1234Ontario Health Team (OHT) Name:	Brampton Etobicoke (BE) Ontario Health Team
Transfer Payment Recipient Name:	William Osler Health System
Reporting Period:	November 16, 2020 to March 31, 2021
We would like to follow you! *If your OHT is active on social media, the ministry would be grateful for the opportunity to follow you and hear about your work in real time!*	Twitter: LinkedIn: Other:

The Year End Report for Fiscal Year 2020-2021 consists of three parts:

1) Narrative and Status Update
2) TPA Performance Indicator Reporting
3) Financial Expenditure Statement

The reporting period for this report is November 16, 2020 to March 31, 2021.

The Year End Report is due to your Ministry of Health (ministry) point of contact by April 30, 2021.

PART ONE: NARRATIVE AND STATUS UPDATE

The Narrative and Status Update collects information about your OHT's progress against TPA outputs and milestones, as well as the overall advancement of the OHT model. There are no word limits to this part of the Year-End Report, but brevity is encouraged.

As you complete this template, please consider and highlight in yellow up to three things that your team feels could be shared more broadly for other teams to adopt or learn from. These could be successes or achievements, activities, or risks and mitigation approaches.

Section A – Baseline Update

The following questions confirm important baseline information that may have changed since the submission of your OHT's Full Application.

Confirming OHT Membership

Your ministry point of contact has shared with you the membership records we have on file for your team. Please validate the list per the instructions included in the provided spreadsheet.

Confirming Year 1 Priorities

Have your OHT's initial target population(s) or implementation plans changed since the submission of your Full Application (e.g., are you extending your focus to additional populations)? If so, please describe the change(s) and associated rationale.

The Brampton Etobicoke Ontario Health Team (BE OHT) initial implementation plan included the development and implementation of three major models of care:

1. Integrated Care Hub (ICH) to provide 24/7 system navigation and coordination to all patients/clients within the BE OHT catchment area.
2. Seamless Care Optimizing the Patient Experience (SCOPE) service to provide urgent system navigation and coordination services for BE OHT primary care providers. In addition to the primary care providers themselves, the target population who would benefit from access to SCOPE services was the approximately 200,000 patients/clients of the primary care providers signed on to the BE OHT.
3. A clinical care pathway for complex patients/clients with diabetes. The target population for this care pathway was defined as patients/clients identified as socially complex (e.g. facing challenges related to the social determinants of health) who were also living with diabetes. The BE OHT estimated that at least 40,000 patients/clients would fall into this category.

Due to COVID-19, two of the above OHT initiatives were put on hold. The BE OHT Collaboration Council determined that the ICH would be placed on hold as the resources that were allocated to support the ICH were deployed to support COVID-19 testing indefinitely. The care pathway for complex patients/clients with diabetes was also put on hold, as new information about the impact of COVID-19 on the BE OHT's most vulnerable populations prompted the Collaboration Council to re-evaluate and prioritize the needs of the community. Conversely, the SCOPE model remained a priority for the OHT as the Collaboration Council recognized its value to respond to the pandemic by improving access to care for urgent patient needs in a virtual manner, while reducing emergency room visits. With such, the BE OHT's priority populations shifted to support patients/clients with COVID-19 and patients of primary care providers participating in SCOPE.

The BE OHT participated in a number of pandemic response activities including but not limited to: community assessments/testing for COVID-19, long-term care home and congregate setting support, PPE support, mobile community testing clinics, and vaccination planning/implementation. In addition, the SCOPE model was implemented as a pilot starting in October 2020. Based on the success of the pilot, the BE OHT is expanding the SCOPE program to include an increased number of physicians throughout the OHT supported with enhanced resources.

To further develop the BE OHT partnership beyond COVID-19, the BE OHT engaged Santis Health to facilitate a 3-part retreat with the goals of building on established relationships and trust among partners, developing a vision and values for the OHT, and redefining the OHT's priority population(s). The retreat concluded in April, and the Collaboration Council will be using the findings from the retreat to finalize the priority population(s), values and vision with OHT partners in the coming months. Other sources of input that will inform these decisions with partners include: equity considerations, data from multiple sectors, evidence-based practices, perspectives from working groups and advisory bodies such as the Community Medical Advisory Council (CMAC), Equity, Diversity and Inclusion Action Committee (EDIAC), and Patient Family Advisory Council (PFAC), and learnings from other OHTs and the Ministry's Central Program of Supports. The BE OHT has engaged the coach from RISE to inform these discussions as well.

Section B – Showcasing Successes To Date

In recognition that OHTs have been making progress on their plans since their initial approval, please answer the following questions reflecting on the period from your team's approval (December 2019 or July 2019) to March 31, 2021.

To date, what accomplishment is your OHT most proud of?

The BE OHT is most proud of the way the team has learned to work together, which has led to the following accomplishments:

- **Patient/client, family and caregiver engagement and participation**
  - The establishment of the BE OHT Patient and Family Advisory Council (PFAC) with 12 patient and family advisors. A number of these Patient Family Advisors also serve on the Collaboration Council and working groups to help guide the development of the OHT.
- **Physician and clinician leadership, engagement and participation**
  - Overall, the BE OHT has seen improved engagement of primary care providers in the community:
    - 95 community primary care providers signed the BE OHT Collaborative Decision Making Arrangement Framework.
    - The Primary Care Newsletter that was launched in March 2020 now has 189 subscribers, and features up-to-date information about COVID-19 and ways primary care can support the system.
    - The Community Medical Advisory Committee has 11 primary care physicians from a diverse array of models (Family Health Team, Family Health Organization, Family Health Group, Solo Fee for Service [Solo FFS], and Community Health Centre).
    - The primary care lead for SCOPE is a Solo FFS physician who understands the need for access to team-based supports for primary care within the BE OHT.
  - The BE OHT SCOPE line has achieved a 50% ED diversion rate and a 94% primary care physician satisfaction rate to date.
- **Integrated and coordinated service delivery**
  - Development and implementation of the High Intensity Supports at Home Plus (HISH+) Program to pilot long-term care at home within the BE OHT, and Mobile Enhancement Support Team (MEST) to support long-term care homes and congregate settings.
- **Crisis response**
  - Ability for OHT partners to come together in a crisis and support each other by creating networks to share knowledge, learn about collective challenges faced by various sectors in the system, and mobilize resources to respond to collective efforts. This included establishing seven community testing sites within the BE OHT catchment area to support Ontario Health Central's mandate for coordinating a local response to testing, as well as mobilizing BE OHT partners to support the Public Health Units with vaccination efforts.
  - PPE supply chain plan and enhanced access for OHT partners.
- **Team building**
  - The sense of trust built between partners has enhanced opportunities for collaboration.
  - The development of a Resource Allocation Framework for the OHT has enabled the Collaboration Council to achieve consensus on how OHT funds would be allocated in a fair and transparent manner.
- **Equity, Diversity and Inclusion**
  - Commitment to prioritize diversity as a value for the OHT.
  - Development of the Equity, Diversity and Inclusion Action Committee (EDIAC).

Is there a top patient-facing success that your OHT would like to share?

Examples may include improvements or innovations in care delivery that are making a difference to patients.

Two examples of top patient-facing successes for the BE OHT include:

- BE OHT High Intensity Supports at Home Plus (HISH+) Program: The goal of the HISH+ program is to support patients/clients who require services beyond traditional home care to safely transition to their home, creating capacity in acute care and long-term care (LTC) by reducing alternative level of care (ALC) patients/clients and delaying transfer to LTC. The HISH+ program is being used as a proof of concept model to demonstrate how partners come together to provide seamless, more coordinated care to ensure that there are no cold handoffs between providers. To date, 24 patients from hospital and 16 patients/clients in the community received wraparound care at home from a variety of BE OHT partners including: respite care, community paramedicine services, social work, homemaking, geriatric clinical services, etc.
- COVID-19 Testing / Assessment Strategy: There were many areas within the BE OHT geography where vulnerable communities have been severely affected by COVID-19, lacking access to accurate information about COVID-19 and testing, and appropriate supports to isolate safely to stop the spread of COVID-19. Together, OHT partners supported Ontario Health (OH) Central's mandate for coordination of a local testing response to provide equitable access to testing across the hardest hit communities. As a result, the efforts increased the availability accurate information regarding COVID-19 and provided testing to 154,890 individuals, thereby reducing barriers to testing. Wraparound supports were provided to 3,482 patients/clients requiring a COVID-19 test through providing food security and linking to income security and self-isolation options where necessary.

Is there a top provider-oriented success that your OHT would like to share?

Examples may include improvements or innovations that are helping to better support or engage providers, including provider well-being.

The SCOPE line is considered the top provider-oriented success for the BE OHT. SCOPE is a shared virtual interprofessional care team for primary care providers (PCPs), most beneficial to those who are unaffiliated with a Family Health Team or hospital. SCOPE is a platform for PCPs to come together and foster a community of practice, by creating equity among providers through better connection to services for physicians. The first SCOPE program was launched in 2012 by Women's College Hospital and University Health Network with funding from the Toronto Central LHIN, led by Dr. Pauline Pariser.

The BE OHT SCOPE line launched as a pilot in October 2020 with 18 physicians. From October 2020 to March 2021, the model demonstrated a 94% primary care satisfaction rate and 50% emergency department (ED) diversion rate. Physicians' satisfaction with the service is reflected in the testimonial below from a community family physician:

"My experience with the SCOPE project has been a positive one. I have found it quite helpful for urgent cases using the radiology and mental health lines. Those are the two lines I utilized. I felt I had rapid access to advice with immediate short term plans to help manage urgent cases, as well as assistance with long-term goal planning. Having a live and warm voice to explain things to made things a lot better as a clinician as I felt it was easier to explain why I needed the urgent access. Even if patients could not be accommodated right away, resources were provided that I could make interim plans for my patients. I do hope that this project expands and continues to provide this essential access to primary care. This could be helpful in other areas as well, and perhaps we will see this collaborative approach evolve further given our pandemic care and telemedicine approaches."

In addition, qualitative data demonstrates that patients have benefitted immensely from their PCP's access to SCOPE. Patients are thankful to have their care dealt with in a comprehensive manner, and to have avoided lengthy ED visits, as demonstrated by the patient testimonial below:

"I was very grateful to be accommodated the same day for an urgent CT and be managed by my family physician rather than waiting in the ER for hours and having to repeat my story to multiple providers. Since my physician was able to use the SCOPE service, I was able to save time and my family doctor prescribed me the right treatment shortly after receiving my CT that day. I am very happy with the service received and felt well taken care of."

As of March 31, 2021, the SCOPE line has expanded to 48 physicians, using a phased approach to access to the line. The model will be expanded to more physicians in the coming months.

How have the members of your OHT shared resources in support of your OHT's joint work? Has your team seen any efficiencies through this alignment?

To date, the majority of resources for BE OHT activities have been provided through in-kind supports. Some examples of providing in-kind resources include:

- Providing staff to participate on working groups and to lead OHT projects.
- Redeploying staff to OHT partner organizations to support COVID-19 response efforts (e.g. clinical and administrative staff were deployed to testing and vaccination sites to support testing and

vaccination efforts). This has enabled these vital pandemic response efforts to operate efficiently by avoiding more costly staffing solutions.
- Providing funding to support a project or initiative, such as cost sharing to hire Santis Health to lead the retreat sessions mentioned previously.

In addition, facilitating and convening joint planning efforts for pandemic response efforts and other projects has led to efficiencies in planning, as more OHT partners are aware of the broader work being undertaken in the system, avoiding duplication of effort. The BE OHT intends to work towards developing a pool of resources that partners contribute to as a means to support OHT initiatives and maintain efficiency and strong coordination.

Where applicable, describe activities undertaken by members of your OHT to jointly respond to COVID-19 and any lessons learned.	
COVID Response	***Key Activities or Achievements*** *(indicate N/A or leave blank where not applicable)*
Supporting long-term care homes	• LTC Virtual Hotline • BE OHT MEST • Coordinated Incident Management response from acute care and home and community care to support high risk outbreak homes
Supporting other congregate care settings	• BE OHT MEST
Acquiring and distributing PPE	• Working with organizations to procure and distribute PPE to primary care providers and community agencies at discounted rates
Infection prevention and control	• Infection Protection and Control (IPAC) Hub
Implementation of virtual care supports	• LTC Virtual Hotline • Virtual Home Care Delivery • SCOPE
Testing	• BE OHT Community Testing, including the development of COVID, Cold and Flu Clinics • Informing High Priority Communities Strategy
Vaccination/Planning for vaccination	• BE OHT vaccination planning tables • BE OHT physician and FHT participation in the AstraZeneca pilot
Supporting vulnerable populations or communities disproportionately affected by COVID-19	• Informing High Priority Communities Strategy
Other	• HISH + (partnership with the Region of Peel, Ontario Health (Central), Home and Community Care Support Services Central West, William Osler Health System and 3 community support services providers: CANES Community Care, Peel Senior Link and Etobicoke Services for Seniors)

Reflecting on the above COVID related activities, please describe whether working together as an OHT has benefited or enabled these activities or alternately posed challenges.

Working as an OHT provided immense benefits to the COVID-19 response in the BE OHT catchment area. As COVID-19 hit, the newly established BE OHT Steering Committee (now named the OHT Collaboration Council) continued to meet on a bi-weekly basis with a focus on COVID-19 and how partners could work together to support the COVID-19 response. This evolved into a weekly meeting of the Collaboration Council continuing to focus on COVID-19 response and other OHT development projects.

Some lessons learned from working together as an OHT to support the COVID-19 response include:

- Importance of partnership
    - Developing relationships based on mutual respect and trust.
    - Negotiating collective contributions, benefits and strengths.
    - Respecting each other's scope, policy and values to find synergy.
    - Agreeing on shared outcomes, risks, responsibilities, and successes.
    - Involving reflective leaders who consider different perspectives and are willing to take risks.
- Community engagement
    - Listening to the community voice to better understand what the community needs.
    - For community testing, supporting the implementation of a model that is true to the unique context of each part of our OHT community.
    - Recognizing that a sense of urgency and joint sense of purpose can be a useful enabler for partnership when in a low rules / unclear environment, as experienced in the early stages of establishing community testing sites and community-based vaccination clinics.
    - Forging relationships to better serve smaller and underserved communities within the OHT geography (e.g. West Woodbridge and North Etobicoke) is critical to identifying local needs, although equity of resources can be challenging.
    - Working collaboratively with neighbouring OHTs is important for a coordinated response (e.g. OHT panel member at the Metamorphosis Network Forum in February 2020).
    - Created working relationships with the York and Toronto Public Health Units to address gaps in access to mobile and mass vaccination clinics in North Etobicoke and West Woodbridge.
- Support for care providers
    - The BE OHT developed resources (in the 10 top languages for the BE OHT catchment area, including English, Hindi, French, Italian, Portuguese, Punjabi, Chinese, Spanish, Tamil, Urdu) for primary care providers and community agencies to share with their patients/clients to inform them about how to navigate their care needs over the holidays given the many closures, virtual services, and testing/vaccination updates.

Section C: Key Activities and Achievements

Progress related to specific TPA outputs and milestones are reported in section 3; however, the achievement of these is dependent on advancements across key OHT model components (or building blocks) as described in the 2019 OHT Guidance Document and supported by eligible spending categories.

Please highlight any key activities and achievements related to the following model components, reflecting on the period from November 16, 2020 to March 31, 2021. Activities or achievements that occurred before this period may also be highlighted at the discretion of your OHT but should be noted as falling outside the standard reporting period.

Where no relevant activities took place during the reporting period because they were intentionally unplanned for the reporting period, please indicate N/A – Not Planned. Where activities were planned but did not take place due to COVID-19 capacity constraints, please indicate N/A – COVID.

Transforming Patient Care

Detail the activities that your OHT has undertaken to re-design care for your target population(s). Identify your OHT's key objectives for care redesign activities (e.g., improved access, transitions/coordination, communication and information sharing). Describe how/whether you have applied population health management approaches to inform care redesign. Highlight any notable achievements to date.
As noted in the section pertaining to the OHT's year 1 population, the current focus is on patients/clients with COVID-19 and patients of primary care providers participating in SCOPE. The BE OHT is also participating in the High Intensity Supports at Home Plus Program (HISH+), and is working to define a third priority population over the next month as a result of the OHT retreat that commenced in early 2021. Below is a summary of how care has been re-designed for primary care providers participating in SCOPE, patients/clients with COVID-19, and patients/clients participating in the HISH+ program: • COVID-19: Using data pertaining to prevalence rates for COVID-19 and access to testing, to best support the needs of the BE OHT population, the OHT supported the implementation of Ontario Health (OH) Central's equitable approach to testing and vaccination. Data about prevalence rates ('hot spots') was compared to proximity of testing locations, which helped BE OHT partners understand where greater access to testing is needed. For example, Queen Square Family Health Team (FHT) was willing to operate a testing site at their Main St. location in Brampton. However, since there was a gap in testing availability in the Snelgrove area of Brampton (which had a high prevalence rate), the team at Queen Square FHT worked with the OH Central and the community to open a COVID, Cold and Flu Clinic at Snelgrove Community Centre to improve access to testing/assessments for the Snelgrove community. A similar program was developed by Wellfort Community Health Services to address the gap in access to testing and assessments in the Malton community. In addition, recognizing that many of the vulnerable populations in our OHT are disproportionately affected by COVID-19, OHT partners (such as Rexdale Community Health Centre, CMHA Peel Dufferin and Wellfort Community Health Services) were instrumental in implementing the High Priority Community Neighbourhood initiative, working together to provide comprehensive care and resources for vulnerable populations in the OHT with COVID-19 (e.g. access to food/groceries for those self isolating, case management, etc.). OHT partnerships were leveraged in an innovative way to support COVID-19 efforts, such as through leveraging an academic partnership to support a clinical service. William Osler Health System worked with Humber College and the University of Guelph-Humber (UofGH) to expand

access to the COVID-19 vaccine in North Etobicoke catchment area, an area which continues to experience some of the highest incidence of COVID-19. As part of this partnership, Osler will provide oversight of the Vaccine Clinic, and offer practical experience for Humber and UofGH students as vaccinators and supporting administrative/coordination roles.

- SCOPE: Although SCOPE is a provider-facing model, this model has helped improve care for patients with urgent care needs, by providing access to comprehensive care and avoiding emergency room visits where possible.

- BE OHT HISH+ Program: The HISH+ program is being used as a proof of concept model to demonstrate how partners can come together to provide seamless, more coordinated care to ensure that there are no cold handoffs between providers. The program is meant to provide "long-term care at home" to increase capacity in long-term care homes and acute care. Partners involved in the project (Region of Peel, William Osler Health System, Home and Community Care Support Services Central West, Etobicoke Services for Seniors, CANES Community Care, Peel Senior Link and Richview Community Health Services) supported the development of a dedicated service pathway for each OHT partner in the HISH+ program, and worked to ensure all participating partners had access to the same system (Coordinated Care Plan (CCP) in Health Partner Gateway) to support information sharing across all partners in the circle of care. The team developed a project agreement to ensure all parties were aware of their responsibilities and created huddles to ensure constant communication across partners.

Patient, Family, and Caregiver Partnership and Community Engagement

Highlight any notable activities or achievements related to the inclusion of patients, families, and caregivers as partners in OHT work.

If your OHT has also identified measures of success or approaches to track progress in this area, please describe them here.

Over the past year, the BE OHT has made significant progress in authentically engaging patients/clients, families and caregivers as partners in the OHT. Some notable activities/achievements include:

- Development of a strategy to engage patients/clients as partners in the OHT (prior to November 2020)
    - Two dedicated patient partners who have been involved in the OHT since inception, and the administrative lead for patient engagement worked together to create a patient engagement strategy, including plans to establish a BE OHT Patient Family Advisory Council (PFAC).
- Created the BE OHT PFAC (prior to November 2020)
    - Put out a call to all OHT partners to invite their patient partners to join the BE OHT PFAC.
    - Recruited 12 patient partners to sit on the BE OHT PFAC.
- On boarded patient partners to the BE OHT PFAC
    - Vulnerable sector check completed and confidentiality agreement signed by all PFAC members.
    - Recruited patient partners to participate in the following OHT initiatives to contribute to decision making and develop direction:
        - OHT Collaboration Council
        - Digital Working Group
        - Equity, Diversity, and Inclusion Action Committee (EDIAC) [e.g. patient partner provided insight about black-led organizations for the committee to involve in further planning]

        - Community Testing [e.g. patient partner advised on patient experience related to accessing booking for COVID-19 tests]
        - Vaccine Working Group [e.g. patient partner advocated for greater involvement in York Region vaccine planning]
- Initiate OHT work plan development and initiation
    - Initiated the development of the BE OHT work plan related to patient, family and caregiver engagement.
    - Patient partners participated in education/OHT engagement opportunities, including the San-yas Indigenous Cultural Safety Training and the OHT Ministry Symposium in February 2020.
    - BE OHT PFAC budget for 2020-2021 and 2021-2022 developed and approved.
    - PFAC sub-group has commenced development of PFAC Declaration of Values for review/discussion by members prior to submission to Collaboration Council.

Highlight any notable activities or achievements related to engagement with local communities to inform planning and build awareness of OHT work.

If your OHT has also identified measures of success or approaches to track progress in this area, please describe them here.

Through the OHT COVID-19 testing and vaccination efforts, the BE OHT brought awareness to the work of the OHT among community organizations that were not previously engaged in OHT. With such, the BE OHT has made notable efforts to work with the community in the following ways:

- Engagement to Inform Planning
    - The OHT identified the importance of diversity as an overarching value, which led to the development of the Equity, Diversity and Inclusion Action Committee (EDIAC). EDIAC is working with black-led organizations to bring awareness about the work of the OHT and address anti-black racism.
    - The OHT engaged Punjabi Community Health Services (PCHS) and Indus Community Health Services in community testing efforts to ensure that the communities they serve are supported by COVID-19 efforts.
    - Rexdale Community Health Centre worked with Health Commons Solutions Lab to implement strategies to support the North Etobicoke catchment area with access to testing.
- Foster Awareness of the BE OHT
    - The Community Medical Advisory Council (CMAC) has engaged with community physicians and increased engagement in the OHT.
        - The primary care newsletter provides up to date information on COVID-19, policy changes and impact to physicians and their patients, which currently has 189 subscribers. The “open rate” of a newsletter is an indicator of engagement, and the primary care newsletter has an open rate that is above industry benchmarks. Open rates for the last five newsletters range from 44% - 58%.
    - The BE OHT has increased awareness among the community through presentations, including the most recent presentation to the Metamorphosis Network (Community Support and Community Mental Health providers in the Central region) serving on an OHT panel for neighbouring OHTs, and the Integrated Care Summit presentation about lessons learned through COVID-19.

Highlight any notable activities or achievements related to addressing the needs of underserved populations (including but not limited to engagement with Indigenous and Francophone populations).

If your OHT has also identified measures of success or approaches to track progress in this area, please describe them here.

The BE OHT has a strong focus on providing equity across the population, which has led to the following notable activities/achievements:

- For the community testing strategy, the BE OHT supported Ontario Health (OH) Central's efforts to collaborate with partners to reach vulnerable communities and used an equity approach, by identifying communities with barriers to accessing services, lower socioeconomic status of clients and high prevalence rates, to determine the areas in the BE OHT catchment area with the highest needs. Once the communities were identified, extensive work was initiated to understand the needs and how to best support the community. For example, mobile pop-up testing services were implemented in North Etobicoke/Rexdale as a result of extensive community engagement, as many community patients/clients were unable to access static testing sites.
- OHT partners participated in Indigenous Cultural Safety Training to better understand how to provide culturally safe care to indigenous people in the OHT.
- The BE OHT created the EDIAC, with the mandate to develop and entrench the commitment to equity across all partner organizations and guide the OHT's work through an equity framework.
- The BE OHT Co-Chairs and secretariat staff serve on and support Peel Public Health planning and implementation for Mass Immunization and Vaccinations and the Region of Peel Community Equity and Engagement Advisory Table.

Leadership and Collaborative Decision-Making

Highlight any notable activities or achievements related to building a culture of trust, shared accountability, and unified direction across OHT members and OHT leadership.

If your OHT has also identified measures of success or approaches to track progress in this area, please describe them here.

Since the inception of the BE OHT, partners have worked together to foster strong relationships and build a culture of trust, as a result of underlying power dynamics that have traditionally hindered relationships between OHT partners. Building a culture of trust, shared accountability and unified direction is ongoing. To date, the BE OHT has made significant progress, including the following:

- The BE OHT engaged Santis Health to facilitate a retreat to improve trust among OHT leaders and set priorities for the next year, and will engage the broader OHT partnership to finalize vision/values and define the priority population(s).
- The OHT Collaboration Council developed a Resource Allocation Framework and used the framework to achieve consensus on how OHT funds would be allocated, with the purpose of providing clarity, transparency and fairness in resource allocation decision making processes.
- After surveying partners about how to best maintain engagement in the OHT, partners expressed the need for open, constant communication about the work of the OHT and as a result, the BE OHT is prioritizing the development of a comprehensive communications strategy for the purpose of partner engagement.
- The BE OHT is learning about engagement strategies from other OHTs to engage partners, including those who are not formal OHT partners at this time, such as home care service provider organizations (SPOs) and private vendors.

Highlight any notable activities or achievements related to primary care and clinical engagement and involvement, including the inclusion of clinical leaders in OHT work.

If your OHT has identified measures of success or approaches to track progress in this area, please describe them here.

In the BE OHT catchment area, there are approximately 500 physicians, many of which are Solo Fee for Service (Solo FFS) physicians and physicians from non-team based models that have historically had limited engagement and connection to their colleagues and the hospital. Through the leadership of the BE OHT Community Medical Advisory Council (CMAC), the BE OHT has worked tirelessly to engage physicians in the community. Some notable activities/achievements include:

- Physician engagement milestones prior to current reporting period:
  - Creation of the BE OHT CMAC.
  - Engaged 94 community physicians to sign the OHT CDMA.
  - Recruited a primary care lead for the SCOPE program who is a community family physician from a Solo FFS model.
  - Recruited 3 community physicians to sit on the OHT Collaboration Council from various practice types (FHT, FHO and Solo FFS), and elected 1 of the physicians as the co-chair of the Collaboration Council.
  - Developed the OHT primary care newsletter, which currently has 189 subscribers and open rates (a measure of engagement in readership) for the last five newsletters ranging from 44% - 58%.
- Physician Engagement milestones within the current reporting period
  - BE OHT CMAC, in partnership with the Region of Peel and neighbouring OHTs, recruited over 700 physicians in Peel to be vaccinators.
  - Mobilized BE OHT physicians to participate in the AstraZeneca pilot and vaccinated a total number of 3,014 patients in Brampton/Malton.

Digital Health and Information Sharing

Highlight any notable activities or achievements related to the advancement of digital health/virtual care or advancing information sharing across the members of the OHT. Examples could include expanding access to patient-facing digital health solutions (e.g., virtual care, online appointment booking), supporting initiatives that enable access to integrated patient health information in a privacy protected manner, or other solutions which have supported integrated team-based care.

Where activities relate to projects funded by the ministry or Ontario Health (e.g., virtual urgent care, surgical transitions), please simply list the project. Further details will be provided through the relevant TPA reporting mechanism.

Notable Achievements Prior to November 2020:

- Phase 1 of an OHT Data Repository pilot was completed. This pilot was developed in house to support tracking of patients/clients individually and in aggregate across OHT providers. The pilot connected one Family Health Team (FHT) and one acute organization. The pilot demonstrated that the team could realize benefits of linking and tracking patient visits across organizations, and that this information could be used for improved care coordination.
  - Home & Community Care organization patient/client tracking will be explored as a next phase of the OHT Data Repository Pilot.
- Call routing setup completed for the SCOPE line.

Notable Achievements During Reporting Period:

- Virtual Surgical Transitions launched December 29th, 2020. Using Seamless MD application, patients can now be aided in managing their pre and post op (preparation and recovery) needs remotely. Expanding support to alert primary care providers of their patients when follow-up is needed is the pending next step for this work.
- Virtual Urgent Care launched February 24th, 2021. In combination with in house developed online tools and the Savience clarity dashboard, patients can now book online appointments and receive virtual visits 7 days per week. Support for patient assisted registration for these virtual appointments will be launched shortly as a next step.
- Expanded use of Patient Portal solutions via increased utilization of MyChart and SeamlessMD are also in progress.
- More partners implemented virtual care for their patients/clients as a means to maintain care delivery during COVID-19.
- Microsoft Teams platform was set up for the BE OHT Collaboration Council to facilitate collaboration.

Activities funded by the ministry or Ontario Health

1. Virtual Surgical Transition
2. Virtual Urgent Care

Achieving the Quadruple Aim: Performance Measurement, Quality Improvement & Continuous Learning

Highlight any notable activities or achievements related to the collection, sharing or use of data to inform your OHT's work, including performance measurement and quality improvement activities.

Data has been used in various capacities, particularly with supporting COVID-19 efforts and development of the SCOPE model, to inform the work of the BE OHT. Some examples of notable activities/achievements include:

- COVID-19 Testing: Under the leadership of Ontario Health (OH) Central, Public Health Unit (PHU) prevalence data was used to inform the development of community testing sites, as a way to best support the needs of the populations hit hardest by COVID-19.
- COVID-19 Vaccination Planning: In addition to using PHU COVID-19 prevalence data to support COVID-19 testing site locations, prevalence data is being used to help support vaccine clinic planning. Areas with high COVID-19 prevalence rates and the proximity of current vaccine clinic locations are being examined as a way to determine where additional clinic locations would benefit the community (e.g. North Etobicoke). When select primary care providers in Peel participated in the AstraZeneca pilot, the primary care providers chosen to host the pilot included those located in "hotspot" areas, such as Malton (Four Corners Health Centre).
- SCOPE Model: When the SCOPE model was first designed, primary care providers in the community were consulted about what types of services they would most benefit from to support urgent patient needs, which led to the inclusion of mental health as a component of the SCOPE line, along with internal medicine, home and community care, diagnostic imaging and acute care navigation. In addition, the SCOPE project team tracks monthly calls to better understand the types of services being used. When the team was ready to expand the SCOPE model, the location of BE OHT physicians helped support targeted onboarding to those physicians in areas that were underrepresented, such as North Etobicoke, Malton and West Woodbridge.

The BE OHT plans to expand the use of data over time, through the development of a Central Data Repository that partners will be able to feed data into. A proof of concept central data repository was developed prior to November 2020 using Queen Square FHT and Osler data, and the plan is to continue to test the repository using Service Provider Organization (SPO) data.

Section D: Status on Outputs and Milestones

Status of TPA Outputs

Schedule “C” of the Transfer Payment Agreement outlines “Outputs” that the Approved OHT is responsible for producing by a specified date. Identify the current status for each of required Outputs. Where status is Yellow or Red please indicate associated risks in Section E - Risk Register. Any activities that teams have undertaken toward the development of these outputs may be considered when assessing status (regardless of whether Ministry-issued guidance has been released).

Output	Due Date	Status Green – progressing well Yellow – some challenges Red – at risk N/A – not applicable/not yet started	Risk(s)/Barriers to Producing Output by Due Date (if applicable
Patient, Family and Caregiver Partnership and Engagement Strategy	September 30, 2021	**Green**	Please indicate associated risks in Section E
Primary Care Communication Protocol	September 30, 2021	**Green**	
Harmonized Information Management Plan	September 30, 2021	**Green**	
Patient Declaration of Values	Sept. 30, 2021	*N/A*	
OHT Expansion Plan	Mar. 31, 2022	*N/A*	
A Collaborative Quality Improvement Plan (cQIP)	Mar. 31, 2022	*N/A*	

Progress To-Date on TPA Milestones

Schedule “C” of the Transfer Payment Agreement outlines “Milestones” that the OHT is expected to have achieved progress on by March 31, 2022. Appreciating that the advancement of these Milestones will take time, categorize progress to-date for each as “green”, “yellow”, or “red”. For Milestones with “green” progress, identify key achievements. Where status is Yellow or Red please indicate associated risks in Section E - Risk Register.

TPA Milestone	Progress To-Date Green – progressing well Yellow – some challenges Red – at risk N/A – not applicable/not yet started	Upcoming Milestones & Associated Timelines Identify the next major project milestones associated with each TPA milestone and projected timing for completion.
Care has been re-designed for patients in the OHT's priority population(s)	**Yellow**	*Redefine priority population – April 2021*
Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	**Yellow**	*Redefine priority population – April 2021*
Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	**Yellow**	*Redefine priority population – April 2021*
The majority of patients in the OHT's priority population(s) who receive a self-management plan understand the plan, and the majority who receive access to health literacy supports use those supports.	**Yellow**	*Redefine priority population – April 2021*
More patients in the OHT's priority population(s) are • accessing care virtually • accessing their health information digitally • booking appointments online	**Yellow**	*Redefine priority population – April 2021* ** Note: For the COVID-19 population, more patients/clients have access to online/telephone appointment booking and digital health information for COVID-19 results. Due to COVID-19, many BE OHT partners have increased virtual care offerings as a way to safely provide care throughout the pandemic.*

More providers in the OHT are accessing provincially funded digital health solutions (e.g., provincial clinical viewers, Health Report Manager, eServices). *Note: Although not a listed milestone, the commitment to adopt core provincial digital health services is a pre-condition of using implementation funding on digital health, information management, and virtual care implementation activities) per page 23 of the TPA.*	**Green**	*HRM adoption is greater than 80% among BEOHT Primary Care Providers (likely the highest adoption numbers among all OHTs). However, utilization could be further promoted and adapted and the team could further work with providers to obtain feedback on improvements that can be communicated back to Ontario Health.* *As a next step, more active guidance and support will be given to BEOHT member organizations to adopt provincially funded digital health solutions throughout the FY 21/22. The effort will include support for signing up for services and also training and support. A dedicated resource(s) to support this will be available to all BEOHT members interested in increasing utilization of these tools as well as other informatics deemed beneficial in enhancing overall ('digital health tools') utilization and efficiencies for better care collaboration among our OHT.* *Tools to be supported:* • *HRM* • *ConnectingOntario* • *DI-r* • *Olis* • *And other products identified in the playbook*
Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.	**Yellow**	*Work with the CMAC to complete a second call out to community physicians to engage in the OHT – Summer 2021*
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	**Green**	*Develop website – May 2021*
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	N/A	*Redefine priority population – April 2021*
The OHT's performance has improved on measures of access, transition, coordination of care, and integration.	N/A	*Redefine priority population – April 2021*

Section E: Risk Register

Categorize and describe any current risks or challenges to achieving outputs or milestones. General risks to the OHT's implementation plans should also be identified. Describe any mitigation strategies put in place to address the identified risks.

Risk Category	Description of Risk	Mitigation

Partnership Risks – Other (Leadership)	Although the OHT has focused on clients/patients with COVID-19 as a priority population this year, the OHT aims to define an additional priority population using the guidance from the Ministry's Central Program of Supports released recently. Achieving the following milestones will require additional time to properly segment the population and scope the model of care interventions:
	• *Care has been re-designed for patients in the OHT's priority population(s).*
	• *Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs.'*
	• *Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.*
	• *The majority of patients in the OHT's priority population(s) who receive a self-management plan understand the plan, and the majority who receive access to health literacy supports use those supports.*
	• *More patients in the OHT's priority population(s) are:*
	  ○ *accessing care virtually;*
	  ○ *accessing their health information digitally booking appointments online.*
		▪ Continue to work with external facilitator (Santis Health) and RISE Coach to define the third priority population with BE OHT partners.
		▪ Dedicate new secretariat resources/physician leadership to supporting the priority population planning once the population is defined.

Partnership Risk – Other [Engagement]	Achieving the milestone, "*Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT"* as physicians are still	▪ Work with the OMA to address hesitancy about partnering with the OHT.

	expressing hesitancy about joining the OHT.	▪ Work with the OMA/Ministry to acquire a list of all physicians attributed to the BE OHT. ▪ Explore a physician engagement lead role as an extension of the CMAC.
Resource Risk – Human Resource	Resourcing and expertise to develop the Collaborative QIP.	▪ Work with partners to acquire a resource to support the development of the Collaborative QIP.
Partnership Risks - Other	Ability to maintain relationship with Service Provider Organizations (SPOs)/private vendors despite formal OHT partnership at this time.	▪ Work with SPOs to understand how to best maintain engagement. ▪ Work with other OHTs and/or the Ministry to receive guidance on how to proceed with partnership.
Resource Risks - Financial	Ability of ongoing funding for physician engagement, patient engagement and backbone support.	▪ Work with the Ministry to advocate for ongoing funding and address regional underfunding inequities. ▪ Work with partners to pool funding where possible.
Compliance Risks - Legislative	Extent of privacy requirements to facilitate information sharing across partners.	▪ Work with the Ministry to understand the best solution to implement DSAs across OHT partner organizations and physicians. ▪ Acquire resources to support to review privacy needs and develop DSAs.
Patient Care Risks- Other	Ability to provide equity in care across all aspects of the BE OHT catchment area.	▪ Create partnerships with additional organizations/providers in the different geographies to support equity in care for the various communities.

Risk Categories

Patient Care Risks • Scope of practice/professional regulation • Quality/patient safety • Other	**Resource Risks** • Human resources • Financial • Information & technology • Other
Compliance Risks • Legislative (including privacy) • Regulatory • Other	**Partnership Risks** • Governance • Community support • Patient engagement • Other

Section F: Planned Activities for Next Fiscal Quarter

Please provide a brief description of your team's top priorities for the next quarter (Q1 2021-2022) and list key planned activities.
Priorities for the BE OHT for the next quarter include: ▪ Planning and Design: ○ Finalize BE OHT priority population(s), and OHT vision/values in collaboration with RISE Coach and BE OHT partners. ○ Hire additional OHT backbone support. ○ Develop process to review and update CDMA. ▪ Engagement: ○ Develop OHT website. ○ Develop a Service Provider Organization (SPO)/private vendor engagement plan. ○ Recruit more BE OHT physicians. ▪ Care Delivery: ○ Evaluate HISH+ Program. ▪ COVID-19 Response: ○ Support vaccination efforts as required. ▪ Work Towards Completing TPA Milestones: ○ Complete MOH quarterly report. ○ Develop patient engagement framework. ○ Create harmonized information management plan. ○ Implement communications protocols to connect PCPs with the OHT.

PART TWO: TPA PERFORMANCE INDICATOR REPORTING

Please complete and attach the 'TPA Performance Indicator Reporting' template to your submission.

PART THREE: FINANCIAL EXPENDITURE STATEMENT

Please complete and attach the 'Financial Expenditure Statement' template to your submission.