1.0 OHT 2021-22 Q2 Report- CW OHT_ Draft 7Ontario Health Team (OHT) Name:	Central West Ontario Health Team (formerly Brampton Etobicoke Ontario Health Team)
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Transfer Payment Recipient Name:	William Osler Health System
Reporting Period: ☐Q1 ☑Q2 ☐Q3 ☐Q4	July 1, 2021 to September 30, 2021
Due Date: *Once complete, please submit your templates to your Ministry of Health (ministry) point of contact*	October 29, 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 (Optional for Q2)

What accomplishment is your OHT most proud of for this reporting period?
For our second quarter report, the accomplishment the Central West Ontario Health Team (CW OHT) is proudest of is finalizing our rebranding process. The process was initiated to identify a name and graphic identity that feels inclusive to all partners across the CW OHT. This was based on several needs and ideas gleaned from several visioning and retreat sessions with OHT partners. The outcomes of the retreats became the basis of the CW OHT brand identity. Partners across the entire health and care spectrum (patients, physicians, allied health practitioners, and administration workers) were engaged, vetting the findings of the retreat and further discovering what key themes would comprise the branding. Overall, the following deliverables were achieved with respect to the branding: • New name (Central West Ontario Health Team) to be more inclusive of the geographical areas served beyond Brampton and Etobicoke (e.g. Bramalea, Malton, west Woodbridge) and build on community awareness of services in Central West. • New overarching vision and values for the CW OHT, aligned to the Ministry vision for OHTs and reflective of the values needed to promote partnership and integration. • Visual and graphic identity for print and digital media to create a recognizable brand for patients, partners, prospective partners and the general public.

Is there a top patient-facing success that your OHT would like to share for this reporting period?
In previous reporting periods, the CW OHT outlined its experiences implementing an early iteration of the High Intensity Seniors Continuum integrated care model. Funding for further development of this model has been submitted to Ontario Health as part of the Integrated Virtual Care funding stream. This model supported seniors living with frailty at home by providing various wraparound services and supports for patients and caregivers.

Is there a top provider-oriented success that your OHT would like to share for this reporting period?
Building on the work from Q1, SCOPE (Seamless Care Optimizing the Patient Experience) is a clear provider-oriented success for the CW 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. As of June 30, 2021, the SCOPE line expanded to 66 PCPs, established, and maintained a 94 per cent satisfaction rate and had an emergency department (ED) diversion rate of 60 per cent. For this reporting period, 18 additional PCPs (84 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 63 per cent. Finally, as a result of SCOPE and our newsletter, our physician sign-ups to the OHT have increased from 108 to 121 as of this report.

Where applicable, describe any activities or planning your OHT has begun in relation to COVID-19 recovery.
In exploring how the CW OHT can best support COVID-19 recovery, we have begun planning for multiple Pandemic Response Hubs (COVID, Cold and Flu Care Clinics) " within our catchment area, as they will meet local needs. Working closely with Ontario Health Central and Peel Public Health, we are planning hubs that will combine COVID-19 testing, COVID-19 vaccination and assessment for patients and ensures a safe working space for primary care. This will enable PCPs to focus on upstream health for screening and complex issues, reduce emergency department volumes, and provide increased access to these services for patients close to home. The Pandemic Response Hubs (COVID, Cold and Flu Care Clinics)are a multi-organizational initiative. It involves guidance from Ontario Health Central, the CW OHT for additional development, planning and strategy and partners to operationalize. This work could expand into previously identified initiatives, such as remote monitoring or virtual services.

Section B: Key Activities and Achievements (Optional for Q2)

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 CW OHT priority population.	Created a working group with patient, provider and cross-sector representation. Preliminary work has included analyzing data and needs of the priority population.

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 CW OHT.	Patient engagement framework completed. Will be available on the CW website in mid-to-late fall for the public.
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 Collaboration Council (CC) to revise and finalize the CW OHT mission, vision, and values.	Mission, vision and values has been finalized and added to the updated Collaborative Decision Making Arrangement (CDMA) Framework. Will be available on the CW website in mid-to-late fall for the public.
Develop the CW OHT Patient Declaration of Values (PDoV.)	Using the Ministry's PDoV, our own Mission, Vision and Values and working with the community to create a PDoV that is representative for the CW OHT.	Drafted a preliminary PDoV aligned with the provincial PDoV that will be disseminated to the broader community for feedback.

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)***
Develop a Patient Engagement Framework.	Developed of a Patient Engagement Framework for the CW OHT.	Patient engagement framework completed. Will be available on our website in October for the public.
Establish informative and two-way communications with local communities.	Develop communications plan to communicate with the community.	Drafted communications plan to be brought to CW OHT CC for approval. CC has approved overall communication goals, audience (including local community), strategy, measurement and reporting.

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 CW OHT work.	Create an equity framework for the CW OHT.	The Equity Framework has been approved by the CC. An Equity Charter is in development. The Equity Charter will solidify our commitment to equity, diversity and inclusion. Additionally, it will include use of the framework in all of our work and building accountabilities for all partners.
Better understand the CW 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 CW 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.	Completed analysis of the work plan and developed an approach to build trust among partners.
Improve CW OHT partner engagement.	Developed a process to engage with non-CW OHT partner organizations that have collaborated with the BE OHT, including Service Provider Organizations (SPOs) and private vendors.	The CC has revised the approach by partnering with Home and Community Care Support Services to engage with Service Provider Organizations. This would be done on a rotating basis for members of CC to ensure equity and equal representation.
	Developed a CW OHT communications plan.	**Drafted communications plan to be brought to CW OHT CC for approval.** **CC has approved overall communication goals, audience (including local community), strategy, measurement and reporting.**

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.	The open rate for the newsletter (average) is 51.4% opens. Increase from 49.6%.

	Increased total subscribers from organic shares.	224 total subscribers, increase from 211.
Increase primary care sign-ups to the CW OHT.	Align SCOPE sign-ups with sign-ups to the OHT.	Increased OHT primary care sign-ups to 121 from 108.
Complete Primary Care Communications Protocol.	Draft, present and demo primary care communications protocol and tactics to CW OHT CMAC.	CW OHT CMAC approved the strategic goal, enablers, tactics and review process. The CW OHT CC endorsed the Primary Care Communications Protocol.

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)***
Development of the Harmonization Information Management Plan (HIMP)	Create Privacy and Security for HIMP Charter Create HIMP Create HIMP Attestation response	Completed: Charter created and approved. Completed: The plan has been completed, revisions were noted from CC ensuring alignment with priorities and our OHT's current capabilities. Completed: HIMP attestation approved and submitted to ministry prior to due date (Sep 30th).
Assess Potential for Better Integrated Systems	Deliver Surgical Transitions Lessons Learned to the Ministry Review early iterations of the High Intensity Senior's Continuum Program	Completed: Ministry funded Surgical Transition project supported by the CW OHT completed. Lessons Learned submitted to the ministry. Completed: High Intensity Senior's Continuum Program initial needs assessment completed. Due to HIMP, objective has been updated to; "Identify practical ways for the priority population to access virtual care and health records digitally." The goal has also been updated to understand our needs and flag opportunities from all integrated systems attempts during this fiscal year.

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)***
Assess High Intensity Senior's Continuum Program to use key insights to inform future planning.	A framework has been created to assess the High Intensity Senior's Continuum Program based on pre-operational and post-operational work rather than aligning entirely with the quadrants of the Quadruple Aim as a tool to evaluate.	Closeout report is near completion and shall inform the next iteration of the High Intensity Senior's Continuum Program. It was identified that the Quadruple Aim would challenging to use as an evaluation tool due to challenges with how the program was initially set up. Patient privacy and permission were factors in changing the closeout report to a pre-operational and post-operational framework.
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 CW OHT (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 quarterly reports.
Create a collaborative Quality Improvement Plan (cQIP)	Understand the requirements of the cQIP. Review materials to be provided by the MOH. Prepare plan of action.	Assigned a lead for cQIP to handle action items and learning opportunities.

Section C: Status on Outputs and Milestones (Required for Q2)

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 - completed	
Harmonized Information Management Plan	September 30, 2021	Green - completed	
Patient Declaration of Values	November 30, 2021	Green	
OHT Expansion Plan	March 31, 2022	Green	
A Collaborative Quality Improvement Plan (cQIP)	March 31, 2022	Green	

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 D - 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)	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.
Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.
Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.

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.	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.
More patients in the OHT's priority population(s) are • accessing care virtually • accessing their health information digitally • booking appointments online	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat. Digital Steering Team has identified 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.*	Yellow	HRM adoption remains the same as previously reported in the End of Year report - greater than 80% among CW OHT Primary Care Providers. In the previous report, it was reported that the plan is the team will continue to provide more active guidance and support to CW 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 CW 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 This will commence when 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. (Q3 2021-22)
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	Yellow	Launch CW OHT website with refreshed branding as a result of partner engagement sessions. (Q3 2021-22)
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	Green	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat. 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	Co-design, implement and evaluate an integrated care model for older adults experiencing frailty. This process is divided into 5 phases; defining the problem statement, segmentation, co-design, implementation and evaluation/spread of services. A working group has been created to lead the work pertaining to older adults experiencing frailty. Membership of the working group includes Community Agency partners, Patient and/or Caregiver partners, Physician partners and support from the Secretariat.

Section D: Risk Register (Required for Q2)

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/Partners to acquire a list of all physicians attributed to the CW OHT. • Created a physician engagement lead role as an extension of the CMAC. • Use physician peer network to recruit physicians to the CW OHT. • Use the SCOPE program as a way to recruit physicians to the CW OHT.
Resource Risk – Human Resource	Resourcing and expertise to develop the collaborative Quality Improvement Plan (QIP).	• Identified a lead to support the development of the Collaborative QIP. • Create a plan of action early on to establish the cQIP.
Partnership Risks - Other	Ability to maintain relationship with SPOs/private vendors despite lack of formal OHT partnership at this time.	• Coordinate with Home and Community Care Support Services (HCCSS) to work with and engage with SPOs/private vendors. • Utilize the findings from the CW 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, HISH+ Program).	• Work with the Ministry to advocate for ongoing funding and address regional underfunding inequities. • Work with partners to pool funding where possible. • Establish a resource management committee to explore financial sustainability.
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 CW 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 (Required for Q2)

Please provide a brief description of your team's top priorities for the next quarter and list key planned activities.
Priorities for the CW OHT for the next quarter include: • Planning and Design: o Continue to develop an integrated care model for CW OHT priority population..

- Leverage OHT mission, vision and values to build brand identity and organizational trust with partners.
- Review and refresh CDMA.

- Engagement:
  - Launch OHT website.
  - Work with HCCSS to engage with SPOs and private vendors.
  - Recruit more physicians to the CW OHT.
  - Creating Stakeholder Matrix for CW OHT Expansion Plan.
  - Implement Primary Care Communications Protocol.
- Care Delivery:
  - Evaluate early iteration of the High Intensity Seniors Continuum Program
- COVID-19 Response:
  - Develop a plan for Pandemic Response Hubs (COVID, Cold and Flu Care Clinics) as a way to support COVID-19 response.
  - Continue to support COVID-19 testing and vaccination efforts as required.
- Work Towards Completing TPA Milestones:
  - Complete Ministry of Health quarterly report.
  - Develop Patient Declaration of Values (PDoV).
  - Develop collaborative Quality Improvement Plan cQIP.
  - Implement Harmonized Information Management Plan.

PART TWO: TPA PERFORMANCE INDICATOR REPORTING (Deferred for Q2)

Submission of the 'TPA Performance Indicator Reporting' template is not required as part of your Q2 Report in 2021-22. You will be asked to defer Q2 reporting until Q3, at which time you will report on indicators for the Q2 and Q3 periods.

PART THREE: FINANCIAL EXPENDITURE STATEMENT (Required for Q2)

Please complete and attach the 'Financial Expenditure Statement' template to your submission. Please do not submit in PDF format.