2023 OHT Impact Fellows Program

Please complete this form to indicate your OHT's interest in hosting an Impact Fellow.

Interested OHTs are encouraged to reach out to program staff early on to discuss potential ideas. OHTs may submit more than one project idea in their EOI, but may only host one Impact Fellow at a time.
Please note that submitting an EOI does not guarantee that the OHT will be matched with a fellow. The Program Team will follow-up with OHTs once Expressions of Interest are submitted to confirm necessary details before sharing these with potential applicants via the program website.

1. OHT Name	Connected Care Halton
OHT Location	Halton Region (Oakville, Milton and Halton Hills)
OHT Website (if applicable)	www.connectedcarehalton.ca
2. OHT Primary Contact	Karin Swift
Primary Contact Email	kswift@haltonhealthcare.com
Are you willing to be contacted by prospective Fellows to discuss projects?	Yes
3. Host Mentor	Sarah Weberman
Host Position / Title	Project Manager

4. OHT Priority Areas

As per the OHT Path Forward deliverables from Ontario Health in January 2023, the priority areas will focus on common clinical pathways to improve patient care. The CCHOHT will focus primarily on the continued implementation and expansion of the Remote Care Management program with a focus on Diabetes, Mental Health and Addictions, and Palliative Care. The Fellow's expertise will support the expanded implementation, including development of an evaluation and performance framework, data analysis identifying enablers and barriers to scale and spread to priority populations. The Fellow's expertise will help lead/facilitate clinical consultations and engagement to ensure comprehensive and coordinated care.

5. OHT Goals

Over the next year, the CCHOHT would benefit from the Fellow's leadership and attention to:

- Develop and implement an evaluation framework to measure the value of digitally enabled remote care management. This would include clinical outcomes, quality and safety, access to care, patient/family/caregiver experiences, clinician experiences and financial and operational impact (i.e., reduced ED/IP visits, re-admissions, reduced LOS and LOS days savings). This would also be inclusive of embedded environmental factors and social determinants of health and equity.
- Develop and implement clinical criteria and pathways for expansion to Mental Health, Palliative

Care, and Diabetes priority populations.

6. Proposed Projects

The project will focus on the development of a robust evaluation and performance framework for the Remote Care Management Program. This program is currently managing patients/clients with COVID-19, COPD, CHF, ILD, Asthma, and other Respiratory Dx. Additional expansion work will include development of clinical and operational pathways based on clinical best practice guidelines enabled by the technology, which will include the clinical care models, intake criteria, on boarding, management, escalation and processes. Work will include an evaluation/environmental scan of current state, application of quality improvement methodologies, change ideas, change concepts (QI, PDSA tools, etc.), indicator/metric development and analysis, process mapping, gap analysis, and recommendations for improvement.

This work will include developing value streams and evidence of the program impact inclusive of:

- Clinical outcomes, quality and safety
- Access to care
- Health equity
- Patient, Family and Caregiver experience
- Clinician experience
- Financial and operational impact

The overall goal of the evaluation and performance framework will be to demonstrate improvements in clinical outcomes for patients on the program, reduction of avoidable ED and inpatient utilization, calculation of length of days savings, improved primary care capacity, and reduction of administration burden. This framework will also include an environmental scan and current state related to health equity factors in accessing care, such as demographic characteristics and social determinants of health, to identify opportunities to advance equity in digital health care delivery.

Expansion to priority populations:

- Palliative Care: will focus on the outpatient palliative care clinic with oncology diagnoses who have acute symptom burden and would benefit from more frequent monitoring of ESAS (Edmonton Symptom Assessment System) scores and follow-up.
- Mental Health: will focus on the outpatient “Brief Consult Interaction” clinic follow-up for patients/clients who have been discharged from the ED or Inpatient areas with the intent of suicide or aborted plan, which includes ongoing follow up and inclusive of implementation of mood rating and depression scales.
- Diabetes: Development of population identification and inclusive criteria (early identification, ongoing education and management) to assist patients/clients will maintenance of blood sugar levels, educational resources and medication reminder that will include appropriate interventions are provided to encourage self-management at home, review care planning goals.

For all the priority populations (current and expanded), data analysis would include ED/IP visits, EMS calls, GP visits, clinic visits, and interactions with the Remote Care Management team.

This project will be aligned with the various OHT priorities, advancement of the digital maturity assessment, improved population-health and outcomes and includes implementations of applies research, best practice and evidence-based guidelines and an opportunity for a whitepaper publication

Project Summary

The project will include development of an evaluation and performance management framework for the Remote Care Management program. This work will include developing the value streams related to clinical outcomes, quality and safety, access to care, health equity, patient experience, clinician experience, financial and operational impact.
The framework should include elements to determine the evaluation of the success of the program by determining value related to what we are going to evaluate, what aspects of the program can be

identified as successful, what standards and best-practice evidence can be incorporated.
Data analysis will include hospitalization utilization, length of stay, clinical outcomes and maintenance of those patients/clients discharged from the program.
The project is aligned with the Quadruple Aim goals, as it will monitor, measure, and improve the patient experience and provide a flexible model of care utilizing the capacity and resources, while creating efficiencies and reducing per capita patient costs.

7. Desired Competencies

Within these initiatives and projects, our OHT would benefit from hosting a Fellow to expand our work with expertise and competencies to:

- Apply evaluation method and improvement science to understand system, population, and patient outcomes and program evaluation frameworks
- Synthesize evidence, best practices, and data to inform decision making
- Use data to understand care pathways, unmet care needs, and service delivery gaps
- Develop and test new performance indicators (e.g., integration, continuity, equity)
- Apply quality improvement methodologies, such as LEAN, Six Sigma, root cause analysis, process mapping, pareto analysis, and change ideas and concepts
- Apply a population-health equity and co-design lens to our priority populations, including segmentation
- Inform the OHT on directions from Ontario Health, other OHTs, RISE, etc., and recommendations where applicable
- Support the implementation of our corporate initiatives and evaluate the implementation process to understand enablers and barriers

Does your OHT Require a Fellow with Bilingual Proficiency? No

8. OHT Environment

The Fellow will work collaboratively with our management team, partners, specialists, and physicians and participate as an integral team member on all initiatives.
Our core team includes:
Dr. Kristianna Martiniuk, Co-chair of the Collaborative Committee, is a family physician in Oakville, a passionate advocate for system improvement and improved patient and provider experience.
Dr. Corinne Breen has practiced in the Oakville community and at OTMH for over 16 years. She helped co-found the OakMed Family Health Team in 2011 and the Mississauga Halton Primary Care Network in 2014.
Dr. Kiran Cherla, a family doctor in Halton Hills for over 18 years, a representative and a Halton Physician Association liaison on the CCHOHT Collaborative Committee. He is also co-lead for the Mental Health workstream. He is a Board Member for the Ontario Medical Association and the Canadian Medical Association and is an Associate Clinical Professor at McMaster University.
Dr. Tarek Kazem is a Palliative Care Physician and Clinical Lead for the Palliative Care Program at Halton Healthcare. He is a passionate educator the Assistant Clinical Professor at McMaster University supervising medical students, residents, and Fellows. His clinical interests include complex cancer pain management and integrating technology into healthcare to improve patient and family experiences.
Karin Swift, Director of CCHOHT, is an experienced healthcare leader with strengths in community collaborations and community care.
Angela Hobbs, Executive Assistant, has brought exceptional organizational skills and project planning experience to the healthcare sector for the past 22+ years.
Cathy Grilo, Senior Project Manager, has a background in healthcare and academia. An alumna of the University of Toronto, Cathy holds an Honors Double Major degree in Political Science
Sarah Weberman, Senior Project Manager, has worked in the health care industry for over 18 years in project management, analysis, and quality specialist roles.

Preferred Work Arrangement for Fellow

Flexible dependingon candidate needs

9. Opportunities for Professional Growth and Development

The Fellow will apply advanced training in evaluation, implementation science, and engagement strategies across our OHT and surrounding regions with the opportunity of hands-on experience in project implementation and evaluation and fully participate in our efforts to improve patient outcomes and health system efficiencies.

The Fellow has the opportunity to work closely with senior leadership from Acclaim Health, Home and Community Care Support Services, Halton Healthcare, Halton Region, Halton Physician Association, and the CCHOHT Patient, Family and Caregiver Advisory Committee, as well as collaborate with neighbouring OHTs (Mississauga and Burlington), providing additional networking opportunities with health system leaders, decision-makers, academics, and other impact Fellows.

The Fellow will have the opportunity to enhance skills in project management, organizational leadership, change management, quality improvement, and implementation of evidence-based changes, which will include capturing outcome measures, opportunities to scale, spread, and contribute to successful change across CCHOHT, other OHTs, and the province.

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