	• Bayshore Healthcare • Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • GEM Healthcare • ParaMed • Roger Neilson House • SE Health
Across the region's 16 acute care hospitals, there are approximately 111,000 pediatric emergency department visits, 50% of which are provided at CHEO. Analysis is ongoing regarding emergency department visits for our Year 1 populations.	• Almonte General Hospital • Arnprior Regional Health • Carleton Place & District Memorial Hospital • Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • Cornwall Community Hospital • Deep River & District Hospital • Hawkesbury & District General Hospital • Hôpital Glengarry Memorial Hospital • Kemptville District Hospital • Pembroke Regional Hospital • Renfrew Victoria Hospital • St. Francis Memorial Hospital • Winchester District Memorial Hospital
In 2018-19, there were 560,000 pediatric lab tests processed and nearly 80,000 diagnostic imaging tests processed. Analysis is in progress to determine the volume for our Year 1 populations.	• Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre • Eastern Ontario Regional Laboratory Association (EORLA)
We will partner with the 1,400 primary care physicians and community pediatricians in our region to improve vaccine uptake and real-time documentation submission for the children and youth in their care.	• Ottawa Public Health (OPH) • CANImmunize • Participating primary care physicians and community pediatricians.

Other social and community services (including municipal services)	Yes	During Year 1, we will have the capacity to provide other social and community services (including municipal services) to children and youth representing our priority populations of those with medically complex needs/palliative care needs as well as children and youth with mental health and addictions.

In the Kids Come First team there is considerable engagement of social care organizations, which will ensure that we can work collectively to address social determinants of health. The estimated demand for these services amongst our Year 1 populations is unknown at this time.	• Champlain Maternal Newborn Regional Program (CMNRP) • Children's Aid Society of Ottawa • Family Advisory Council, Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre, Chairperson • Family Advisory Council, Roger Neilson House, Chairperson • Family Services Ottawa • Inuuqatigiit Centre (formerly Ottawa Inuit Children's Centre) • Ottawa Child and Youth Initiative (comprising 90 child- and youth-serving organizations) • Ottawa Community Housing Corporation • Pediadent • St. Mary's Home • The Safehaven Project for Community Living • Wabano Aboriginal Health Access Centre • Youville Centre

6.6. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting any of the Year 1 Expectations for Ontario Health Team Candidates set out in the Guidance Document. Please describe any mitigation strategies you plan to put in place to address identified risks.

As part of your response, please categorize the risks you've identified according to the following model of risk categories and sub-categories:

RISK CATEGORY *Select risk category from dropdown list*	**RISK SUB-CATEGORY** *Select risk sub-category from dropdown list*	**DESCRIPTION OF RISK**
PATIENT CARE RISKS	QUALITY	Specialized child and youth health services (hospital, home care, child and youth mental health, rehabilitation, developmental services, etc.) operate at a much smaller scale than comparable services for adults. This creates risks to quality and access when these services are fragmented.
PATIENT CARE RISKS	OTHER	Lack of available, pediatric trained frontline home care providers
PATIENT CARE RISKS	QUALITY	Many non-specialized providers of care for kids (family physicians, general hospitals, community health centres, etc) indicate a lack of evidence-based support and structured clinical pathways for the children and youth
PATIENT CARE RISKS	QUALITY	There are significant geographic disparities in access in our region – families in rural areas often struggle to access appropriate child and youth health services
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	Inability to share personal health information across all partners
RESOURCES RISKS	INFORMATION TECHNOLOGY	Inability for some partner organizations to advance digital health due to current financial constraints

RISK MITIGATION
Through the Kids Come First team, we have the opportunity to create the scale required to increase reach, quality and efficiency.
Establish a community of practice/skills training program to support the development and maintenance of enhanced skills and expertise of home care service provider frontline staff
Our Team will help them provide care closer to home and equip them with the knowledge and clinical pathways to achieve their goal of meeting more of their youngest patients' needs.
Through the increased spread of virtual health and partnership with rural providers we will increase access to services for children and youth living in rural geographies.
Advocate with various Ministries to amend privacy legislation
We will expand the use of existing, proven solutions across the Team to support children across all regions/OHTs, and we will work together to ensure an ecosystem that considers access, affordability and always is centred around patient experience.

Appendix D: Commitment to Collaborate

Ottawa
October 9th, 2019

To :
Ministry of Health
Toronto, ON

COMMITMENT TO COLLABORATE

ENSURING THE SUCCESS OF ONTARIO'S NEW OHT SYSTEM IN EASTERN ONTARIO

Since the announcement of the Government of Ontario's Ontario Health Team process, we have worked closely together to make sure our efforts are connected, effective and reinforce the government's goals. Since the July 17, 2019 start of the Full Application process, ÉSO de l'Est d'Ottawa/Ottawa East OHT, Kids Come First Health Team / Équipe Les Enfants Avant Tout and Ottawa Health Team/Équipe Santé Ottawa have met on a regular basis to co-ordinate our efforts. We commit to our region's population and providers that we will continue to collaborate to advance the Government of Ontario's agenda of improving patient care, experience and outcomes through better, faster and more connected care for clients/patients. To this end, we commit to:

- *Continuing to plan together to avoid duplication of effort and resources.*
- *Ensuring that attribution of populations does not in any way limit or restrict client/patient choice and care across partner teams.*
- *Coordinating public communications in both English and French as much as possible so the public can well understand the emerging system.*
- *Streamlining engagement and co-ordinating planning processes (as much as possible) for individual providers, clients/patients/families/caregivers, and agencies, including the Indigenous and francophone communities as well as other health equity groups.*
- *Developing mechanisms to ensure seamless transitions between health teams.*

ENGAGEMENT À COLLABORER

ASSURER LE SUCCÈS DES NOUVELLES ÉQUIPES SANTÉ ONTARIO DANS L'EST DE L'ONTARIO

Depuis l'annonce du processus d'Équipe Santé Ontario du gouvernement de l'Ontario, nous avons travaillé en étroite collaboration pour nous assurer que nos efforts sont reliés, efficaces et renforcent les objectifs du gouvernement. Depuis le début du processus de soumission complète le 17 juillet 2019, ÉSO de l'Est d'Ottawa /Ottawa-Est OHT, Équipe Les Enfants Avant

Tout / Kids Come First Health Team et Ottawa Health Team/Équipe Santé Ottawa se sont rencontrées sur une base régulière pour coordonner nos efforts. Nous nous engageons envers la population et les fournisseurs de soins de notre région à continuer de collaborer pour faire progresser le programme du gouvernement de l'Ontario visant à améliorer les soins, l'expérience et les résultats des patients grâce à des soins améliorés, plus rapides et plus branchés pour les patients. À cette fin, nous nous engageons à :

- *Continuer à planifier ensemble afin d'éviter le dédoublement des efforts et des ressources,*
- *Veiller à ce que l'attribution des populations ne limite ni ne restreigne en aucune façon le choix*
- *et les soins des clients/patients dans les équipes partenaires.*
- *Coordonner autant que possible les communications publiques en français et en anglais afin que*
- *le public puisse bien comprendre le nouveau système.*
- *Assurer un processus d'engagement simplifié, et coordonner autant que possible nos efforts de*
- *planification, en particulier pour les prestataires individuels, les clients/patients/familles/leurs*
- *proches et les autres organismes, y compris les communautés autochtones et francophones*
- *ainsi que d'autres groupes visés par l'équité en santé.*
- *Élaborer des mécanismes pour assurer une transition harmonieuse entre les équipes de santé.*

Alex Munter
President & CEO, CHEO
Lead reps for each of the collectives

Claire Dawe-McCord
Co-Chair, Steering Committee, Kids Come First/
Les Enfants Avant Tout

Dr. Bernard Leduc
CEO, Hôpital Montfort

Simone Thibault
CEO, Centretown Community