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	Southlake Community OHT
OHT Location	Newmarket
OHT Website (if applicable)	https://southlakecommunityoht.ca/
2. OHT Primary Contact	Ami Sheth
Primary Contact Email	asheth@southlakeregional.org
Are you willing to be contacted by prospective Fellows to discuss projects?	Yes
3. Host Mentor	Gayle Seddon
Host Position / Title	OHT Director

4. OHT Priority Areas

Our focus is on population health management with a special focus on older adults and equity deserving populations. Using digital health platforms and digital data mapping, we have initiated various projects to manage health conditions and advance system priorities. Currently, we have 8 initiatives to address the needs of frail seniors and those with a designation of Alternate Level of Care (ALC) and are designing a feasible test of change to modernize home care services. Overall, through robust and comprehensive governance structures we have 19 initiatives in various stages which can advance the system.

5. OHT Goals

Refer to attached document in the PPT (Slide 10, 11, 12)
The goal for the OHT Impact fellow are the following 2 goals;
1) Focus on cQIP indicator- Reduction of ALC rate. Evaluate processes, outcome or its impact of the following,
a) Current initiatives/pilot projects (8) designed to reduce the ALC rate;
b) Evaluate current operational programs within Southlake Community OHT Geography;
c) Determine current gaps, and provide recommendations

2) Review quantitative and qualitative data related to c-QIP- Reduce ED visits as a first point of contact for MHA related conditions indicator, and provide insights related to gaps in care.

6. Proposed Projects

See attached document in the PPT (Refer to Slide 10, 11, 12)
Focus on cQIP indicator- Reduction of ALC rate. Evaluate processes, outcome or its impact of the following initiatives/projects

Senior Friendly Leading Practices and Targeted Actions
--Proactive Identification and Long Term Management
1) Consulting with Geriatric Experts to select a frailty screening tool that could be used by a variety of providers in a number of different settings;
2) Improving LTC residents' timely access to primary care for conditions sensitive to primary care
3) Remote Care Monitoring-Frail Seniors in collaboration with Toronto Grace Health Center
4) Avoid Unnecessary Admission
Daily ED Rounds:
5) Prevent Social admits and ensure a dedicated intervention for those who were into the ED overnight or ON SU patients
•begin the discharge planning process at admission, thus identifying home supports requirements upon discharge;
•Increase accountability of members of the care team.
Program- Southlake@home and Southlake@Plus programs designed for individual experiencing multi-factor complexity to transition to home from the hospital.
Avoid Hospital Harm and Enhance Well Being
6)Complex Discharges-Long Stay >100 days: Address the needs of ALC designated patients with complexities related to discharge from acute care such as following:-(implemented)
•Multiple declines from Long-term Care (Behaviours);
•No acceptances to Long-term Care;
•Homelessness;
•Complex social, developmental and physical care needs.

7) Joint Discharge Rounds to identify patients who have Length of Stay of 10 days or greater, Blaylock positive, or complex discharge presentations

8) Community Resource Education for discharge planners to ensure community resources are implemented before discharge to ensure smooth transition into the community setting

9) Establish sustainable care-pathways for patients in acute care who are deemed palliative to transition to a safe community setting and/or home

Review quantitative and qualitative data related to c-QIP- Reduce ED visits as a first point of contact for MHA related conditions indicator, and provide insights related to gaps in care.

The test of change being planned is going an approval process, to be confirmed by end of April 2023. However, we would like the fellow to review the current data related to MHA conditions from readily available data sources, and few organizational specific data sets to gain insights on the current services, and the gaps in the current system for MHA related conditions.

Project Summary

The project aims to reduce Alternate Level of Care rate within Southlake Community OHT. It includes implementing the few recommended practices by repurposing current resources. For details related to implemented practices, please refer to question 4.
The second part of the project will include reviewing the current data and conducting focus groups interviews with the service providers to determine the current gaps in the system related to MHA related care delivery. The insights from the data will help us determine a feasible test of change which

can be implemented at the OHT level.

7. Desired Competencies

The fellow must have background in healthcare and understanding of integrated healthcare systems, familiarity with statistical analysis, evaluation and working with large data sets.

Change management and project management experience is and working knowledge of Geographic Information Systems(Geoanalytics) will be an asset.

Does your OHT Require a Fellow with Bilingual Proficiency? No

8. OHT Environment

Southlake Community OHT serves the fastest growing urban population and has a large rural area, and therefore, the complexities of serving both rural and urban needs in a historically underfunded area lends itself an interesting challenge. Despite these challenges, through various advocacy efforts, SC OHT has received continuous funding to advance its digital health goals. The OHT environment currently is ripe for change, and innovation, which has been built by layers of strong governance, and by building upon the successes of the past. The described projects were drafted after months of discussions with senior leaders and thus this would be the right time to draft an evaluation framework for the projects, projects and review the data. Lastly, the OHT director is very keen to have a fellow, as she is spearheading both the projects, and has been supported by the primary care physician, and key higher-level leadership from few community organizations.

Preferred Work Arrangement for Fellow Hybrid | Flexible depending on candidate needs

9. Opportunities for Professional Growth and Development

OHT Impact fellow will gain valuable experience of working in a mix of rural and suburban community and will gain insights related to drive innovation in a landscape of growing community, and where focus on research and its applications is becoming the norm. The OHT fellow opportunity is a hands-on experience with the project while supported by leadership team. Through the hands-on experience, the OHT fellow will meet with the key leaders of the organizations which are generally very lean, and hence the opportunity to meet with the key- decision makers will be high thereby driving the impact needed for the projects. Due to a hands-on approach, the impact fellow will be able to understand key change management principles required to integrate the system. Our OHT, also recently completed a strategic planning exercise, wherein the projects mentioned are considered a key priority for the OHT.

10. Additional Information

Please review the slides attached to understand the current state of SC OHT

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SC OHT- OHT Impact Fellow … .pdf