**OHT Cohort 1: 2022-23 Mid-Year Progress Report**

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| **Ontario Health Team (OHT) Name:** | Central West Ontario Health Team |
| **Reporting Period:** | April 1 to December 31, 2022 |

The Mid-Year Progress Report consists of three components:

1. Financial Expenditure Statement (which was due November 30, 2022)
2. Narrative & Progress Update
3. TPA Performance Indicator Reporting

As the financial expenditure statement was already submitted, this template pertains to *Part Two: Narrative & Progress Update* and *Part Three: TPA Performance Indicator Reporting* only.

The Mid-Year Progress Report is due on January 20, 2023 and should be submitted to [ontariohealthteams@ontariohealth.ca](mailto:ontariohealthteams@ontariohealth.ca)**.**

**PART TWO: NARRATIVE & PROGRESS UPDATE**

The Narrative & Progress Update provides the opportunity for your OHT to report back on progress against TPA outputs and milestones, specifically deliverables outlined in the Population Health Management and Equity Plan (or ‘OHT Plan’) on July 29, 2022.

There are no word limits to this part of the Mid-Year Progress Report, but brevity is encouraged. **Please submit this part of the Report as a Microsoft Word document (please do not submit in PDF format)**.

# Summary

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| **Strategic Plan:**  If your OHT has a Strategic Plan, please provide a link here or share as an attachment when submitting your report. | The CW OHT strategic planning process has commenced in early January 2023, and is scheduled to be completed in March 2023. |
| **Measurement & Evaluation:**  If your OHT has a measurement or evaluation plan, please provide a link here or share as an attachment when submitting your report. |  |
| **Sharing Achievements:** Across all TPA priority areas, please highlight any achievements that your OHT is particularly proud of for this reporting period**.**  *Please note that information provided by OHTs this section may be shared more broadly with stakeholders and other OHTs to promote knowledge exchange of leading practices.* | |
| * Increasing our commitment to equity, diversity and inclusion by launching a leadership diversity survey and conducting a needs assessment to reinforce an equitable and diverse culture. * Scaling the CW OHT SCOPE service to provide urgent access to community, specialist and hospital services to143 community primary care providers. Nearly 1000 calls to date have resulted in the service's 93% clinician satisfaction rate, and over 200,000 patients have access to it via their primary care provider. * Nearly 1,500 unique patients have accessed virtual urgent care (VUC) services since February 2022, of which 87% avoided a potential ED visit. For this reporting period (April 1, 2022 – December 31, 2022), the VUC saw almost 2,000 total visits from 1,303 unique patients, with less than 12% presenting to an ED within 48 hours of their VUC visit. * Completing the first physician network event, focusing and finding solutions for physician wellness. * Completing our [Website 2.0](https://urldefense.com/v3/__https:/centralwestoht.ca/__;!!NWi02Ox1v1CzuzE!qOPmWWp_Nsl3aJfgl5YMSwnuligMgd8NQuK1s9vKPACHSxIyouo4r_KDhmisCs_1ioQfYV0UcktKhSYB7J14yEF0nhxN2xYhZd8$), including [patient navigation supports](https://urldefense.com/v3/__https:/centralwestoht.ca/services/navigate-health-services/__;!!NWi02Ox1v1CzuzE!qOPmWWp_Nsl3aJfgl5YMSwnuligMgd8NQuK1s9vKPACHSxIyouo4r_KDhmisCs_1ioQfYV0UcktKhSYB7J14yEF0nhxNWvlei-o$) * Implementing a human-centred design approach to plan for an OHT-level navigation service. | |

Ontario Health is partnering with Home and Community Care Support Services (HCCSS) to better understand how to strengthen home care engagement in OHTs.

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| **Is your local HCCSS a signatory partner of your OHT?** | Yes  No |
| **How actively engaged is your local HCCSS in OHT planning and clinical working groups?** | Very engaged  Somewhat engaged  Not engaged |
| We have a representative from Home and Community Care Support Services Central West (HCCSS-CW) on our Collaboration Council as a voting member. Furthermore, HCCSS-CW leadership and staff have been integral to working groups and initiatives, including the Priority Population and patient navigation working groups as well as the SCOPE program and digital sub-committee amongst others. As we move forward, towards integration, the Central West OHT will continue to value and incorporate the important role and input that leadership at HCCSS-CW offers. | |

# Priority Area 1: Integrated Care through Population Health Management & Equity Approaches

In [*Ontario Health Teams – The Path Forward*,](https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_path_forward.pdf?utm_source=Connected+Care+Updates&utm_campaign=062dd012e1-EMAIL_CAMPAIGN_CC_15102019_EN_COPY_01&utm_medium=email&utm_term=0_bb924cd748-062dd012e1-23082969) released by the Ministry of Health in November 2022, the phased introduction of integrated clinical pathways for OHTs to help deliver proactive, evidence-based care for patients with specific conditions was announced. OHTs working on the development and implementation of integrated care pathways for chronic diseases can report on this as part of TPA deliverables related to Priority 1.

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 1:** Enhance care planning and delivery and outcomes for initial target population(s) based on local drivers. | **Yellow - Some Challenges** |
| 1. Has your OHT implemented at least one improvement for your year one target population, as identified in your OHT plan? | Yes  No |
| 1. Describe any achievements related to this deliverable for the reporting period. | |
| The CW OHT is progressing well toward the implementation of a home-based primary care program for older adults experiencing frailty. This program will launch in a pilot stage in mid-January 2020 and will provide wrap-around interdisciplinary care, reducing emergency department utilization. The team has successfully collaborated with multiple partners within the catchment area to address the needs of those at risk of alternate level of care (ALC) or currently ALC, have high or very high utilization of the emergency department, have a fragile caregiver network and/or are currently home-bound.  Challenges such as limited resource capacity within partners, lack of funding confirmation and availability to back-fill existing roles have impacted the workflow of the Home-Based Primary Care Program. This has resulted in a delay for recruitment of the clinical care team and launch of the pilot. Additionally, availability of primary care providers with a Care of the Elderly designation has been limited and difficult to secure. | |
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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 2:** Design and implement population health interventions for additional target populations aligned with provincial direction and built on broadened OHT partnerships. | **Green - Progressing Well** |
| 1. Has your OHT implemented an improvement for one or more additional population, as identified in your OHT Plan? | Yes  No |
| 1. Describe any achievements related to this deliverable for the reporting period. | |
| The CW OHT is currently developing change ideas for other populations as they align with the Collaborative Quality Improvement Plan (CQIP). The Mental Health and Addictions (MHA) CQIP group is targeting children and youth and is 1) conducting a focus group with them to learn about their experiences and challenges in accessing community resources, 2) organizing a campaign to increase awareness and use of community resources among them, and 3) focusing on the topic of children and adolescent care during a mental health educational series being created for primary care physicians.  The preventative screening CQIP group, the team is targeting under screened women and focused on increasing PAP smear rates in Malton and North West Brampton, two areas with the lowest PAP smear rates and lowest number of primary care providers. This may include but is not limited to offering education sessions, PAP clinics and connecting patients to primary care providers.  In addition to the items above, the Virtual Urgent Care (VUC) team has been working with community partners to improve access to care for patients who do not have a primary care provider and/or access to care when their primary care provider is not available. The VUC has been working with the following stakeholders to promote access to the patients/clients they serve:   1. Health Connect Ontario: Encouraging use of VUC for unattached patients where appropriate 2. Canadian Mental Health Association Peel Dufferin: Using VUC to support the physical component(s) of a mental health crisis where needed. 3. Community Paramedicine: Provide paramedics with access to VUC for clients when enhanced care is needed. 4. Home and Community Care Support Services: Offer VUC to clients who need access to care when primary care is not available. | |

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 3**: Identify opportunities to expand care redesign efforts to serve the OHT’s full attributed population. | N/A - Not Yet Started |
| ***Note: Cohort 1 OHTs are not required to report on this deliverable at this time.*** | |

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 4:** Implement enhanced approaches to partnering with patients, families and caregivers in execution of the Population Health Management and Equity/OHT Plan. | **Yellow - Some Challenges** |
| 1. Has your OHT implemented any changes to your approach to engaging with patients, families and caregivers during the reporting period? | Yes  No |
| 1. If yes to above, please describe. | |
| Multiple Working Groups of the CW OHT continuously consult with the Patient Family Advisory Council and the William Osler Health System Patient and Family Advisory Committee to gather additional lived experience from caregivers, patients and their families for relevant projects. Additionally, representation from patients, families and caregivers is also reflected across most working groups, committees and councils. The CW OHT launched a robust plan for additional recruitment of members for the CW OHT PFAC and and has recruited one new PFAC member. The campaign will continue to add more PFAC members in this calendar year. Some challenges include adding additional work streams and further expansion of the CW OHT PFAC to continue this engagement. | |
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| Describe how your team is measuring and evaluating clinical improvements in population health including tracking self-selected indicators aligned to the Quadruple-AIM Framework. | |
| The CW OHT team has identified multiple indicators that will be used to evaluate the success of the proposed Home-Based Primary Care Program. The indicators that have been identified align with the four objectives of the quadruple aim, as highlighted below. Please note, these indicators are not final and will need to be refined and developed further with the appropriate working group.   1. Improving the patient and caregiver experience.  * The patient and caregiver experience will be captured through a patient experience survey assessing satisfaction, timeliness, and confidence measures.  1. Improving the health of populations.  * This will be assessed through the coordinated care plan, evaluating measures related to the patient journey and delivery of care.  1. Reducing the per capita cost of healthcare.  * The proposed metrics are the reduction in annual ED visits per patient and the 30-day non-admitted ED revisit rate for seniors, one of the CW OHT’s three performance indicators.  1. Improving the work life of providers.  * This will be measured and evaluated using a provider facing survey. The goal of this survey is to capture areas such as provider-provider communication, effective utilization of frailty scores and additional process related measures.   In addition to identifying indicators for the Home-Based Primary Care Program, the OHT also spent time evaluating current performance indicators, and updated to reflect current focuses as an OHT. As such, the following indicators were approved by the OHT Collaboration Council in the Fall:   * Thirty day ED Return Visit Rate for Patients 65+ (non-admitted) * Number of Primary Care Providers Signed onto the CW OHT * ED Visits Best Managed Elsewhere | |
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# Priority Area 2: Patient Navigation and Digital Access

**Updates – Patient Navigation**

***Key Definitions***

Navigation is defined as a service that assists the public/clients/patients with:

* Needs assessment/screening for eligibility (in some cases)
* Finding available health and social services to meet individual needs
* Assisting with access to those services (warm transfers)

It may be provided on the internet (e.g., virtual care, chat, potential for mature AI algorithms to be leveraged), through live phone services, or in-person. Services can be provided anonymously or non-anonymously and can involve on-going support and follow-up in some cases.

At a minimum, OHTs should aim to provide OHT-level support 7 days per week, ensuring daytime and evening coverage. After hours and holidays, Health Connect Ontario (HCO) may supplement the OHT-level navigation support. In these cases, there should be a mechanism in place for the HCO service to link the OHT-level navigation support (i.e., ability for HCO to book a call for the patient with the OHT-level navigation supports if required). This mechanism will be co-designed over time with OHTs.

A warm transfer/handoff ensures that both the patient and providers understand the next step in the patient journey before ending an interaction (i.e., transferring the patient to the next care provider on the telephone while the patient is on the line, assisting the patient with booking an appointment with the next care provider, etc.), and that the patient’s story follows them (i.e., does not need to be retold).

***Digital Navigation***

Digital navigator applications can complement traditional navigation services. They can provide one place for patients to find information about OHT programs and services and access their health information, among other helpful features. However, on their own, digital navigational applications are not considered a comprehensive 24/7 navigation service because they do not yet support a needs assessment or warm transfers.

In the fall of 2022, following an assessment of the synergies between the Multitenant Navigator (MTN) and Health Connect Ontario (HCO) by OH and an external consultant (the assessment took into consideration business requirements, vendor capabilities, costs, and timelines), and subsequent OH MTN-HCO steering committee recommendations, MOH has indicated their support for leveraging HCO as the provincial platform to surface OHT content and services, as well as OHT portal integration needs and access to the provincial patient data viewer. The extensive OH and OHT work, feedback, and requirements to date that informed the MTN initiative will be incorporated into the HCO implementation. Ontario Health will work with OHTs to onboard to the HCO platform, which will allow for patients to be served local-level content and service information, as well as access to their digital health data.

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 1:** Implement patient navigation supports and report on patient utilization[[1]](#footnote-2). | **Green - Progressing Well** |
| 1. Does your OHT have a 24/7 patient navigation plan in place? | Yes  No |
| 1. Has your OHT implemented any 24/7 patient navigation related supports or improvements for your attributed population? | Yes  No |
| 1. Does your OHT have any existing plans in place to measure these improvements?   If yes, please describe (below) the approach to evaluation, including any metrics and indicators. | Yes  No |
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| **Updates – Patient Portals**  In the Fall of 2022, the decision was made by OH with the support of the MOH to leverage Health Connect Ontario as the provincial platform to surface OHT content and services, as well as OHT portal integration needs and access to a provincial patient data viewer. HCO will act as the digital front door for patients, leveraging provincial digital identity standards and streamlining access to their provincial health data and services, including the provincial patient viewer. Ontario Health is in the process of procuring a provincial clinical viewer for patients and providers to view electronic health data.  In light of this new direction:   * Cohort 1 OHTs are **not** required to include a plan or progress update in their Mid-Year Report related to patient portals. * OHTs should not invest in procuring net-new or further expansion of existing patient portals (as it relates to the access to patient health data) at this time. * Further detail will be shared in the coming months as the procurement process wraps up and a vendor for the viewers is finalized. | |
|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 2:** Develop and implement a patient portal that gives patients access to their health information. | **​N/A - Not Yet Started ​** |
| ***Note: Cohort 1 OHTs are not required to report on this deliverable at this time.*** | |
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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 3:** Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings. | **N/A - Not Yet Started** |
| 1. Has your OHT advanced access to OAB to additional primary care settings? | Yes  No |
| 1. If yes, please describe the approach taken and the number of additional providers now offering OAB. | |
| The CW OHT reached out to additional providers in the catchment area offering support implementing OAB in their clinics. The interested clinics and providers were provided information on the nature of support towards implementation and marketing to offer OAB at their clinics.  The onboarding champions and clinical champions were identified who were instrumental in taking forward the process. An initial orientation session was organized to explain the process, including but not limited to; vendor onboarding, EMR integration, data reporting, license fee re-imbursement and marketing support.  This year, there are 10 new providers offering OAB, as a result of the support from the CW OHT.  To date, the CW OHT supported a total of 108 providers in implementing OAB. The total providers with OAB by year end is expected to reach 127. | |

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 4:** Report on enhancing virtual care maturity and access. | **Green - Progressing Well** |
| 1. Has your OHT completed a virtual care assessment (of your members)? | Yes  No |
| 1. Has your OHT developed a virtual care plan based on this assessment? | Yes  No |
| 1. If yes to the above (b), please describe the virtual care plan. | |
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|  | **Self-reported progress** |
| **OPTIONAL:** Has your OHT made progress on any other digital or virtual care priorities, including activities related to data governance and privacy, including expanding/revising your existing Harmonized Information Management Plan? | Yes  No |
| 1. If yes, please describe. | |
| The CW OHT has made efforts to mature our policies and process capabilities. In May 2022, eight Health Information Custodian (HIC) organizations have gone through a pilot privacy and security self-assessment ensuring each group had policies and processes in place. This was done with the intention of confirming the group meets the limited capability designation (as per the Canadian Institute for Health Information (CIHI) maturity model). Additional phases and Collaboration Council approval are required prior to continuing this effort.  There has been work completed on developing a data sharing agreement (DSA) to use with CW OHT collaborative projects. The most appropriate approach is to build a Master DSA that all OHT participants sign which identifies the purposes of data sharing, roles and responsibilities, as well as how data sharing may work when a specific project/initiative is undertaken. Data sharing initiatives will be defined on a project basis where a specific DSA will be executed amongst participating OHT members. A number of DSA templates are being developed that can be utilized by OHT partners, where data sharing may include any of the following: EMR Access, agency agreements, and/or support for de-identifying sensitive information. Next steps include developing a data sharing checklist as a general reference to partner organizations. As this work continues, it is anticipated that a finalized set of templates and governance documents will be available by the end of this fiscal year.  Finally, William Osler Health System has been in the process of preparing a request for proposal (RFP) to be released in the first quarter of 2023 for the modernization of their health information system (HIS). As certain modules of an HIS may be of benefit to OHT members, e.g. Ambulatory Care Module, Patient Portal and Population Health Management Tools, they have given members of the OHT the option to be named parties in the RFP, and in the resulting supply contract. The understanding is that OHT members may adopt the system on their own preferred time horizon, of their own choosing, as their budgets and capacity permits when and if they choose to do so. To date, eight members of the OHT have indicated interest in being included in the HIS RFP as optional entities (these names have been listed below).   1. Canadian Mental Health Association Peel Dufferin 2. CANES Community Care 3. Etobicoke Supports for Seniors 4. Home and Community Care Support Services Central West 5. Peel Senior Link 6. Queen Square Family Health Team 7. Region of Peel 8. Wellfort Community Health Services | |

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# Priority Area 3: Collaborative Leadership, Decision-Making and Governance

In November 2022, the Ministry of Health announced that OHTs will be expected to form not-for-profit corporations for the purpose of managing and coordinating OHT activities to support the future state vision of integrated clinical and fiscal accountability. In addition, the ministry announced new groups that must be included in decision-making structures. The ministry advised OHTs to wait for more guidance and support before incorporating.

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 1:** Implement an enhanced governance model and processes that align with provincial direction. | **N/A - Not Yet Started** |
| ***Note: Cohort 1 OHTs are not required to report on this deliverable on this time.*** | |
| **OPTIONAL: Membership Self Assessment**  Which of the following groups are currently involved in your OHT’s collaborative decision-making? | |
| Primary care providers  Home and community care providers  Community care providers  Public Hospitals  Mental Health and Addictions providers  Patients, Families, and Caregivers  Physicians and other Clinicians  French-language Service providers  High priority Community Lead agencies  Indigenous-led Service providers  Long-Term Care Homes  Municipalities  Emergency Health Services & Community Paramedicine providers  Public Health Units  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. **OPTIONAL:** Identify any key issues your OHT would like to see addressed in the forthcoming guidance on OHT governance, membership and operational capacity for consideration. | |
| The CW OHT would appreciate receiving additional clarity regarding timelines for formalizing OHT governance structures. | |

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 2:** Report on progress implementing Patient, Family and Caregiver Strategy. | **Green - Progressing Well** |
| 1. Has your OHT implemented the planned engagement approaches as outlined in your Patient, Family and Caregiver Strategy? | Yes  No |
| 1. Identify the equity-deserving populations that have been represented and engaged through your clinical improvement work (this may include, but is not limited to, First Nation, Inuit, Métis, urban Indigenous, racialized and Francophone populations). | |
| The CW OHT has collaborated with organizations that support racialized populations within the catchment area such as Punjabi Community Health Services, Indus Community Services and Roots Community Services as well as a High Priority Community Strategy with these two organizations and Rexdale and Wellfort CHCs. Engagement with these community organizations has provided an enhanced lens on certain vulnerable populations as it relates to OHT projects. Specific populations include South Asian, Indigenous, Francophone and Black communities.    We have used the HEIA for supporting William Osler Health System (Osler) projects like the Virtual Urgent Care Clinic, Remote Care Management (respiratory illness) and for Osler and CANES combined proposals to reduce ALC pressures by creating transitional care for patients with behavioral issues who no longer need acute care. Home-based primary Care program has constantly engaged with Older Adults to co-design the program to support them. Additionally, the CW OHT has used the Health Equity Impact Assessment (HEIA) on multiple occasions to identify how certain change-ideas will impact certain vulnerable populations (highlighted above). | |

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# Priority Area 4: Primary Care Engagement and Leadership

In November 2022, the Ministry of Health confirmed that the ministry and Ontario Health will work to support greater primary care involvement in OHTs, including more consistency in how they are involved in OHT decision-making. Additional guidance is forthcoming.

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|  | **Self-reported progress**  (select from drop down) |
| **Deliverable 1:** Implement a model and process(es) to enable primary care providers to have a collective voice in OHT activities and at OH tables. | **Green - Progressing Well** |
| 1. Does your OHT have a primary care network, physician association or similar structure in place? | Yes  No |
| 1. Identify which (if any) engagement/governance models your OHT is implementing (e.g., primary care network, physician association) to engage and connect all providers in the OHT by selecting from the drop down. Other structures may exist that include small numbers of primary care representatives (i.e., advisory groups).   If your OHT has an existing or planned model for primary care engagement or governance, please describe the membership, structure and functions of this group. | |
| **Primary Care Network operational**    If other, please describe. | |
| 1. Does your OHT have a primary care strategy or plan with defined priorities? If yes, please provide a link or attach the strategy to your submission. | Yes  No |
| 1. Describe any other achievements related to this deliverable for the reporting period. | |
| The Community Medical Advisory Committee (CMAC) held their first in-person event for the broader physician network. This event included a well-known physician wellness speaker, Dr. Mamta Gautam, a solutions-based engagement session to address systemic issues related to provider burnout and an outreach opportunity for organizations and initiatives such as Toronto Metropolitan University, SCOPE and the Canadian Mental Health Association. Additionally, the CMAC held their first election, adding two new members. | |

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|  | **Self-reported progress** (select from drop down) |
| **Deliverable 2:** Implement a plan to connect additional primary care providers and clinicians to the OHT. | **Green - Progressing Well** |
| 1. Has your OHT connected additional primary care providers and clinicians to the OHT during the reporting period? | Yes  No |
| 1. If yes, please describe the approach and outcome. | |
| During the reporting period, the CW OHT completed mailers for unconnected physicians. The CW OHT also held its first physician network event. Next steps include a move towards more in-person events with an increase in targeted messaging. Additionally, a dedicated resource for door-to-door visits as well as operationalizing sign up as physicians join partner organizations are in the planning phase.  These tactics have seen an increase from 161 providers at the end of FY21/22 to 186 as of Q2 FY22/23. | |

# Priority Area 5: COVID-19 Response and Recovery

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| **Deliverable 1:** Implement a plan for COVID-19 response and recovery in alignment with provincial direction. | **N/A - Not Yet Started** |
| 1. Has your OHT collaborated with your local Public Health Unit(s) to coordinate the administration of COVID-19 and flu vaccines? | Yes  No |
| 1. If yes, please describe the approach taken to collaborate with local Public Health Unit(s), along with any other achievements related to this deliverable. | |
| The CW OHT crosses 3 public health regions – Toronto, York and Peel.  Toronto:   * Participated in OH Toronto integrated offerings table and liaised with OH to provide information about vaccine clinics available in north Etobicoke. * Supported Rexdale CHC with vaccine efforts, as required.   Peel:   * Participated in touch base meetings led by Region of Peel to support COVID -19 efforts (vaccine and assessments). * Gathered feedback from CW OHT physicians regarding COVID-19 vaccines in office to support vaccine planning.   York Region:   * Share and disseminate information about COVID-19 related initiatives by remaining active on newsletters and email distribution lists.   Many primary care providers are offering flu shots and there are providers offering COVID-19 vaccines in office as well. Otherwise, we are in frequent contact with Public Health units/partners to support as required. | |

# Support Requests

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| Customer review with solid fillWhat supports and/or resources would help you with completion of your deliverables? |
| * Sustainable funding for backbone supports, primary care engagement, and broader community/PFAC engagement * Legal support for DSAs and formal partnership agreements when implementing joint clinical/community programs * Ability to triangulate data from multiple sectors to stratify population and ensure programs are meeting health needs * Detailed primary care data that captures solo, fee-for-service and walk-in providers in our catchment area in addition to Patient Enrollment Models, to ensure targeted and effective primary care outreach * Continued funding for implementation of Online Appointment Booking for primary care * Funding (and spending flexibility) to implement integrated care services including home-based primary care program and OHT navigation deliverables |

**PART THREE: TPA PERFORMANCE INDICATOR REPORTING**

Please use the template shared with you for the Mid-Year Report and complete column G “Mid-Year Report” and J “Mid-Year Report.”

1. **Note:** Cohort 1 OHTs are **NO LONGER REQUIRED** to report on patient utilization as part of this TPA deliverable. Teams can instead consider reporting on patient experience. [↑](#footnote-ref-2)