Western Ontario Health Team (WOHT)

Activities during October 2020

Acknowledging new Council members

The Council welcomed Dr. Vineet Nair, family physician and interim primary care representative.

Chronic COVID Management

- COVID-19 Remote Patient Monitoring:
  - Application for Ontario Health funding to support implementation of Vivify app to allow for remote patient monitoring and create an integrated care pathway for patients with COVID-19 diagnosis. It will integrate into LHSC EMR and assist with communication with primary care providers.
  - Note: Ontario Health funding is only for 6 months but Remote Patient Monitoring will require ongoing funding. Options aren't entirely clear – discussions ongoing with Ontario Health West.
  - Community implementation will continue.
  - Pathway will continue to be built and be functional.

Year 1 Population Work (People with Advanced COPD and CHF)

- Recruiting a Patient/Client Caregiver Partner to join the Year 1 Target Population work group to provide leadership and valuable perspective.
- Supported by Best Care team members, Drs. Christopher Licskai and Robert McKelvie are facilitating a clinical sub-group that is developing a guidance document outlining the current health ecosystem that exists within the WOHT. This guidance document will support Western OHT health system integration by assisting working group members to:
  - manage the complexity of our health system
  - create a common understanding of current health system
  - foster system-based thinking and collaboration,
- In parallel to the patient care pathway work, a co-design process will provide opportunity for health service providers and patient caregiver partners to review proposed changes and define goals and the work to be accomplished in year 1.

Digital Health

Virtual Care Funding

Coordinating Council considered two virtual care proposals:

1. Virtual care urgent services – goals are to:
   a. allow patients to access virtual care for lower acuity issues within a specific time period to avoid unnecessary ED visit
   b. facilitate in person ED visits as needed
   c. support continuity of care through a 'warm handover'.
2. Surgical transition virtual care – goals are to:
   a. ensure patients receive optimal care before surgery and to monitor their recovery to ensure best care

b. leverage transition solutions to augment preoperative care, shorten hospital stay, reduce risk of complications, reduce in person office visits, ED visits and reduce re-admission risk.
c. Implement surgical transitional models to address hospital capacity and surge challenges related to virtual care.

Discussion points:

- Proposal shouldn't necessarily be vendor-specific.
- Terms of proposal includes collaboration and collaboration across sectors. Hamilton has already launched the same service, so the team can learn from them.
- Key stakeholders: primary care, mental health and addictions.
- Important to bring health equity lens into any development work – consider infrastructure and equipment for all populations, e.g., phone.
- Suggestion: add project to existing working group, e.g., COVID-19 Remote Patient Monitoring project as there are common elements.
- Question: What are we going to stop doing or what have we stopped doing to allow capacity for this?

Consensus to proceed to develop Virtual Urgent Care Services proposal. The plan will come to the next Coordinating Council meeting for discussion.

Generative Discussion on Digital Health

Coordinating Council also considered the overall topic of digital health (e.g., what we know/don't know). The discussion identified the following:

Barriers

- Connectivity, e.g., spotty wifi.
- Technical literacy, e.g., too many platforms for patients/providers to learn.
- Patients who do not have access to technology.
- Patient privacy issues with virtual care – too many people at home.
- Ability to use virtual tool depends on access AND ability/willingness to change.
- Facilitation of change and making it easier for people.
- Aligning transitions and communication between silos.
- Equally important to recognize inequity for in person visits as well (availability, parking or transport, child care).

What can we do to align the provider side to enable a better experience for patients?

- Centralized access for communication, similar to centralized referral.
- Push information to providers vs. having providers having to log into portal to get it.
- Testing multiple technologies in different areas within a sector can be confusing -- vendors make it easy for providers to adopt technologies but don't speak to all sectors involved before marketing to one sector. This can create pressures in other parts of system. A higher level view is required for integration.
- Digital is a great enabler but we need to think about care processes and what is the best modality for the patient. Sometimes picking up the phone is the best.
- Multiple ways to communicate with patients are needed - phone, email, text, portal, etc.
- Main barrier is providers/caregivers not having complete information when needed. If we can help with that, the patient experience will improve.

- Patient facing modality – use one tool so we people only have to learn one. Provider should adapt, not patient.
- Common process that we all are accountable to follow.

What environmental factors enable or disable our ability to collaborate?

- Disable:
    - Cost
    - Ease of use/integration
    - Technology linked to organization because we own it/spent money on it;
- Enable:
    - Technology owned by everyone -- take a community/common lens to selection/ purchasing.
    - How? Look at purchase from population benefit perspective. How can the population benefit yet allow the organizations to meet their obligations?

What are tangible steps WOHT can take?

Example: data sharing agreement (DSA) across all sectors

- This requires a governance structure in all clusters as well as the same level privacy and cybersecurity understanding and implementation throughout the data chain through all clusters/computers
- Who is responsible when communication breakdown (not data breach) culminates in adverse events?
- We need to balance the risks of sharing data with the risks of not sharing data. Cyberattacks can and do happen in the absence of data sharing.
- We are all accountable for lack of communication. We can sort out clinical processes that do not add technological risk.
- The lack of communication is more about process and behavioural change – change management would result in a data sharing agreement (DSA). We are all healthcare data custodians. We are in it together.
- System approach would encourage adherence to best practice which can prevent cyberattacks.
- Is it reasonable to find a solution across all our sectors given obligations and products that we are already using? Wonder how we overcome the barriers we all have to ensure that all these products - CHRIS, Cerner, primary care EMRs, other - allow sharing of information? Data sharing agreements as talking about but also on level of these companies allowing access to the data within these products.
- Suggestion: use decision matrix, get consensus on what the problem is, then get consensus what technology is needed to resolve the problem.

Can we use savings to re-deploy elsewhere to accomplish goals?

- Differentiate between cost savings and cost avoidance.
- Need to start thinking in terms of cost savings, however.
- What other measures of success we can look at rather than just financial? Example: freeing up beds to decrease wait times when our hospitals are typically full.

Coordinating Council will review proposal for home and community care funding for patients. Council was asked to look at proposal with community lens – re-imagining how home and community care could be provided. Proposal is due November 9 and there is a possibility of submitting a multi-OHT proposal.

Discussion re: multiple funding proposals coming to Coordinating Council for review:

- Suggestion: look at funding proposals with year 1 population lens, i.e., stream funding into outcomes WOHT is trying to achieve.
- Also need to look at ahead to years 2-5; what we put in place for year 1 population group needs to be applicable to other population groups.
- Need to be cognizant that most funding is short term so doesn't allow for funding initiatives on an ongoing basis
- Questions:
    - No clear cut pathway for receiving or disseminating proposals; call for proposals may only go to certain people because they're known or on a mailing list
    - Funding opportunities come from different ministries – how do we link different ministries?
    - People within WOHT vying for same dollars – how do we link them together vs competing?

Consensus that for now funding proposals will be distributed to Coordinating Council to share with colleagues. In future, this will require a cultural shift – a system funding model as we evolve vs. a sector/organization funding model.

WOHT Governance

- OHT Lead recruitment is ongoing – interviews scheduled first week of November. Co-chair Linda Crossley-Hauch is leading this process.
- Foundational governance structure:
    - Member categories
        - proposing change in categories to health organization vs. community organization (includes different populations, e.g., Francophone community)
        - all of primary care would be one cluster with three representatives – one from a primary care organization and two primary care providers.
    - Ensure Francophone input to in Coordinating Council and Patient and Caregiver Council: consensus to advance recommendations on linking with francophone community.
    - Discussion about using phrase "quadruple aim" vs. "quintuple aim". Governance working group will look at this again.
    - Dispute resolution process will be developed in a separate process.
    - Discussion about how to connect with other sectors, e.g., child and youth mental health; children and adolescents general health care, non-LHIN funded services, community specialists, midwives, Regional Integration Table for women and children's health, etc. To consider:
        - include them when their attributed patient population is involved.
        - reach out to them and see how they see themselves having a voice to CC
        - look at who's missing from a specific cluster vs who's missing from Coordinating Council
    - Maturity principle – WOHT will look different in future as it evolves and that will inform what clusters and Coordinating Council look like.
    - As we serve populations that will require service across all sectors/clusters, WOHT needs to ensure that there is good representation of the provider groups needed to care for that population at Coordinating Council and working groups.
    - Next steps:

- All Coordinating Council members to take back finalized governance documents to their clusters for a final read.
- Adopt this governance framework by consensus at November 12 Coordinating Council meeting.

WOHT Funding

- Awaiting funding letter from the Ministry of Health.
- Recent memo from Ontario Health West indicated some rising priorities for funding. The OHT lead will be accountable for delivering a plan for approval that balances those priorities.
- Member funded contributions: using RISE fund-sharing agreement template with organizations who have volunteered to fund the OHT. This fund-sharing agreement will define the level of accountability between Thames Valley Family Health Team and collaborating partners until such time as foundational governance and collaborative agreement work is done.

Communication with patients, stakeholders and public

- Members will distribute this monthly update widely through their sectors/clusters
- Some initial discussions about a communications strategy for WOHT in advance of OHT Lead hiring. A communication strategy will support an overall WOHT implementation strategy.

Coming in November 2020

- Long term plan for London COVID-19 Assessment Centres
- Recruitment of core OHT operations roles (OHT lead, project management support, admin support)
- Virtual Urgent Care Services proposal
- Proposal for home and community care funding for patients

Coordinating Council	Secretariat
Linda Crossley–Hauch – Co-Chair Michael McMahon – Co-Chair	Nancy DoolKontio Janet Dang Patricia Hoffer Matthew Meyer Daniel Pepe Shannon Sibbald Drina Silva Susan Vollbrecht Katey Young
Linda Sibley, Addictions Alternate: Beth Mitchell, Mental Health	
Judi Fisher, CSS Alternate: Carol Walters, CSS	
Vineet Nair, Primary Care Gord Schacter, Primary Care	
Scott Courtice, Primary Care Organization Alternate: Gail McMahon	
Daryl Nancekivell, Home & Community Care	
Gillian Kernaghan and Paul Woods, Hospital Alternate: Todd Stepaniuk	
Neal Roberts, EMS	
Anna Foat, Patient/Caregiver Louise Milligan, Patient/Caregiver	
TBD, Long Term Care	
Chris Mackie, Public Health	
Joe Antone, Indigenous Health	
Craig Cooper, City of London	
Bill Rayburn, County of Middlesex	