2021-22 OHT Year-End Report

Ontario Health Team (OHT) Name:	Central West Ontario Health Team (formerly Brampton Etobicoke Ontario Health Team)
Transfer Payment Recipient (TPR) Name:	William Osler Health System
Reporting Period:	April 1, 2021 to March 31, 2022

The Year End Report for Fiscal Year 2021-22 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 April 1, 2021 to March 31, 2022.

The Year End Report is due to your Ministry of Health (ministry) point of contact by April 29, 2022.

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. **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 or achievements, activities, or risks and mitigations approaches.

Section A – 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 April 1, 2021 to March 31, 2022.

To date, what accomplishments are your OHT most proud of?

For fiscal year 2021/2022 the Central West Ontario Health Team (CW OHT) is most proud of these accomplishments.

Collaborative Quality Improvement Plan During the last fiscal quarter, the CW OHT has completed the first stage of its Collaborative Quality Improvement Plan (CQIP). To complete the plan, the OHT created a virtual engagement session and brought together our organizational partners, service provider organizations, patients, family, caregivers and primary care practitioners (PCPs). Representatives from across the partnership were in attendance, with 69 total attendees. The biggest challenge was to expunge the importance of this work for the recovery of the health system despite being in the middle of COVID's fifth wave.

Rebranding
A rebranding process was initiated to identify a name and graphic identity that feels inclusive to all partners across the CW OHT. This was based on many needs gleaned from several visioning and retreat sessions with CW 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 that is more inclusive of all the geographic regions we serve.
- 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.

Launching Digital Media Channels
In our third quarter report, the CW OHT launched our digital media channels, including the website and social media. The website, https://centralwestoht.ca includes information about what an OHT is, how it helps key stakeholders, a list of all partners that comprise the CW OHT and information on navigating health and related services over the holiday period.

Some patient content is also hosted on our website, including the CW OHT Patient Family Engagement Framework and the Patient, Family and Caregiver Declaration of Values for Ontario (PFCDOV).

Patient, Family and Caregiver Declaration of Values and Engagement Framework
In Q3 of this reporting period, the CW OHT Patient, Family Advisory Council (PFAC) completed its Patient Engagement Framework and CW OHT Patient Family Caregiver Declaration of Values (PFCDOV.) Both processes required the engagement of patients/clients, families and caregivers beyond the CW OHT PFAC. Then, both pieces were launched on our website, following dissemination with the partners on the framework, enabling the tools to help guide the work of the OHT and ensure that a culture promoting meaningful engagement at various levels with patients/clients, families and caregivers is developed.

Priority Population
During the 2021/2022 fiscal year, the Priority Population Working Group has leveraged population demographics and care services data from the organizational partners across the CW OHT. The Priority Population Working Group also finalized defining, segmenting and identifying needs and gaps of its priority population: older adults experiencing frailty.

More specifically, the group reviewed data pertaining to emergency department utilization rates, alternate level of care rates and data regarding homebound patients. A review of this data helped identify the segmentation for the priority population (ranging from high risk to those managing well). Additionally, to better understand the patient journey, the group collaborated with over 30 community partners in two process mapping sessions.

As an outcome, the group identified multiple change ideas and recommendations. The first change idea is to develop a home-based primary care program which provides coordinated access to timely, respectful and effective services for older adults experiencing frailty. The goal of the second recommendation is to identify an integrated navigation services directory that is readily available for caregivers and family members in addition to patients.

Equity Diversity and Inclusion (EDI) Framework
The Equity Charter has been created for all partners to sign to solidify our commitment to equity, diversity and inclusion as an OHT. The charter also includes the use of an equity framework to be used in all of our OHT projects and for building accountabilities among all partners. It has been approved by our Collaboration Council. It has also been shared with partners to use as a guide to develop their own EDI values and framework where needed.

Primary Care Communications Protocol
The Primary Care Communication Protocol finalized three key components of our primary care communications strategy: strategy, enablers and tactics. Strategy was created with the Community Medical Advisory Council (CMAC) and further ratified by the Collaboration Council. Two sets of enablers were identified. The first, is highlights the expected outputs from the Primary Care Communications Protocol. The second, is an identification of the work required to enable the protocol. Finally, two tactics were approved, the continuation and update of the Primary Care Newsletter (one-way communication) and the creation of a Primary Community Portal (two-way communication) on Slack.

Are there top patient-facing successes that your OHT would like to share?

The top patient-facing success from the CW OHT, the PFCDOV, engaged with the larger community including patients/clients, family and caregivers to develop regional values. This was based on, and aligned with, the provincial patient declaration of values.

From the strength of the provincial PDOV we were able to build and enhance our local PFCDOV (patient, family, caregiver declaration of values). Similar to other provincial patient materials, the PDOV provided a framework in order to have the conversations that highlights our regional values as an OHT.

Are there top provider-oriented successes that your OHT would like to share?

Previously, we reported on our SCOPE initiative being our top provider-oriented success. Per quarter, SCOPE has facilitated growth for physician sign-ups while making the primary care practitioner experience more efficient and easier to navigate.

Overall, for fiscal 21/22, our top provider-oriented success has been the engagement and recruitment strategy behind SCOPE and, more broadly, physician recruitment. We have built a communication structure for physicians to engage with each other and revised our informative communications platform. This has resulted in consistent engagement with our content, despite engagement around COVID-19 slowing in general.

This strategy has resulted in an increase from 44 SCOPE users to over 100 from March 31, 2021, to March 31, 2022. For total OHT physician partners, the CW OHT has grown from 94 to 142. This number will continue to grow as recent engagement efforts yield results.

To engage with physicians in our region, we developed physical mailers (that included our key messages, key benefits and a summarized version of our Collaborative Decision Making Arrangement [CDMA]) and used the College of Physician and Surgeons of Ontario (CPSO)'s data to create a list of PCPs that could potentially practice in our region, as our OHT does not have access to a comprehensive list of physicians. There have been lessons learned as a result of the tactics implemented to support with physician engagement, sign-up and onboarding that will shape our future engagement tactics.

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?

Throughout this reporting period, members of the OHT came together to share in-kind resources, contributing to working groups, advisory councils and structure for the long-term sustainability of the CW OHT. Most notably, the partnership continues to see a wide range of organizational and stakeholder representation from mental health and addictions to education-based services.

The team has seen a reduction of duplicate work, a willingness to provide access to services that may have been impacted by COVID-19 and a facilitation of staffing support for organizations experiencing shortages. Ultimately, the OHT enables a space and resources for organizations to communicate and streamline health and care services.

Where applicable, describe activities undertaken by your OHT to jointly respond to COVID-19 and any lessons learned. Where possible, please note which members of the OHT were involved, and their respective role(s)/ responsibilities.	
COVID-19 Response	***Key Activities or Achievements*** *(indicate N/A or leave blank where not applicable)*
COVID-19 vaccination planning and deployment *(Has your team used the OHT-PHU COVID-19 Vaccine Resource Document, released on December 17, 2021, to support the planning of vaccine deployment events?)*	The OHT worked with the Region of Peel to support vaccinations and fill gaps for clinics and Long-Term Care Homes. We also saw partners (specifically service provider organizations) staff the hospital clinic at William Osler Health System. Through our newsletter we provided information to primary care providers and partner organizations to support through COVID and coordinate resources. The OHT also facilitated vaccine distribution with William Osler Health System and Humber College when vaccinations were in need. Finally, the CW OHT worked with the Region of Peel to pilot offering Pfizer in primary care provider clinics including Queen Square Family Health Team, West Brampton Family Health Team, North Peel Family Health Team and Kennedy Medical Centre.
Supporting long-term care homes (LTC)	The IPaC Hub (Infection Prevention and Control) Hub supports protocols and best practices for areas hardest hit by COVID-19. Additionally, the Hub provides advice, guidance and direct support for long-term care homes during outbreaks (in partnership with Public Health Units) and builds capacity for LTC homes to more proactively implement IPaC procedures. The Nurse Practitioner-Led Outreach Team (NLOT) also supported LTC homes to mitigate ED transfer of residents by coordinating with acute care and home and community care services. The NLOT team also facilitated timely and safe repatriation of patients to LTC homes and educated staff and medical directors on various aspects of care and coordination for LTC residents. The IPaC Hub and the NLOT are supported by William Osler Health System and have been moved to the Integrated Health Systems portfolio at William Osler Health System under the leadership of the CW OHT's Executive Lead, better promoting integration and alignment with CW OHT priorities.

Supporting other congregate care settings	The Infection Prevention and Control (IPaC) Hub supports protocols and best practices for areas hardest hit by COVID-19, including retirement homes and other congregate care settings. Additionally, the Hub provides advice, guidance and direct support for these during outbreaks (in partnership with Public Health Units) and builds capacity for these settings to more proactively implement IPaC procedures.
Acquiring and distributing PPE	At the beginning of Wave 5, the CW OHT Secretariat attempted to coordinate and streamline the PPE procurement and distribution for the CW OHT region based on interest from primary care partners and organizations to support an OHT-led process. After conducting due diligence on the process, the logistics were found to be challenging to implement given the OHT's current infrastructure. In parallel, Ontario Health and the Ministry of Health updated their processes for PPE support across the province, and the CW OHT focused its efforts on educating and connecting partners to provincial PPE solutions.
Infection prevention and control	William Osler Health System supported free mask fit testing for frontline staff at OHT partner organizations and primary care providers across the CW OHT. Additionally, as stated above, the IPaC hub supported long-term care homes, retirement homes and other congregate settings by providing advice, guidance and direct resources to enable best practices in IPaC.
Implementation of virtual care supports	The bi-weekly primary care newsletter provided update support for resources, education pieces and sharing staffing needs. The SCOPE line continued to support primary care providers with streamlined access to services (supported by William Osler Health System, Home and Community Care Support Services, and CMHA Peel Dufferin). And finally, the Virtual Urgent Care Clinic (VUCC) supported patients seeking care for non-life-threatening ailments (supported by community primary care providers, and William Osler Health System). Engagement with the Region of Peel Paramedicine Program and CMHA Peel Dufferin is being conducted to assess future opportunities.

COVID-19 testing	In exploring how the CW OHT can best support COVID-19 recovery, we support multiple COVID, Cold and Flu Care Clinics (CCFCC) within our catchment area. Working closely with Ontario Health Central and Peel Public Health, we are supporting hubs that combine COVID-19 testing, COVID-19 vaccinations and assessment for patients and ensure a safe working space for primary care. This enables 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 Queen Square Family Health Team implemented the first CCFCC in the area of northwest Brampton. This was followed by WellFort Community Health Services, offering a primary care and health promotion clinic. These initiatives were supported by the Region of Peel, Home and Community Care Support Services Central West who have offered front line and leadership staff support to these initiatives. Additionally, other OHT partners offered High Priority Community programming and referral pathways to support the CCFCCs.
Supporting vulnerable populations or communities disproportionately affected by COVID-19 (e.g., through collaboration with a lead agency under the High Priority Communities Strategy)	Many OHT partners rallied to support vulnerable populations affected by COVID-19, including but not limited to: Rexdale CHC championing vaccine strategy rollout in north Etobicoke, Wellfort CHS offering vaccines in Malton and Brampton in partnership with the Region of Peel, Peel Senior Link advocating and informing the vaccine strategy for homebound seniors, the Region of Peel leading vaccine rollout in various settings to reach as many people as possible, and multiple OHT organizations serving as lead agencies under the High Priority Communities Strategy to provide wraparound supports for those living with COVID-19.
Other	

Reflecting on the above COVID-19 related activities, please describe whether working together as an OHT has benefited or enabled these activities, or alternately, posed challenges.
Working together as an OHT, combined with the low rules environment to respond to the pandemic, helped facilitate streamlined care and reduced possible duplications in work. Due to the level of coordination that the OHT offers, the collective experience and intelligence from multiple sectors helps to inform effective service design, delivery and response for the population. This was especially true when unearthing barriers to access to COVID-19 services (vaccines, testing, etc.) from an equity, diversity and inclusion lens. Working together also helped coordinate resources and share health human resources across partners when staffing shortages occurred during COVID-19's fifth wave. Lastly, many projects and their outputs are further along than they would be otherwise as a result of the partnership. For example, the Integrated Care Hub (ICH), was an original goal for the CW OHT's partners. With support from the OHT's partners, this work has been re-initiated and partners are able to contribute to and envision an ICH that will help patients access care in a way that is consistent with the Ministry's vision.

Section B: Key Activities and Achievements

Progress related to specific TPA outputs and milestones are reported in Section C; 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 April 2021 to March 2022. 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-19'.

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.
For this reporting period, activities for transforming patient care include: • Created a Priority Population Working Group • The group leveraged population demographics and care services data from its OHT Organizational Partners to better understand the needs and gaps of older adults experiencing frailty. • The group has reviewed data pertaining to emergency department utilization rates in addition to data regarding homebound patients. • CW OHT has held two process mapping sessions where over 30 community partners shared lived experience to better understand the unique concerns of the priority population within our region. Next steps include finalizing the population segments and leveraging the data to inform the co-design of a potential primary care program for homebound and at-risk older adults.

Patient, Family, and Caregiver Partnership and Community Engagement

Highlight notable activities or achievements related to partnership, engagement and co-design with patient, family, and caregiver partners in OHT work. How have patient, family and caregiver partners been involved in OHT decision making?

Patient, Family and Caregiver Declaration of Values and Engagement Framework (PFCDOV)
In Q3 of this reporting period, the CW OHT Patient, Family Advisory Council (PFAC) completed its PFCDOV. Both processes required the engagement of patients/clients, family and caregivers beyond the CW OHT PFAC. Then, both pieces were launched on our website, following dissemination with the partners on the framework, enabling the tools to help guide the work of the OHT.

Collaborative Quality Improvement Plan
In Q4, an engagement session was held to discuss and receive feedback on indicators across the CW OHT. This engagement session also included members of the PFAC.

In general, the PFAC acts as an advisory council to the working groups and project teams through the CW OHT. Furthermore, two members of the PFAC are active in the Collaboration Council and its decision-making process, and almost every working group has PFAC members contributing as an active participant.

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

Three key projects were and/or are related to engagement with local communities.

Virtual Urgent Care Clinic

- Shared with PCPs through the Central West OHT (a reach of 836)
    - This included an infographic and magnet that has been shared with PCPs to share with the larger communities they serve.
- Shared VUCC content with our partner organizations and the communications teams to further disseminate and engage with the community through social media.
- Shared information with local community groups (Facebook) and plan to reach out to demographic specific stakeholders in the near future (Humber College for example).

Patient, Family and Caregiver Declaration of Values and Engagement Framework (PFCDOV) Survey
During the process of finalizing the PFCDOV, a survey and engagement was held during a partner meeting as well as shared with PFACs in partner organizations.

COVID, Cold and Flu Care Clinics (CCFCCs)
Exploratory conversations held to determine feasibility of creating clinics for specific communities. For example, the OHT engaged with ROOTS to determine the feasibility of creating a clinic for the Black, African and Caribbean (BAC) populations and built awareness of the OHT in the process. OHT secretariat worked with the Region of Peel, Ontario Health, ROOTS and Queen Square Family Health Team to explore setting up a BAC-focused CCFCC in Downtown Brampton. This was to be staffed by Black, African and Caribbean staff, including physicians. However, due to staffing limitations, the stand-alone clinic was put on hold, with efforts shifted to support the BAC community through resources and other support.

Highlight notable activities or achievements related to addressing the needs of underserved populations (including, but not limited to, describing engagement and inclusion efforts/activities

aimed at promoting equity among Indigenous, Francophone, marginalized and racialized populations).
The CW OHT supported Region of Peel vaccine targeting for marginalized communities. This type of support was further exemplified by the creation and location of two COVID, Cold and Flu Care Clinics (CCFCC) in areas with the highest positivity rate for COVID. The CW OHT has also begun engaging with Entité 3 to understand and identify key activities to benefit the Francophone population as well recruit a patient advisor. Finally, our Equity, Diversity and Inclusion (EDI) Lead has engaged with partner organizations, to build a repository of supportive materials for patients, family and caregivers as well practitioners and organizations. This work has extended to community organization beyond the partners of the OHTs with many supporting marginalized and/or racialized populations.

Leadership and Collaborative Decision-Making

Highlight any notable activities or achievements related to building a culture of trust, shared goals and accountabilities, and collective decision-making across OHT members and OHT leadership.
An important achievement to build a culture of trust, shared goals and accountabilities is to give key stakeholders beyond OHT leadership a voice to express feedback on current engagement systems. A part of that was to re-evaluate our previous partner engagement structure that largely focused on informative or one-way communication. An engagement session was held, and the partners agreed that a monthly newsletter paired with ad hoc engagement sessions would be more valuable. Likewise, a refresh of the CDMA was important, as it reflected extensive changes in structure of the OHT as well as the long-term vision that the partners share for the direction of the CW OHT. A part of the long-term sustainability for the CW OHT was to reinstate the Governance and Foundations Working Group. It was identified that a group driving leadership structure would directly impact the growth and maturity of the OHT. This group has facilitated conversations around becoming a legal entity, engagement with organizational partner governance as well as the future of the OHT. Some notable activities include beginning strategic planning and fiscal sustainability for a 3–5-year plan and, Physician Network and Governance to formalize the structure of the CMAC. The CW OHT has used targets from the TPA agreement as local, OHT directives to establish shared goals and effectively process collective decision-making across partners and the Collaboration Council.

Highlight any notable activities or achievements related to engaging primary care physicians in your OHT's work. Describe how clinical leaders are being included in the design and delivery of relevant OHT work.
There are multiple channels for engaging primary care physicians in the OHT's work. Two primary ones include a newsletter for informative communication and a community portal for two-way communication and feedback. We have maintained our subscriber list throughout the year for our newsletter and our community portal is steadily growing. Additionally, primary care physicians remain an important part of working groups and decision-making structures. For example, our Priority Population working group and our Collaboration Council are both co-led by a physician. This ensures that a primary care physician is a part of decision making at a macro level.

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 personal health information in a privacy protected manner, or other digital health or virtual care solutions which have supported integrated team-based care.
Projects associated with digital health advancement and that are also funded by Ontario Health and the Ministry include: • Virtual Urgent Care • Online Appointment Booking Additionally, a Data Sharing Agreement initiative has begun. This has resulted in an information/engagement session with legal counsel, and the development of a working group to enable the CW OHT to better share aggregate data and service level data for joint decision making, where appropriate.

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

Highlight any notable performance measurement and quality improvement activities and achievements.
The Collaborative Quality Improvement Plan Working Groups (CQIP WGs) created an initial plan for evaluation and feedback on the three areas of focus and associated performance indicators. The CQIP WGs will continue to plan its quality improvement activities, monitor Ministry of Health (MOH)/Ontario Health metrics to inform planning and develop custom metrics for evaluating the progress and impact of CQIP initiatives. The CW OHT has also established a Performance Indicators Working Group (PIWG) to oversee and facilitate the reporting of the three selected performance indicators in FY 21/22. The PIWG also helps advise on data collection and sharing requirements, analyze population health data to inform planning activities (e.g., with the Priority Population Working Group) and aid with indicator development for OHT-specific initiatives.

Highlight any notable activities or challenges related to the collection, sharing or use of data to inform your OHT's performance measurement and quality improvement efforts.
The CW OHT has begun the work of creating a Data Sharing Agreement across the partners. This will help facilitate the collection, sharing and use of data enabling efficiencies with patient hand-offs while also providing new data sets for performance measurement and quality improvement efforts. The CW OHT also used the data from MOH and HSPN data sets, as well as local data sets, to inform long-term planning as much as possible with current reporting tools at partner organizations' disposal. Challenges remain with the ability to identify which patients are part of the OHT's attributed population in order to align performance to MOH data, and target population segments accordingly when devising quality improvement activities. Finally, once a Data Sharing Agreement is in place between partners, there are anticipated challenges with being able to incorporate data from partners who do not currently use OHIP numbers but still provide health or care services to patients/clients. This challenge will be explored as part of the CQIP work for Mental Health & Addictions where options for incorporating data from non-OHIP community services with other data will be trialed to demonstrate the impact that these valuable services have on the OHT's health outcomes.

Please highlight any supports and resources offered by the ministry, Ontario Health and/or the OHT Central Program of Supports that your team has found particularly helpful in accomplishing the key activities and achievements above. For example: Ministry Guidance, RISE PHM Coaching, ADVANCE Leadership Workshops, and/or supports events included in the OHT Supports Events Calendar (https://www.mcmasterforum.org/rise/join-events/oht-supports-events-calendar)

Some supports and resources that have been helpful are: RISE Coaching and events, HSPN webinars, online learning collaborations, ministry guidance, and having an assigned ministry contact.

Section C: 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 D - Risk Register. Any activities that teams have undertaken towards 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 Yet Started	For completed deliverables, please identify what activities and/or strategies your team is using to ensure continued implementation and evolution of the objectives set out in these deliverables (if applicable). For outstanding deliverables, please identify what actions are being taken to complete the deliverables before the end of the funding agreement (if applicable).
Patient, Family and Caregiver Partnership and Engagement Strategy	Sept. 30, 2021	**Green - Progressing Well**	Completed and is currently in the initial implementation phase. The strategy contains two sections, the first is recruitment and the second is ongoing engagement. The plan requires applications to apply to the PFAC on an ongoing basis. Those that aren't selected will be invited to join a Community Engagement Panel where larger questions can be posed to an audience on an interim basis.
Primary Care Communication Protocol	Sept. 30, 2021	**Green - Progressing Well**	Completed and continuing to be implemented. Similar to the Patient, Family and Caregiver Partnership Engagement Strategy, there are two components. The first is recruitment, having physicians sign up to the CW OHT, and the second is ongoing engagement through our newsletter and community portal.

Harmonized Information Management Plan	Sept. 30, 2021	**Green - Progressing Well**	Charter created and approved. The plan has been completed, revisions were noted from Collaboration Council ensuring alignment with priorities and our OHT's current capabilities. HIMP attestation approved and submitted to ministry prior to due date. 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 of the HIMP has also been updated to understand our needs and flag opportunities from all integrated systems attempts during this fiscal year. In the process of submitting a proposal for funding to support 'IDENTOS' (a means of single sign on), in combination with 'Connect My Health' (a web-based application). These tools will connect patients to the OHT's inventory of patient portals and digital tools. If funding is approved, implementation will begin in FY2022/23 and will continue until FY2023/24.
Patient Declaration of Values	Nov. 30, 2021	**Green - Progressing Well**	Completed and presented to key stakeholders for feedback and dissemination. Broader engagement is being planned.
A Collaborative Quality Improvement Plan (CQIP)	Mar. 31, 2022	**Green - Progressing Well**	Initial plan is complete, next steps include re-engaging with working groups per indicator and implementation planning.

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 June 30, 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 D - Risk Register.

TPA Milestone	**Progress To-Date** **Green** – progressing well **Yellow** – some challenges **Red** – at risk N/A – 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)	*E.g.,* ***Green***	For Q1 of 22/23, the Priority Population Working Group defined the co-design and implementation of a home-based primary care model for older adults experiencing frailty. The goal of this program is to provide access to ongoing primary medical care; maximize independence and function; enhance patient safety and quality of life; link patients to supportive home care services and reducing emergency department and hospital admissions. The implementation of such a program will meet the following TPA milestones: • 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'. • More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • The OHT's performance has improved on measures of access, transition, coordination of care, and integration. Additionally, the group is also aiming to refine change ideas related to navigation and information sharing of existing community support services. The goal of this work stream is to develop a more coordinated and organized system for navigation services and have information related to these services be readily available and accessible to the public.

Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	**Green - Progressing Well**	For Q1 of 22/23, the Priority Population Working Group defined the co-design and implementation of a home-based primary care model for older adults experiencing frailty. The goal of this program is to provide access to, ongoing primary medical care; maximize independence and function; enhance patient safety and quality of life; link patients to supportive home care services and reducing emergency department and hospital admissions. The implementation of such a program will meet the following TPA milestones: • 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'. • More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • The OHT's performance has improved on measures of access, transition, coordination of care, and integration. Additionally, the group is also aiming to refine change ideas related to navigation and information sharing of existing community support services. The goal of this work stream is to develop a more coordinated and organized system for navigation services and have information related to these services be readily available and accessible to the public.

Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	**Green - Progressing Well**	For Q1 of 22/23, the Priority Population Working Group defined the co-design and implementation of a home-based primary care model for older adults experiencing frailty. The goal of this program is to provide access to, ongoing primary medical care; maximize independence and function; enhance patient safety and quality of life; link patients to supportive home care services and reducing emergency department and hospital admissions. The implementation of such a program will meet the following TPA milestones: • 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'. • More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • The OHT's performance has improved on measures of access, transition, coordination of care, and integration. Additionally, the group is also aiming to refine change ideas related to navigation and information sharing of existing community support services. The goal of this work stream is to develop a more coordinated and organized system for navigation services and have information related to these services be readily available and accessible to the public.

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 - Progressing Well**	For Q1 of 22/23, the Priority Population Working Group defined the co-design and implementation of a home-based primary care model for older adults experiencing frailty. The goal of this program is to provide access to, ongoing primary medical care; maximize independence and function; enhance patient safety and quality of life; link patients to supportive home care services and reducing emergency department and hospital admissions. The implementation of such a program will meet the following TPA milestones: • 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'. • More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • The OHT's performance has improved on measures of access, transition, coordination of care, and integration. Additionally, the group is also aiming to refine change ideas related to navigation and information sharing of existing community support services. The goal of this work stream is to develop a more coordinated and organized system for navigation services and have information related to these services be readily available and accessible to the public.

More patients in the OHT's priority population(s) are: • accessing care virtually • accessing their health information digitally • booking appointments online	**Green - Progressing Well** The OHT has also joined the Regional Patient Portal Working Group to support the rollout of IDENTOS (for simplifying digital identity) and ConnectMyHealth (a portal of portals for offering a single doorway to access patient health records from multiple sources) to support the initiative of identifying practical ways for our priority population to access their health information digitally. Secondly, enabling new clinical providers throughout our OHT to offer online appointment booking has been the dedicated focus for the past quarter. We now have 61 new clinical providers offering online appointment booking with another 20 to be enabled within the month of April.	The team will continue to support in the regional initiative to help co-design the Patient Portal navigator interface. Next milestone: Sunnybrook MyChart IDENTOS integration Apr-May 2022. Technical development of provincial navigator solution ConnectMyHealth: Change management planning April-Sept 2022
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 - Progressing Well** Tied into online appointment booking we are currently rolling out the use of Ocean and Verto throughout our primary care groups. Health Report Manager now has 86.1% use within our area according to the 'Physicians Live on HRM by LHIN for 2021-2022 report. This is the 3rd highest (among the 8 LHIN groups listed). Source: OntarioMD Stakeholder Report	Online appointment booking is a two-year initiative. The team will be applying for funding to support sustainment of the initial 81 clinical providers and will be evaluating an additional 87 clinical providers to determine if they can be enabled with these approved digital health solutions as net new providers enable booking appointments online. The sustainment proposal is to be completed by May 2022. New provider proposal to be completed by June 2022 with implementation work beginning shortly after.

Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.	**Green - Progressing Well**	For Q1 of 22/23, the Priority Population Working Group defined the co-design and implementation of a home-based primary care model for older adults experiencing frailty. The goal of this program is to provide access to, ongoing primary medical care; maximize independence and function; enhance patient safety and quality of life; link patients to supportive home care services and reducing emergency department and hospital admissions. The implementation of such a program will meet the following TPA milestones: • 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'. • More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence. • The OHT's performance has improved on measures of access, transition, coordination of care, and integration. Additionally, the group is also aiming to refine change ideas related to navigation and information sharing of existing community support services. The goal of this work stream is to develop a more coordinated and organized system for navigation services and have information related to these services be readily available and accessible to the public.
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	**Green - Progressing Well**	Our website has been launched and contain links to partner organizations. A goal for the CW OHT is to revise the current website to link patients directly to services. The website redesign is currently in its planning stage.
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	**Green - Progressing Well**	The SCOPE program hosts regular onboarding and physician education/feedback sessions to ensure standardization in the way SCOPE services are accessed. The Priority Population Working Group is designing an integrated care model for patients that will try to reduce variation in care and implement clinical standards according to best practice (including coming up with a common way to assess frailty and which services should be attached to patients that meet the definition of frail).

The OHT's performance has improved on measures of access, transition, coordination of care, and integration.	**Green - Progressing Well**	Progress towards establishing a DSA for the OHT will enable the ability to share information in ways that will improve transitions, coordination of care and integration. OHT work throughout the pandemic to improve access to COVID testing. Testing utilization was one of our three performance indicators, and as part of that work, partners did their best to ensure enough testing capacity was available throughout the OHT. The Priority Population Working Group is designing an integrated care model for patients that will improve access to care, coordination and transitions between providers in an integrated way.

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	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. • Leverage list of all physicians attributed to the CW OHT. • Created a physician engagement lead role as an extension of the CMAC. • Hired an outreach lead to facilitate physician onboarding • Use physician peer network to recruit physicians to the CW OHT. • Use the SCOPE program to recruit physicians to the CW OHT.
Resource Risk – Human Resource	Resourcing and expertise to develop the Collaborative Quality Improvement Plan (CQIP).	• Identified a lead to support the development of the Collaborative QIP (CQIP). • 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, High Intensity Seniors Continuum 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 • Access to supports for OHT development • 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 (Q1 2022-2023) and list key planned activities.

Priorities for the CW OHT for the next quarter include:
• Planning and Design
  ○ Launch an integrated care model, implementing CW OHT priority population approach
  ○ Create plan for implementation of Collaborative Quality Improvement Plan (CQIP)
  ○ Hold Strategic Planning session, 3-5 years TBD
• Engagement:
  ○ Continue to work with HCCSS to engage with SPOs and private vendors
  ○ Recruit more physicians to the CW OHT
  ○ Recruit additional PFAC members to support expanded engagement role patients/clients, family and caregivers will play in the CW OHT
  ○ Implement board engagement plan following partner survey feedback
  ○ Collect outstanding CDMA refresh signatures
• COVID-19 Response:
  ○ Support Snelgrove CCFCC relocation
  ○ Continue to support COVID-19 testing and vaccination efforts as required
• Work Towards Completing TPA Milestones and Deliverables, including:
  ○ Population Health Management and Equity Plan

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.