Central West
ONTARIO HEALTH TEAM

OHT COHORT 1: 2021-22 Quarterly Report

Ontario Health Team (OHT) Name:	Brampton Etobicoke Ontario Health Team (BE OHT)
Key OHT Contact for Report: *Please indicate a contact for any questions pertaining to this report*	Saleem Chattergoon
Transfer Payment Recipient Name:	William Osler Health System
Reporting Period: ☑Q1 ☐Q2 ☐Q3 ☐Q4	April 1, 2021 to June 30, 2021
Due Date: *Once complete, please submit your templates to your Ministry of Health (ministry) point of contact*	August 31, 2021 (extended from July 30, 2021)

This Report consists of three parts:

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

PART ONE: NARRATIVE AND STATUS UPDATE

The Narrative and Status Update collects information about your OHT's progress against transfer payment agreement (TPA) outputs and milestones, as well as the overall advancement of the OHT model. There are no word limits to this part of the Report, but brevity is encouraged. Please submit this part of the Report as a Microsoft Word document. Please do not submit in PDF format.

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, achievements, activities, risks, and/or mitigation approaches.

Section A – Showcasing Successes To Date

What accomplishment is your OHT most proud of for this reporting period?
For this reporting period, the accomplishment the BE OHT is most proud of is re-defining the priority population to focus on for the next year. After pausing initial OHT priority population (complex patients with diabetes) work due to COVID-19, the BE OHT Collaboration Council (CC) took the opportunity to re-evaluate priorities for the community in Fall 2020. At that time, the CC made the decision to engage Santis Health to facilitate a three-part retreat series. Santis Health engaged the entire OHT partnership, including the PFAC, CMAC, and EDIAC committee members, focusing on improving trust and collaboration, defining a BE OHT mission, vision and values, and establishing priorities for the next year. These priorities included an emphasis on patient/family, primary care and equity committee engagement. As a result of the retreat, the CC was able to achieve consensus on the new priority population: elders experiencing frailty. The BE OHT chose this based on the learning from COVID-19 and the vulnerable populations within our catchment area. This accomplishment demonstrates dedication and collaboration among the CC.

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

We have been able to continue to support patients/clients in the High Intensity Supports at Home (HISH) + Program, after the expiration of Ministry of Health funding, thanks to the participating partners' commitment to bridge support until we achieve a sustainable infrastructure. 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 BE OHT is using the HISH+ program 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. Since the program launch, a total of 20 patients/clients within the community received wraparound care at home from a variety of BE OHT partners including: respite care, community paramedicine services, social work, personal support services, homemaking, geriatric clinical services, etc. This success is helping to shape how we can expand this program to others in our priority population.

This work was seen as valuable by our partners, as the program has led to reduced pressures on our acute care system that was overwhelmed by COVID-19, by freeing up ALC beds to support patients with COVID-19. Due to the commitment of our OHT partners, 9 patients/clients and their caregivers can continue to benefit from the program. Recently, HISH+ received great interest by Association of Municipalities Ontario (AMO) and Ontario Community Support Association (OCSA) as it demonstrates how various sectors like the Community Support Sector (CSS), Home & Community Care, Municipalities, Acute Care, and others can come together to provide comprehensive integrated care for a population.

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

The SCOPE (Seamless Care Optimizing the Patient Experience) line continues to be 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 creates equity among providers through better connection to services for PCPs. Services include internal medicine, mental health, medical imaging, a nurse navigator and home and community care. The Women's College Hospital and University Health Network first launched SCOPE in 2012 with funding from the Toronto Central LHIN, led by Dr. Pauline Pariser.

Our SCOPE line launched as a pilot in October 2020 with 18 PCPs. From October 2020 to March 2021, the model demonstrated a 94 per cent primary care satisfaction rate and 50 per cent emergency department (ED) diversion rate. As of March 31, 2021, the SCOPE line expanded to 48 PCPs, using a phased approach to access to the line. Lastly, for this reporting period, 17 additional PCPs (66 total) have joined SCOPE with the total number of calls reaching 296. Primary care satisfaction remained 94 per cent and our ED diversion rate rose to 60 per cent.

Where applicable, describe any activities or planning your OHT has begun in relation to COVID-19 recovery.
The BE OHT has begun to explore how to best support COVID-19 recovery. BE OHT partners had preliminary conversations about how to use key learnings from programs implemented during COVID-19, such as COVID@HOME (e.g., centralized remote monitoring program), and virtual services. The purpose of these conversations is to determine how to transfer patient care into the community, where possible, so the acute care system can focus resources to support acute-care centred backlog (e.g., surgeries).

Section B: Key Activities and Achievements

Progress related to specific TPA outputs and milestones are reported in section C; however, achieving 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.

Whereas the Cohort 1 Year End Report 2020-2021 focused on notable highlights, the Cohort 1 quarterly reports (Q1-3) draw focus to specific objectives, activities, and results achieved by teams for each reporting period in alignment with the OHT building blocks and eligible TPA spending categories.

In situations where there were no relevant activities that took place during the reporting period because none were planned, please indicate this using N/A – Not Planned. Where activities were planned but did not take place due to COVID-19 capacity constraints, please indicate this using N/A – COVID-19.

Transforming Patient Care

Detail activities that your OHT has undertaken to re-design care for your target population(s), including the application of population health management approaches.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Implement and evaluate integrated care model for our priority population.	Developed a process to implement and evaluate an integrated care model for the BE OHT priority population.	Consensus achieved on priority population across entire BE OHT partnership (elders experiencing frailty). Process has been developed and will be brought to the BE OHT Collaboration Council for approval.

Patient, Family, and Caregiver Partnership and Community Engagement

Detail activities related to the inclusion of patients, families and caregivers as partners in OHT work. Where applicable, please include details about the work undertaken with your patient, family and caregiver partners.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Develop a Patient Engagement Framework.	Developed of a Patient Engagement Framework for the BE OHT.	The BE OHT Patient Family Advisory Council (PFAC) created the BE OHT Patient/Client and Family/Caregiver Engagement Model & Framework, which was endorsed by the BE OHT Collaboration Council.

Finalize BE OHT mission/vision/values.	Conducted engagement sessions with BE OHT partners, PFAC, Equity, Diversity and Inclusion Action Committee (EDIAC), and Community Medical Advisory Council (CMAC). and the CC to revise and finalize the BE OHT mission, vision, and values.	Initial engagement session with the BE OHT partners has been completed and the drafts have been revised. Engagement sessions will be held in early July with PFAC, EDIAC and CMAC before going to the CC for final approval on July 23rd, 2021.

Detail activities related to engagement with local communities to inform planning and build awareness of OHT work.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Implement and evaluate integrated care model for our priority population.	Developed a process to implement and evaluate an integrated care model for the BE OHT priority population.	Consensus achieved on priority population across entire BE OHT partnership (elders experiencing frailty). Process has been developed and will be brought to the BE OHT Collaboration Council for approval.
Better understand the BE OHT population from an equity perspective.	Explored asset mapping with Health Commons Solutions Lab to inform the priority population work. Used sociodemographic data to help understand the needs of the priority population from an equity perspective.	Initial conversation held with Health Commons Solutions Lab. Once the priority population is defined further, a follow up conversation will be held to initiate asset mapping work. Initial sociodemographic data sources have been identified.

Detail activities related to addressing the needs of underserved populations and/or populations that face barriers to accessing services (including but not limited to engagement with First Nations, Inuit and Métis, racialized or marginalized communities, and Francophone populations).		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Embed equity into all aspects of the BE OHT work.	Created of the Equity, Diversity and Inclusion Action Committee (EDIAC).	EDIAC was created in early 2020 and has been mandated by the BE OHT

		Collaboration Council to create an Equity Framework for the BE OHT. The BE OHT was invited to present its journey towards equity at the upcoming RISE OHT Collaborative on July 15, 2021.
Better understand the BE OHT population from an equity perspective.	Explored asset mapping with Health Commons Solutions Lab to inform the priority population work. Used sociodemographic data to help understand the needs of the priority population from an equity perspective.	Initial conversation held with Health Commons Solutions Lab. Once the priority population is defined further, a follow up conversation will be held to initiate asset mapping work. Initial sociodemographic data sources have been identified.

Leadership and Collaborative Decision-Making

Detail activities related to building a culture of trust, shared accountability, and unified direction across OHT members and OHT leadership.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Build a culture of trust among BE OHT partners.	Held retreat sessions facilitated by Santis Health with BE OHT partners to identify and address real and perceived issues of trust, and strategies for overcoming these challenges.	Santis Health provided a report with recommendations on how to move forward after the BE OHT retreat sessions. The Collaboration Council conducted a preliminary review of the report and tasked a sub-group to conduct a thorough analysis and bring back key recommendations on how to continue to build trust among BE OHT partners.
Improve BE OHT partner engagement.	Developed a process to engage with non- BE OHT partner organizations that have collaborated with the BE OHT, including Service Provider Organizations (SPOs) and private vendors.	The CC approved the development of a SPO Engagement Sub-Group, with plans to launch in Fall 2021. Resources have been acquired to support the development of a BE OHT

	Developed a BE OHT communications plan.	comprehensive communications plan to support partner engagement.

Detail activities related to primary care, clinical or specialist engagement and involvement, including the inclusion of clinical leaders in OHT work.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Improve primary care provider engagement.	Created and maintained a bi-weekly primary care provider newsletter. Increased total subscribers from organic shares.	The open rate for the newsletter (average) is 49.6% opens. 211 total subscribers

Digital Health and Information Sharing

Detail activities 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.		
Objectives	**Activities**	**Results Achieved** *(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)*
Explore how to connect the BE OHT-endorsed surgical transitions program for hip and knee, and remote care monitoring to primary care providers.	Attended Community Medical Advisory Committee (CMAC) meeting on March 31st, 2021, for input on non-urgent-follow-up, and it was concluded primary care providers already receive most reports from physician dictations.	This deliverable was cancelled, as primary care providers are concerned with liabilities. Evaluation of information provided to primary care providers via Health Report Manager (HRM) concluded available information from physician dictations would be sufficient.
Convert the BE OHT-endorsed surgical transitions for hip and knee, and remote care monitoring to operations.	Closure completed on May 31st, 2021, as documentation was sent to ministry including lessons learned, sustainability reports and patient provider experience survey.	Enabled expansion of hip & knee pathways for surgical transitions via SeamlessMD. Added remote monitoring for orthopedic patients with an escalation pathway.
Transition the BE OHT endorsed- Virtual Urgent Care (VUC) to operations.	Closure completed on April 30th, 2021, as documentation sent off to ministry including lessons learned, sustainability reports and surveys.	Patients able to complete virtual booking for VUC assessments. Public Go Live – Feb 24, 2021 LTC Go Live – Mar 31, 2021 (Community Partner Intake form went live Mar 31, 2021)

Assessment for HISH+ information sharing.	Sub-committee was formed on June 11th, 2021 to complete needs assessment, refine objectives and build draft charter.	Project deliverables are currently being refined. Needs assessment in progress (to ensure benefits to all stakeholders). Output to be a charter describing deliverables for the next phase.

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

Detail activities related to performance measurement and quality improvement, including the collection, sharing, or use of data to inform your OHT's work.		
Objectives	**Activities**	**Results Achieved** ***(e.g., outputs, outcomes, challenges that were overcome, risks that were mitigated)***
Evaluate High Intensity Supports Home + Program (HISH+) to use key insights to inform future planning.	Created a sub-group to develop evaluation framework for HISH+ using the Quadruple Aim.	Collaboration Council has approved the overall evaluation approach and planning has commenced.
Report on Ministry of Health OHT indicators.	Using the Ministry of Health end of year report, created a process for how to report on Ministry of Health indicators.	The BE OHT Performance Indicator Working Group developed a process and completed the End of Year report. This process will be used for future reporting, including the Q1 report.

Section C: Status on Outputs and Milestones

Status of TPA Outputs

Schedule "C" of the TPA outlines "Outputs" that the Approved OHT is responsible for producing by a specified date. In the chart below, please identify the current status for each of these required Outputs. Where status is Yellow or Red please indicate associated risks in Section D - 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 - completed	Please indicate associated risks in Section D
Primary Care Communication Protocol	September 30, 2021	Green	
Harmonized Information Management Plan	September 30, 2021	Green	
Patient Declaration of Values	September 30, 2021	Green	
OHT Expansion Plan	March 31, 2022	Green	
A Collaborative Quality Improvement Plan (cQIP)	March 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 progressed by the end of the funding agreement period. Appreciating that the advancement of these Milestones will take time, please 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/clients in the OHT's priority population(s)	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22)
Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22)
Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22)
The majority of patients/clients 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.	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty).

		Create a steering committee/working group to lead the priority population work. (Q2 2021-22)
More patients/clients in the OHT's priority population(s) are • accessing care virtually • accessing their health information digitally booking appointments online	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22). Work with Digital Steering Team to identify and use provincial assets to support our priority population.
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.*	N/A	HRM adoption remains the same as previously reported in the End of Year report - greater than 80% among BE OHT Primary Care Providers (likely the highest adoption numbers among all OHTs). In the previous report, it was reported that the plan is for the team will continue to provide more active guidance and support will be given to BE OHT 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. Dedicated resource(s) to support this will be available to all BE OHT 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 reviewed: • HRM • ConnectingOntario

		• DI-r • Olis • And other products identified in the playbook The plan is to commence this work after the Harmonized Information Management Plan is finalized and privacy and security work is launched.
Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.	Yellow	Launch communications and marketing strategy to further support physician sign on to the OHT. (Q2 2021-22)
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	Green	Launch BE OHT website with refreshed branding as a result of partner engagement sessions. (Q2 2021-22)
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22)
The OHT's performance has improved on measures of access, transition, coordination of care, and integration.	Green	Receive approval by the BE OHT Collaboration Council on the process to implement and evaluate an integrated care model for our priority population (elders experiencing frailty). Create a steering committee/working group to lead the priority population work. (Q2 2021-22)

Section D: 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 (please indicate any risks added or removed since last reporting period)	Mitigation
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 expressing hesitancy about joining the OHT.	• Work with the OMA to address hesitancy about partnering with the OHT. • Work with the OMA/Ministry to acquire a list of all physicians attributed to the BE OHT. • Created a physician engagement lead role as an extension of the CMAC. • Use physician peer network to recruit physicians to the BE OHT. • Use the SCOPE program as a way to recruit physicians to the BE OHT.
Resource Risk – Human Resource	Resourcing and expertise to develop the Collaborative Quality Improvement Plan (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 lack of formal OHT partnership at this time.	• Launch the BE OHT SPO Engagement Sub-Group to improve engagement. • Utilize the findings from the BE OHT Retreat facilitated by Santis to facilitate better communication with SPO/private vendor partners. • 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. Ability to continue offering services that received one-time funding (e.g. Mobile Enhancement Support Team, High Intensity Support at Home + Program).	• 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 Data Sharing Agreements (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 E: Planned Activities for Next Fiscal Quarter

Please provide a brief description of your team's top priorities for the next quarter and list key planned activities.

Priorities for the BE OHT for the next quarter include:
• Planning and Design
  ○ Implement BE OHT priority population approach to develop and evaluated an integrated care model.
  ○ Finalize OHT mission, vision and values in collaboration with BE OHT partners.
• Engagement:
  ○ Launch OHT website
  ○ Hold the inaugural Service Provider Organization Engagement Sub-Group meeting
  ○ Recruit more physicians to the BE OHT
• Care Delivery:
  ○ Evaluate High Intensity Supports at Home (HISH)+ Program
• COVID-19 Response:
  ○ Continue to support COVID-19 testing and vaccination efforts as required.

- Explore how the BE OHT can continue supporting COVID-19 care as it becomes more primary care focused and continue to support COVID-19 recovery efforts where applicable.

- Work Towards Completing TPA Milestones:
  - Complete Ministry of Health quarterly report.
  - Develop Patient Declaration of Values (PDoV).
  - Create Harmonized Information Management Plan.
  - Develop and implement Primary Care Communications Protocol.

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.