November 21, 2019

Addendum to the Ottawa Health Team/Équipe Santé Ottawa Submission Section 2.7 and 2.8

Our October 9th submission indicated that we would submit an addendum by December 9th that would outline the number of the Year 1 populations we could serve in an integrated manner. This addendum outlines what we propose to do in Year 1 to establish the foundation for scaling up in the following year.

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.

Adults with moderate to complex mental health and addictions

A high rate of adults with MHA issues that visit emergency departments (ED) are unattached, suggesting that visits can be prevented through more regular contact with primary care. In 2018/19, the cohort of ED visitors with MHA that were unattached is estimated to be 2,350 individuals (with alcohol-related disorders affecting a smaller subset of some 620 individuals).

An integrated and comprehensive team-based approach will be developed to address the priority health and social service needs of adults with MHA issues that present at the ED. Leveraging and realigning the existing services and resources of partners, the approach will include an active offer of:

- care coordination aligned with stepped care approach (level aligned with need)
- connection/attachment to team-based primary health care
- access to addictions medicine
- streamlined access to mental health and addictions services
- supports for self-management.

The model will be developed and implemented with 200 clients and then scaled upon demonstration of effectiveness. Simultaneously work will be done to evolve hubs in the community that enable streamlined and timely access to a more integrated and comprehensive service response, reducing avoidable use of the ED.

Frail older adults with declining function many with limited social supports and low income

The OHT/ÉSO will re-align existing services to offer a more integrated approach reducing transitions and improving the experience of the frail older adult with limited social supports and low income. This population group is often on a trajectory toward hospitalization and alternate level of care given a lack of access to the level of integrated care required in the community.

At least 19% of our attributed population is 65 years or older – some 20,000 would be considered frail and some 3,500 would be considered most frail. All would benefit from improved integrated care.

a. Frail older adults requiring integrated care and supports in community

An integrated and comprehensive team-based approach will be developed to address the self-identified priority health and social service needs of frail older adults that are at risk and on a trajectory toward declining function and avoidable hospitalization.

The intent is to provide streamlined and timely access to the required level of care and combination of services and supports that enable the senior to be supported and live well in the community. Leveraging the existing services and resources, the approach will include:

- care coordination linked to primary care
- blended model of home care and community supports
- supports for greater health literacy and self-management
- access to specialized assessments and consultations with specialists
- planning for higher level of care within the community or sub-acute care
- early identification and access to palliative care.

Using existing resources, the model will be developed and implemented with 200 frail older adults and then scaled up if it is demonstrated to be effective. One sub population for initial focus is those on the waitlist for Primary Care Outreach to Seniors or those currently being served but experiencing barriers to accessing key services (estimated 1,160 in October 2019).

b. Frail older adults transitioning from hospital including ALC

An integrated and comprehensive team-based approach will be developed to address the self-identified priority health and social service needs of frail older adults that are transitioning from hospital back to community. With new funding, home care providers will offer comprehensive inter-disciplinary support for a 12-week period prior to transitioning to the appropriate level of integrated care and supports.

The model will be developed and implemented with 200 frail older adults and then scaled up as appropriate. At any one point in time there are an estimated 45-50 frail older adults in transitional care or ALC that could potentially return home with integrated care.

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.

As outlined in Table 1, the OHT/ÉSO partner organizations collectively offer a significant breadth and depth of services. Together we serve our attributed population of 564,267 people. Partners will sustain our current level of service as we re-align services to ensure excellent care

transitions and reduced barriers to care for clients. All partners are prepared to contribute to realign the health system toward the vision, mission and commitments of the OHT/ÉSO.

Through a co-design process with client partners at the centre, the OHT/ÉSO partners will leverage and re-align existing resources to re-design services and care pathways to improve the client experience, facilitate and streamline access to services. Given the complexity of the initial populations – adults with moderate to complex mental health and addictions issues and frail older adults with limited social supports and living on a low income – and the level of cross over and collaboration required to serve them, calculating overall capacity by identifying the current level of service provided by any one partner or predicting demand for any one service area will not provide a clear picture of capacity or demand.

At this point partner organizations have not identified excess capacity which can be applied to new or expanded services other than the new Program for ALC transitions. Accordingly, partners will have to work together to create capacity within our existing demands for care. We intend to do this by:

1. reducing the burden on primary care providers by integrating community supports with primary care (for both populations) thereby creating more primary care capacity
2. reducing the number of people on waiting lists for services which are not appropriate to their needs and
3. enhancing uptake of community support services to reduce demand on health care services while improving quality of life for participants.

As outlined in Section 2.7, new models will be designed, metrics determined, tested with a cohort of the population, evaluated and then scaled up as appropriate.

Table 1 outlines most of the services currently funded and provided by partners for the attributed population. Many are multi-service organizations and may offer additional services that are not outlined in the table. Some services are regional or city-wide.

Table 1: OHT/ÉSO Existing Service Capacity

Services	Partner organizations offering these services
Interprofessional team-based primary care	Carlington CHC Centretown CHC Pinecrest Queensway CHC Sandy Hill CHC Somerset West CHC South East Ottawa CHC The Ottawa Hospital Academic Family Health Team
Physician primary care	Greenboro Family Medicine Centre
Acute care – inpatient	The Ottawa Hospital
Acute care – ambulatory	The Ottawa Hospital
Home care	Carefor Community & Health Services SE Health Ottawa West Community Support

Table 1: OHT/ÉSO Existing Service Capacity	
Services	**Partner organizations offering these services**
Community support services	Bruyère Continuing Care Carefor Community & Health Services Eastern Ottawa Resource Centre Meals on Wheels Ottawa Olde Forge Community Resource Centre Ottawa West Community Support Rideauwood Addiction & Family Services Rural Ottawa South Support Services South East Ottawa CHC The Dementia Society of Ottawa Renfrew The Good Companions Seniors' Centre The Perley and Rideau Veteran's Health Centre
Mental health and addictions	Amethyst Women's Addiction Centre Carlington CHC Centretown CHC Canadian Mental Health Association Ottawa Counselling and Family Service Ottawa Crossroads Children's Mental Health Centre Dave Smith Youth Treatment Centre Empathy House Family Services Ottawa Jewish Family Services of Ottawa Maison Fraternité Ottawa Community Immigration Services Ottawa Inner City Health Inc. Ottawa Salus Pinecrest Queensway CHC Royal Ottawa Mental Health Centre Sandy Hill CHC Serenity House Sobreity House Somerset West CHC Upstream Ottawa Vesta Recovery Program for Women Inc.
Long-term care homes	Bruyère Continuing Care The Bess and Moe Greenberg Hillel Lodge The Perley and Rideau Veteran's Health Centre
Other residential care	Bruyère Continuing Care Options Bytown Non-Profit Housing Ottawa Inner City Health Inc. Ottawa Salus The Perley and Rideau Veteran's Health Centre Salvation Army Ottawa Booth Centre Shepherds of Good Hope Ottawa
Hospital-based rehabilitation and complex care	Bruyère Continuing Care The Ottawa Hospital
Community-based rehabilitation	Carefor Community & Health Services VHA Home Healthcare
Short-term transitional care	Bruyère Continuing Care

Table 1: OHT/ÉSO Existing Service Capacity	
Services	**Partner organizations offering these services**
	SE Health (new Program) Carefor Community & Health Services (new Program) SE Health (new Program) The Perley and Rideau Veteran's Health Centre
Palliative care (including hospice)	Bruyère Continuing Care Champlain Hospice Palliative Care Program Hospice Care Ottawa Ottawa Inner City Health Inc.
Emergency health services (including paramedic)	Ottawa Paramedic Service The Ottawa Hospital
Laboratory and diagnostic services	The Ottawa Hospital
Midwifery services	Community Midwives of Ottawa
Health promotion and disease prevention	Ottawa Community Health Centres Ottawa Public Health
Other social and community services (including municipal services)	Carlington CHC Centretown CHC Eastern Ottawa Resource Centre Lowertown Community Resource Centre Nepean Rideau Osgoode Community Resource Centre Orléans Cumberland Community Resource Centre Ottawa Community Immigration Services Pinecrest Queensway CHC Rideau Rockcliffe Community Resource Centre Sandy Hill CHC Somerset West CHC South East Ottawa CHC Vanier Community Service Centre Western Ottawa Community Resource Centres
Other health services	Partners offer a wide range of services and supports for specific conditions and/or population groups. Examples include:
Care coordination	Health Links - South East Ottawa CHC Primary Care Outreach Services - South East Ottawa CHC w. Ottawa CHCs
Diabetes education and management	Centretown Community Health Centre
Geriatric assessment	Regional Geriatric Program of Eastern Ontario
Lung health and respiratory care	Somerset West Community Health Centre
Newcomer health and interpretation services	Somerset West Community Health Centre