Ontario Health Team (OHT) Name:	Middlesex London OHT
Transfer Payment Recipient (TPR) Name:	Thames Valley Family Health Team
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?

In 2020/2021, the Middlesex London OHT established a governance structure, vision and values that has served as a foundation for building and strengthening partnerships and trust across our OHT.

Throughout 2021/2022, our OHT has honoured its commitment to co-design:

- established a co-design process, including an equity matrix to ensure all voices are heard
- interviewed patients, clients, care partners and providers across the healthcare system
- brought patients, clients, care partners and providers together to validate the findings and prioritize the resulting themes (via large co-design events)
- secured project funding and established projects that align with the prioritized themes
- co-designed and co-developed project deliverables.

The Middlesex OHT applied for and was awarded Test of Change funding for an ambitious proposal to implement a shared care record via health information exchange and develop an Attributed Population Registry.These proof-of-concept projects are aimed at bringing Population Health Management to life in Ontario, with the potential to significantly improve equitable access to care, health system integration, transitions and coordination of care.

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

Co-Design

The Middlesex London OHT is committed to applying a co-design and engagement approach across all areas of work aimed at health system transformation.

Through building and sustaining relationships with local patients/clients, care partners, providers, and health system administrators, a co-design process is being used to collect individuals' experiences, and co-design and implement system improvement strategies. Q1 focused on setting up an effective co-design process with effective recruitment strategies, equity matrix to ensure diversity of voices being heard and interview guides. Q2 focused on completing discovery interviews with patients/clients, care partners and providers to understand current health system experiences and opportunities for change.

In Q3, MLOHT hosted 2 large co-design sessions, where we worked with patients/clients, care partners and providers to validate and prioritize identified challenges (themes that emerged from our discovery phase). Participants (patients, care partners, providers, and health system administrators) in the co-design sessions (n= 46) prioritized the following themes as areas where the MLOHT should focus their efforts:

- Access to and Awareness of Services
- Sustained Care Relationships

Q4 focused on embedding these co-design themes in project work to help co-develop solutions to the identified challenges. Project funding was secured, and projects were initiated that align with the co-design themes and further co-design of project deliverables was incorporated into the project plans (e.g., care pathways, self-management website, shared care record, attributed population registry, navigation services, referral management). Project planning and execution included multiple co-design sessions where project deliverables such as the self-management website and general eReferral templates were co-design and co-developed.

We have created a document that summarizes our co-design processes and lessons learned.

Consolidated Self-Management Website

There are multiple self-management programs and associated websites offering in-person and virtual workshops across the West region, but they operate independently.

To improve access to and awareness of self-management programs, Middlesex London OHT received Integrated Virtual Care funding to develop a consolidated Self-Management Website. This website consolidates information on self-management workshops from 4 sub-regions (South West Self-Management, Waterloo Wellington Self-Management, Erie-St Clair Self-Management, Hamilton Niagara Haldimand Brant Self-Management).

- The website design, name and functionality were co-designed with patients, clients, care partners and providers.
- The website back-end was co-designed with regional self-management staff that will be responsible for maintaining up-to-date website content.
- The Marketing & Communication plan was developed with input from patients, clients, care partners, providers and staff
- The Sustainability plan was co-designed with regional self-management staff and Ontario Health West.
- The website, named "Self-Management Programs Network", was successfully launched on March 31st 2022: https://selfmanagementprograms.ca/

Improving Equitable Access to Vaccine

As a partnership with the Middlesex London Health Unit, the London Middlesex Primary Care Alliance, Cross Cultural Learner Centre, the London Intercommunity Health Centre, the Middlesex London Ontario Health Team, Northbrae Public School, London Muslim Mosque, and Hindu Cultural Centre, we supported 3 first-dose, 3 second-dose and 1 third dose/children's cultural community COVID vaccine clinics. These clinics were focused on improving access to the vaccine for people experiencing barriers to vaccine (e.g., newcomers, refugees, refugee claimants, people whose language of comfort is not English, people without a health card). Over 2400 people were vaccinated across these 7 clinics.

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

Referral Management

Through our co-design interviews, in alignment with the Access and Awareness of Services theme, we heard referrals are an administrative burden to healthcare providers. We heard the lack of transparency of referral wait times and limited specialist choices are barriers to care for patients.

The Referral Management Project was launched to:

- Develop a standardized referral form to simplify workflow
- Use eFax functionality to facilitate transition of Primary Care Providers and Specialists to eReferrals
- Improve interprofessional communication by reducing administrative workload associated with referrals

This project is co-led by Middlesex London OHT and the London Middlesex Primary Care Alliance (LMPCA) and includes a close collaboration with the eHealth Centre for Excellence (eCE). This project was successful in securing Central Waitlist Management funding.

Phase 1 deliverable focused on developing a standardized eReferral template. This template will support e-referrals/e-fax to specialists that don't have a referral form on the Ocean eReferral platform. This form will also become the standard specialists can build their referral form from when onboarding to Ocean eReferral.

To develop the generic eReferral template:

- Scoping review was partially completed to understand how the literature describes a "quality" referral
- Review was completed of 150 referral forms to characterize what receiving providers typically want in a referral form
- Standard eReferral template was co-designed with 27 providers (a mix of primary care providers, Specialists, and other system administrators)

Phase 2 is still in progress and focuses on testing the new eFax functionality to support the transitioning to eReferrals. eFax will enable primary care providers to send more referrals through eReferral regardless of specialist registration. Specialist referral responses will be automatically read by Ocean eReferral platform to update online referral acceptance and booking information.

To support the eFax proof of concept:

- 56 surgical specialists were identified as high-volume receivers in the Middlesex London region. Their information, fax number and specialty details are updated in Ocean
- Two primary care physicians were identified by LMPCA, that will complete the initial testing of eFax
- An internal Directory of Specialists in Middlesex London Region was created and their information in Ocean updated.
- Recruitment of primary care providers to onboard to Ocean eReferral and join the eFax Proof of Concept is ongoing.

N95 Mask Fit Testing

We know a fit-tested N95 mask is important to keeping our healthcare providers safe. In response to an identified need, MLOHT hosted eight N95 mask fit-testing clinics in January & early February, testing over 100 community-based healthcare providers.

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?

We are grateful to and dependent on partners contributing human resources/time formally and informally, as demonstrated by the following examples:

- Coordinating Council members dedicate significant time preparing for and actively participating in monthly meetings
- Cluster tables (e.g., London Middlesex Community Support Services Network, London Middlesex LTCH FLAG, London Middlesex Addiction and Mental Health Network) dedicate time on their agendas to discuss OHT priorities to inform directions/upcoming decisions
- Patient, Client, Care Partner Council members actively participate in additional OHT work outside of their designated meetings (e.g., OHT Operations Team interviews)
- Health representatives from each of the three local First Nation communities meet with OHT leadership monthly and participate in additional meetings, to accelerate ongoing work in partnership
- London Middlesex Primary Care Alliance (LMPCA) Executive dedicate time on their agendas to discuss OHT priorities to inform directions/upcoming decisions
- Working Group/Project Team members prepare for and actively participate in meetings and complete work between meetings to advance OHT priorities
    - Our Governance Working Group is led by and supported administratively, in-kind, by a community organization
- Multiple MLOHT Operations Team members participate in-kind, thanks to support by their host organizations:
    - 0.2 FTE Co-Design Lead
    - 0.6 FTE Population Health Lead
    - 0.5 FTE Care Pathway Lead
    - 0.2 FTE Strategic Support
    - 0.8 FTE Project Consultant – Digital Health
    - 0.2 FTE Administrative Assistant
    - 0.1 FTE Quality & Analytics Co-Leads (x2)
- Partners within our OHT and across OHTs have contributed to joint funding proposals and resultant work (e.g., Test of Change, CHF QBP Funding)
- Integrated Care Pathway early adopter partners are committed to supporting implementation with some in-kind contributions
- Partners within our OHT and across OHTs have collaborated to advocated for sustainable funding for key programs (e.g., MINT, Best Care)

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	In the SW sub-region, each OHT geography has an existing triad of COVID response support that includes representatives from primary care, hospital and long-term care and meets bi-weekly to weekly; in Middlesex London, the triad meets with the Middlesex London Health Unit, Home and Community Care Support Services, Ontario Health, and the MLOHT Lead. This triad also attends the MLOHT Coordinating Council meetings to ensure that the members of the MLOHT are aware of the ongoing COVID response, current metrics, and the recovery process. MLOHT will continue to actively engage in the response and recovery in Middlesex London and across the South West through its participation in the existing response and recovery structures. MLOHT participated in bi-weekly meetings with the Middlesex London Health Unit and London Primary Care Alliance to stay aligned in COVID-19 response and offer support where needed. Provided administrative support to these meetings since January 2022. Supported the MLHU by distributing through our communication channels, calls for clinical staff and vaccinators to expand the capacity of their mass vaccination sites. Distributed a call for volunteers (including MLOHT staff) to serve as navigators at mass vaccination sites. Partnered to plan and execute cultural community COVID Vaccine clinics (see detail previously/below)
Supporting long-term care homes	
Supporting other congregate care settings	
Acquiring and distributing PPE	In response to an identified need, MLOHT provided N95 mask fit testing for over 100 community-based staff across the healthcare system.
Infection prevention and control	

Implementation of virtual care supports	The MLOHT financially supported a primary care representative to re-engage with the London Middlesex COVID Response Triad and the South West Covid Response/Recovery table and resultant work. His work to date has included: Development and communication of a pediatric COVID care pathway, ongoing communication with peers regarding remote care management, planning and implementation of the COVID Clinical Assessment Centre, and planning and implementation of Paxlovid administration. MLOHT Operations Team members also supported care pathways and planning for our regional remote care monitoring programs (delivered through LHSC's London Urgent COVID-19 Clinic and HCCSS Remote Patient Monitoring).
COVID-19 testing	The MLOHT supported planning and process changes for the expansion of one of our COVID Assessment Centres to become a COVID Clinical Assessment Centre (CAC) and continues to support ongoing process changes. MLOHT has also supported CAC communications to regional partners.

Supporting vulnerable populations or communities disproportionately affected by COVID-19 (e.g., through collaboration with a lead agency under the High Priority Communities Strategy)	As a partnership with Middlesex London Health Unit, the London Middlesex Primary Care Alliance, Cross Cultural Learner Centre, the London Intercommunity Health Centre, the Middlesex London Ontario Health Team, Northbrae Public School, London Muslim Mosque, and Hindu Cultural Centre, we supported 3 first-dose, 3 second-dose and 1 third dose/children's cultural community COVID vaccine clinics. These clinics were focused on improving access to the vaccine for people experiencing barriers to vaccine (e.g., newcomers, refugees, refugee claimants, people whose language of comfort is not English, people without a health card). These clinics were hosted in their communities, supported by their cultural community members/leaders to improve access to the COVID vaccine for people who may not be able to or be comfortable accessing the vaccine through mass vaccination clinics. Over 2400 people were vaccinated across these 7 clinics. Key success factors included: active 'reach out' from trusted community members to book appointments by phone; availability of walk-in appointments, in addition to booked appointments; in-person interpretation support, active participation of cultural community members/leaders at the clinics (e.g., volunteer greeters, navigators); ability of family members to experience the full vaccination process together; reliance on community members to determine how to best promote the clinics (e.g., community Facebook posts, posters in targeted businesses/housing areas); locating clinics in familiar/welcoming environments; staffing the clinics with health care professionals and volunteers from the community; tremendous dedication and work effort of the Vaccination Task Force Group who started meeting in March 2021. Over the course of the clinics, we developed a 'clinic in a box', that can be tailored for future clinics. The Middlesex London OHT applied for and was awarded Alliance for Healthier Communities funding to improve equitable access to the COVID-19 vaccine: • Selected an on-demand virtual interpretation application and made it available to primary care providers to support vaccine discussions and delivery • Provided 600 adult bus tickets and 650 children's fobs to Vaccination Clinics, primary care providers, and community resource centres to distribute to people needing support in accessing the COVID-19 vaccine.

	In response to a need identified by our community partners, developed handouts, social media posts and voiceover of Q&A webinar in Nepali and Arabic to promote children's COVID-19 vaccination
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.
Supporting our partners throughout COVID-19 response and recovery has been a tremendous opportunity to establish/strengthen relationships across the healthcare sector and community and build trust across our OHT. The urgency of the pandemic response has proven to be an opportunity for innovation, integration, and remaining nimble and health equity-focused. For example, MLOHT was instrumental in ensuring equitable access to COVID remote patient monitoring across our region, including urban and rural geographies. We are optimistic that regular connections established to respond to COVID-19 in our community will be sustained – for example, the Middlesex London Health Unit, the London Middlesex Primary Care Alliance, and the MLOHT are discussing the possible evolution of regular meetings to discuss COVID vaccination into regular meetings to discuss/address shared priorities beyond the pandemic.

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.

Co-Design Themes

The Middlesex London OHT is committed to applying a co-design and engagement approach across all areas of work aimed at health system transformation. Through relationships with local patients/clients, care partners, providers, and health system administrators, a co-design process is being used to collect individuals' experiences, and co-design and implement system improvement strategies. Co-design participants prioritized the following themes as areas where the MLOHT should focus their efforts:

- Access to and Awareness of Services: *Patients and care partners are not regularly being referred to available community supports and programs. Providers have difficulty keeping track of all available services and programs in our community.*
- Sustained Care Relationships: *Patients, care partners, and providers talked about the importance of establishing strong care relationships as patients move through the system.*

Projects were launched that align with the prioritized co-design themes:

Access to and Awareness of Services

Healthcare Navigation Services OHT 24/7 navigation
Referral Management
Consolidated Self-Management Website
Mental Health & Addictions Support for Trauma in First Nation Communities

Sustained Care Relationships

COPD & CHF Care Pathways
Attributed Population Registry
Shared Care Records via Health Information Exchange

COPD & CHF Care Pathway

Through co-design interviews, we heard of a need for greater clarity on patient care pathways and models of care. The purpose of this project is to design and implement health pathways for patients with COPD and/or CHF to support:

- Equitable access to care – agreement on, communication of, and ensuring access to 'always for everyone' events
- System-wide integrated care pathway design – wholistic, coordinated care

- Capacity planning – the right support at the right time provided by the right resource for our full population

The pathway was developed by combining information from the Health Ecosystem mapping work, COPD/CHF best practice guidelines, Care Pathway Advisory Group and Working Group members and co-design participants. A Delphi survey and co-design approach was applied to obtain consensus on pathway activities. MLOHT is now actively working with key early adopter primary care sites to implement pathway changes, refine pathways through a PDSA approach, and evaluate impact. This will inform expansion to other sites across our region.

Attributed Population Registry

OHTs are intended to be accountable for primary and secondary care needs for their full attributed population (MLOHT = 525,829). However, we do not have individual-level information on this population.

The purpose of this project is to establish the foundation for Population Health Management by testing an Attributed Population Registry to enhance the digital health backbone that is currently lacking in Ontario. This project is supported by Test of Change funding and was initiated late 2021. To date, project has focused on developing a governance structure and establishing requirements. Successes include excellent engagement and working relationships established with working groups and the steering committee, and the Provincial Client Registry being identified as preferred solution. The project has engaged a number of OHTs across the province and is working to establish a solution that will work for all OHTs in time.

Shared Care Records via Health Information Exchange

Through co-design interviews, we heard accessing key health information across record systems is challenging.

The purpose of this project is to design and implement a Health Information Exchange (HIE) solution that would give providers access to information from other systems (e.g., Primary Care, Hospital, Home and Community Care) in real time, in the EMR of their choice, without the need for a separate login.

This project is supported by Test of Change funding and was initiated late 2021. To date, project has focused on developing a governance structure and establishing HIE requirements. Successes include excellent engagement (including physicians, other healthcare providers, patients and family care partners), working relationships established with working groups and the steering committee, HIE core requirements established, a detailed draft of functional/technical requirements, vendor partners identified and engagement of partners at Ontario Health to support alignment with provincial direction.

Healthcare Navigation Services

Through our co-design interviews, we heard patients and care partners are not regularly being referred to available community supports, and providers have difficulty maintaining awareness of available services.

The purpose of this project is to build a 24/7 navigation platform/model for patients, caregivers, and providers alike that will work in conjunction with the provincial Health Care Navigation Service (HCNS).

This project is supported by HCNS funding and was launched in late 2021. A Patient Navigation Planning Lead was hired to support MLOHT along with Elgin, Oxford and Area. We also partnered with Oxford and Elgin, respectively, in hiring a Primary Care Lead and most recently, a First Nations/Indigenous Lead to ensure appropriate focus on these two key stakeholder groups.

To date, project has focused on interviewing navigators and stakeholders across the healthcare and social system to:

- Understand how patients are being supported to get and find help to connect to services (e.g., Home and Community Care)
- Understand if patients or providers are using any existing directories to help patients navigate the system (e.g., Excel document, 211, thehealthline.ca, ConnexOntario)
- Develop an actionable implementation plan for a local 24/7 navigation supports model

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?

The MLOHT has developed a backbone infrastructure (Co-Design, Governance, Communications) that offers multiple levels at which patients, clients and care partners can engage. This includes the full spectrum of engagement from providing input (consulting) through surveys and interviews, to leadership and empowerment through participation on the Patient, Client Care Partner Council (PCCPC), Coordinating Council and Co-Design working groups.

MLOHT Governance

The MLOHT Governance is structured to empower the voice of patients, clients and care partners.
The PCCPC plays a key role in supporting patient/client and caregiver health system governance, accountability and stewardship towards achieving the aims of the MLOHT. PCCPC members are stewards for rights of patients and caregivers, are autonomous, and work in partnership with the Coordinating Council.
PCCPC is represented on the Coordinating Council as an equal voice (with an equal vote) and has a moral accountability to the attributed population of MLOHT. There are three members on the Coordinating Council: two voting and one non-voting (the non-voting member co-chairs the Coordinating Council).

Middlesex London OHT Patient, Family and Caregiver Partnership and Engagement Strategy

The Middlesex London OHT Patient, Family and Caregiver Partnership and Engagement Strategy was developed collaboratively by our Patient, Client, Care/Partner Council (PCCPC) and our Operations Team. This was an opportunity to reflect on our commitment to engaging with patients, clients and care partners in our planning, implementation and operations.

Co-Design

The Middlesex London OHT is committed to applying a co-design and engagement approach across all areas of work aimed at health system transformation.
Through new and sustained relationships with local patients/clients, care partners, providers, and health system administrators, a co-design process is being used to collect individuals' experiences, and co-design and implement system improvement strategies. Q1 focused on setting up an effective co-design process with effective recruitment strategies, equity matrix to ensure diversity of voices being heard and interview guides. Q2 focused on completing discovery interviews with patients/clients, care partners and providers to understand current health system experiences and opportunities for change.
In Q3, MLOHT hosted 2 large co-design sessions, where we worked with patients/clients, care partners and providers to co-design solutions for the identified challenges (themes that emerged from our discovery phase). At these sessions, the themes identified through discovery interviews were validated and prioritized. Participants in the co-design sessions (n= 46) prioritized the following themes as areas where the MLOHT should focus their efforts:

- Access to and Awareness of Services
- Sustained Care Relationships

Project funding was secured, and projects were initiated that align with the co-design themes and further co-design of project deliverables was incorporated into the project plans. Q4 project planning and execution included multiple co-design sessions where project deliverables such as the self-management website and general eReferral templates were co-design and co-developed with patients, clients, care partners and providers.

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

MLOHT Website
The MLOHT website (Home - Middlesex London OHT (mloht.ca)) was launched February 2022 and the Western OHT was re-branded as Middlesex London OHT. To ensure that the name and brand of the Middlesex London OHT resonates with our local community, the website and brand was developed in collaboration with patients, providers, communication specialists, and MLOHT operations team members.

MLOHT Newsletter
MLOHT monthly membership newsletter is circulated to all MLOHT members and interested stakeholders, a current mailing list of 222 contacts, and shared on the MLOHT website.

Co-Design
As noted in previous sections, MLOHT is committed to applying a co-design and engagement approach across all areas of work aimed at health system transformation. Through relationships with local patients/clients, care partners, providers, and health system administrators, a co-design process is being used to collect individuals' experiences, and co-design and implement system improvement strategies. Co-design to date has engaged the input and feedback from over 150 providers and health care administrators, and over 40 patients and care partners across our region.

MLOHT Team Lead Outreach
To ensure that the priorities and the work of the Middlesex London OHT are guided by and informed by the people in our community who need system improvements the most, we continue to engage with sectors, organizations, and individual partners across the Middlesex London geography to build understanding of our membership process and opportunities to get involved.

PCCPC Outreach
PCCPC has initiated a working group whose aim is to engage with patient & caregiver tables/committees/groups across Middlesex London to build awareness of the MLOHT and further strengthen community partnerships and the patient & caregiver voice.

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).

Co-design – Health Equity Matrix and Community Health Centre Partnership
We are committed to, and hold ourselves accountable to, authentically engaging people from various backgrounds and experiences to ensure we are building improvements that serve those who need them most. We recognize and respect the diversity of our community. We take our time, engage in hard work, and resist the status quo, to achieve a culturally appropriate health system that effectively reduces health disparities to become a truly equitable health care system. We developed a Health Equity Matrix to track and identify gaps in our engagement. To ensure the voices of people living our community who experience barriers to care are included in informing our OHT priorities, we supported the London InterCommunity Health Centre to lead Co-Design Discovery interviews with people who are marginalized (example, people experiencing homelessness, new immigrants, low-income families).

First Nations Engagement

We established meaningful partnership and regular meetings with the 3 local First Nation communities. MLOHT Leadership attended Oneida Nation of the Thames, Munsee-Delaware Nation, and Chippewas of the Thames First Nation Chief and Council meetings and received positive reception to the invitation for First Nations representation at the OHT Coordinating Council.
In alignment with endorsement of the First Nations Health Policy by Coordinating Council on June 24th, 2021, on February 24th, 2022, the Coordinating Council unanimously supported:

- Immediately expanding the Indigenous Communities representation model to include one representative from each local First Nation community - Oneida Nation of the Thames, Munsee-Delaware Nation, and Chippewas of the Thames First Nation (3 representatives).
- Including one Urban Indigenous Health cluster representative, should ongoing engagement with Indigenous health partners confirm this direction.

The MLOHT recently hired a First Nations/Indigenous Co-Design Lead that is supporting both the Healthcare Navigation project and co-design with First Nations. In alignment with key themes identified by health representatives across all 3 local First Nations communities, the co-design initiative will focus on co-defining and co-designing Mental Health and Addictions Support for Trauma, Virtual Care, and Health Care Navigation in First Nation communities.

MLOHT Website
The MLOHT website, re-naming and branding was developed in collaboration with the Francophone Community. The website is available in a French-Canadian translation, and has the ability to be translated into Arabic, Chinese, Dutch, French, German, Hebrew, Indonesian, Italian, Nepali, Polish, Portuguese, Punjabi, Russian and Spanish through a Google Translate integration.

Health Equity Evaluation
The MLOHT welcomed a MHA student to our Operations Team Meetings, PCCPC and Co-Design Working Group meetings to evaluate our patient and caregiver engagement from a health equity perspective.

Improving Equitable Access to Vaccine
As a partnership with Middlesex London Health Unit, the London Middlesex Primary Care Alliance, Cross Cultural Learner Centre, the London Intercommunity Health Centre, the Middlesex London Ontario Health Team, Northbrae Public School, London Muslim Mosque, and Hindu Cultural Centre, we supported 3 first-dose, 3 second-dose and 1 third dose/children's cultural community COVID vaccine clinics. These clinics were focused on improving access to the vaccine for people experiencing barriers to vaccine (e.g., newcomers, refugees, refugee claimants, people whose language of comfort is not English, people without a health card). Over 2400 people were vaccinated across these 7 clinics.

The MLOHT applied and was awarded Alliance for Healthier Communities funding to improve equitable access to the COVID-19 vaccine:

- Selected an on demand virtual interpretation application and made it available to primary care providers to support vaccine discussions and delivery
- Provided 600 adult bus tickets and 650 children's fobs to Vaccination Clinics, primary care providers and community resource centres to distribute to people needing support in accessing the COVID-19 vaccine.
- In response to a need identified by our community partners, developed handouts, social media posts and voiceover of Q&A webinar in Nepali and Arabic to promote children's COVID-19 vaccination

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.

In 2020/2021, the Middlesex London OHT established a governance structure, vision and values that has served as a foundation for building and strengthening partnerships and trust across our OHT.

Consensus Decision-Making Process
The MLOHT Coordinating Council applies a Consensus Decision-Making Process
MLOHT has adopted a representational Consensus Decision-Making process to provide each recognized cluster of members and the Patient, Client, Care Partner Council (PCCPC) with a voice in decision-making. Consensus Decision-Making is a process for guiding members to reach a consensus on a decision that:

- reflects the input of the members
- is acceptable to those members who are likely to be impacted by a decision

Decision-Making Framework
The Middlesex London Ontario Health Team (MLOHT) decision making framework describes the MLOHT's decision-making process. This includes which decisions are made at the level of the MLOHT Lead, the MLOHT Operations Team and the MLOHT Coordinating Council, and the respective decision-making process at each level.

Decision Tool
Decision Tool was developed to support the prioritization of work that aligns with the MLOHT purpose, goals and commitments (including prioritized co-design themes).
The decision tool is applied by the Operations Team when:

- Assessing requests for MLOHT support,
- Seeking funding for MLOHT initiatives/launch of projects, and
- Prioritizing projects based on estimated impact and effort associated with our purpose, goals, and commitments

Continuous Improvement of Decision-Making Process
Decision-Making Process was improved based on feedback from Coordinating Council (CC) members to allow for more engagement with their cluster/PCCPC and more clarity of voting levels and how they impact decision process. Improvements include:

- Post CC meeting package 2 weeks in advance to allow for timely engagement with cluster/PCCPC
- Opportunity to provide and address feedback on documents via MS Teams
- Clarified what decision levels result in further group discussion to address issues, potentially resulting in modification of decision
- Process avoids an effective "veto"
- Simplified Decision-Making Framework Document
- Better consistency in Consensus Decision-making among clusters and partners

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.

We value embedding the voices and experiences of primary care physicians and partners and specialists in our Middlesex London OHT work, acknowledging primary care as a cornerstone of our OHT. The Middlesex London OHT has taken a broad approach to engaging with Primary Care, leveraging the approach of the London Middlesex Primary Care Alliance (LMPCA) in its inclusion of clinicians, providers, organization, and administrative leaders.

- MLOHT Coordinating Council includes 3 Primary Care Representatives and thereby 3 votes

- MLOHT Clinical Lead meets with primary care and physician partner stakeholders to establish communication channels, identify priorities and challenges; this has included: monthly attendance at LMPCA Executive meetings as well as Town Halls/special meetings to provide two way dialogue with primary care re OHT activities; meetings with hospital physician leadership and presentations to LHSC and St. Joseph's Physician Leadership Council and Quality Council; meetings with Middlesex Hospital Alliance regarding communication and engagement and their challenges recruiting psychiatry
- MLOHT co-developed the Primary Care and Physician Partner Communications Protocol with the LMPCA and others
- Completed a primary care stakeholder analysis to understand the breadth of primary care models and expertise
- Based on feedback from LMPCA Executive, transitioned role of Primary Care Digital Health Lead to Primary Care Digital Health Working Group, to allow more fulsome representation and participation
- The OHT financially supported a primary care representative to re-engage with the South West COVID Response/Recovery table and resultant work.
- Identified physician/clinical leads for projects to support co-leadership approach
- Referral Management Project is co-led by MLOHT and LMPCA and includes 2 physician co-leads, both primary care providers.
- Primary Care physicians (3-10 physicians per group) have been engaged in the Test of Change Steering Committee, Attributed Population Registry working group, Health Information Exchange working group, and EMR vendor working groups.
- Recruited primary care providers for Co-Design Sessions
- 20 primary care providers participated in Referral Management Co-Design Sessions
- 7 primary care providers participated in Co-Design sessions, validating and prioritizing co-design themes

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.

Attributed Population Registry – Test of Change funding
OHTs are intended to be accountable for primary and secondary care needs for their full attributed population (MLOHT = 525,829). However, we do not have individual-level information on this population.

The purpose of this project is to establish the foundation for Population Health Management by testing an Attributed Population Registry to enhance the digital health backbone that is currently lacking in Ontario. This project is supported by Test of Change funding and was initiated late 2021. To date, project has focused on developing a governance structure and establishing requirements. Successes include excellent engagement and working relationship established with working groups and steering committee, and Provincial Client Registry being identified as preferred solution.

Shared Care Records via Health Information Exchange – Test of Change funding
Through co-design interviews we heard accessing key health information across record systems is challenging.
The purpose of this project is to design and implement a Health Information Exchange (HIE) solution that would give providers access to information from other systems (e.g., Primary Care, Hospital, Home and

Community Care, Community Mental Health & Addictions): In real time; In the EMR of their choice; Without the need for a separate login.
This project is supported by Test of Change funding and was initiated late 2021. To, date project has focused on developing a governance structure and establishing HIE requirements. Successes include excellent engagement and working relationship established with working groups and steering committee, and HIE core requirements established along with the drafting of detailed functional/technical requirements.

Referral Management – Central Waitlist Management Funding
Through our co-design interviews, in alignment with the Access and Awareness of Services theme, we heard referrals are an administrative burden to healthcare providers. We heard the lack of transparency of referral wait times and limited specialist choices are barriers to care for patients.
The Referral Management Project was launched to:

- Develop a standardized referral form to simplify workflow
- Use eFax functionality to facilitate transition of Primary Care Providers and Specialists to eReferrals
- Improve interprofessional communication by reducing administrative workload associated with referrals

This project is co-led by Middlesex London OHT and the London Middlesex Primary Care Alliance (LMPCA) and includes a close collaboration with the eHealth Centre for Excellence (eCE). This project was successful in securing Central Waitlist Management funding.

Consolidated Self-Management Website – Integrated Virtual Care Funding
There are multiple self-management programs and associated websites offering in-person and virtual workshops across the West region, but they operate independently.
To improve access to and awareness of self-management programs, Middlesex London OHT received Integrated Virtual Care funding to develop a consolidated Self-Management Website. This website consolidates information on self-management workshops from 4 sub-regions (South West Self-Management, Waterloo Wellington Self-Management, Erie-St Clair Self-Management, Hamilton Niagara Haldimand Brant Self-Management).

- The website design, name and functionality were co-designed with patients, clients, care partners and providers.
- The website back-end was co-designed with regional self-management staff that will be responsible for maintaining up-to-date website content.
- The Marketing & Communication plan was developed with input from patients, clients, care partners, providers and staff
- The Sustainability plan was co-designed with regional self-management staff and Ontario Health West.
- The website, named “Self-Management Programs Network”, was successfully launched on March 31st 2022: https://selfmanagementprograms.ca/

Virtual Interpretation to support equitable access to Vaccine – Alliance for Healthier Communities Funding

- Selected an on demand virtual interpretation application and made it available to primary care providers to support vaccine discussions and delivery

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

Highlight any notable performance measurement and quality improvement activities and achievements.

To establish an evaluation framework which is in line with the principles of an Equity driven Quadruple aim, the following was accomplished:

- Established a Quality and Analytics Working Group that oversees Performance Measures and Evaluation activities in the Middlesex London region. Working group is co-chaired by representatives from primary care and hospital Quality teams. (see additional detail below)
- Developed a draft evaluation framework for our Key Performance Indicators (KPIs). These KPIs include the 3 indicators stated in our Transfer Payment Agreement (Patient-Reported Outcome Measures (PROMs), Patient-Reported Experience Measures (PREMs), and Access to Primary Care), and the 5 cQIP indicators). Additionally, our evaluation framework focuses on process, balancing, and formative measures to evaluate the maturity of our OHT and its impact on improving health systems in our region.
- Driver Diagrams are being created to show the relationships between the Key Performance Indicators and change initiatives that can have impact on each KPI
- Preparing to collect PROM and PREM related baseline data for our initial population of priority (people living with COPD and/or CHF). Working with early adopter sites to identify patients with COPD and/or CHF for the purpose of collecting baseline data.

Established a Quality and Analytics Working Group to adapt/develop tools, develop strategies, and coordinate activities and procedures to implement quality improvement and evaluation efforts within the Middlesex London OHT.

- Formed a core team for the Quality and Analytics Working Group
- Welcomed two individuals with experience in quality improvement work to co-lead our Quality & Analytics Working Group (in-kind roles)
- Reached out to the Middlesex London OHT's partner organizations and invited their Quality Improvement leads to join the Middlesex London OHT Quality and Analytics Working Group
- Created Terms of Reference for the Working Group which illustrates the structure, roles, processes, and practices used by the Quality and Analytics Working Group to carry out quality improvement efforts within the Middlesex London OHT.

To develop a collaborative Quality Improvement Plan to systematically identify and bridge gaps in care using quality improvement and change management initiatives and employing an equity lens in the Middlesex London region, the following was accomplished:

- Identified Quality Improvement leads at our partner organizations and invited them to participate in Collaborative Quality Improvement Plan Working Groups for each of the 3 areas of focus for the cQIP (ALC rates, ED as first point of contact for MHA, cancer screening).
- Total of eight cQIP Working Group meetings have taken place to make plans on Quality related initiatives for the indicators.
- Working with our partner organizations to coordinate/design Quality Improvement initiatives and strategies, using a driver diagram approach, to positively impact the five cQIP indicators

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.

- There is a desire to collect baseline and follow-up data related to PREM and PROM at an individual patient level. We are currently developing a survey tool to capture patients' experiences as they interact with our health system. There is a process underway to conduct a cognitive debriefing and pilot this tool prior to its use on a large scale to collect data from our initial population of priority. Since we are taking a rigorous approach to the development and testing of this tool, we may not be able to collect data from a large number of COPD and/ or CHF patients to collect baseline data and

report it to the Ministry by May 31, 2022. The plan is to collect baseline data from as many as 30 people with the condition and report on it.

- One of our KPIs submitted to the Ministry of Health as part of our Transfer Payment agreement deliverable was “Timely Access to Primary Care.” However, our discussion and engagement with our key stakeholders and system partners suggested that it is challenging to measure “Timely Access” and there are several people in our OHT who do not have access to Primary Care. The MLOHT consulted with the Ministry, Coordinating Council, and the LMPCA to shift from “Timely Access to Primary Care” to “Access to Primary Care” as a TPA deliverable as an initial step to improving equitable access to Primary Care before we work to address timely access to care. We have plans to engage primary care providers in our OHT to undertake a driver diagram approach to identify data source and develop an implementation plan around the change initiatives to improve Access to Primary Care in the MLOHT.
- There is also a challenge in a timely access to data to support our collaborative quality improvement (cQIP) work in our OHT. The cQIP indicators and baseline data are provided to us. The cQIP working group indicated that some of the indicators are difficult to measure whether or not there are improvements as a result of the cQIP work. The plan is to use all the available data (e.g., relying on data from our partners) to suggest key drivers and change initiatives to move a needle on the indicators.

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)

We have found many of the Central Program of Supports resources helpful over this fiscal year, including:

- Ministry/Ontario Health webinars and guidance documents/templates (e.g., April 14/21 OHT Information Session: Guidance Documents for TPA Deliverables, OHT Virtual Engagement Series, April 8/22 OHT Year End Update)
- Although we have experienced turnover with our Ministry key point of contact, we have found this connection helpful and have experienced that Joyce Lee, our current key contact, has successfully pulled in colleagues, depending on the topic of conversation, to support advancing the conversation/shared understanding, which we have appreciated – a key personal, point-of-contact has been important/valuable
- ADVANCE Leadership Workshops and Coaching calls
- RISE OHT Collaboratives
- RISE Population Health Management Webinars
- HSPN Webinars, although, wondering if these could be shortened to 1 hour

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**	**Complete. Ongoing and remaining activities have been incorporated into the appropriate Terms of References and Work Plans**
Primary Care Communication Protocol	Sept. 30, 2021	**Green - Progressing Well**	**Complete. Communication remains ongoing and incorporated into both overall MLOHT communication plans and individual project communication plans.**
Harmonized Information Management Plan	Sept. 30, 2021	**Green - Progressing Well**	**Complete. Test of Change projects launched in alignment with the Harmonized Information Management Plan.**
Patient Declaration of Values	Nov. 30, 2021	**Green - Progressing Well**	**Complete, approved by PCCPC and Coordinating Council. Incorporated into PCCPC Terms of References.**
A Collaborative Quality Improvement Plan (cQIP)	~~Mar. 31, 2022~~ May 30, 2022	**Yellow - Some Challenges**	• **In Progress, extension received until May 30th, 2022** • **Associated Risk: HR & COVID** • **cQiP Working Group established that includes Quality Improvement leads from partner organizations across Middlesex London.** • **Sub-groups identified to focus on each of the cQiP indicators.** • **Working with our partner organizations draft Driver Diagrams to build on existing Quality Improvement initiatives and strategies to address commonly agreed up on Quality Improvement related gaps in our region.** • **Driver diagram is being drafted for the five cQIP indicators**

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)	**Green - Progressing Well**	COPD and CHF care pathways have been mapped and validated through a delphi survey with advisors, co-design, and best practice review. Early adopter primary care sites have been identified and implementation plans are being developed. Implementation is focusing on supporting delivery of 'always for everyone events', a minimum standard set of activities that should be provided to all patients with COPD and/or CHF across their care journey.
Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'	**Yellow - Some Challenges**	Informed by our co-design findings, Referral Management Project Phase 1 was launched and project executed, resulting in a standardized eReferral template. This template will support e-referrals/e-fax to specialists that don't have a referral form on the Ocean eReferral platform enabling primary care providers to use the eReferral platform for all their referrals regardless of destination. Phase 2 is still in progress and focuses on testing the new eFax functionality to support the transitioning to eReferrals. Central Waitlist Management funding application was approved in January 2022. This delay in funding has resulted in delay in launch of the eFax functionality and thereby delay in transitioning providers to Ocean eReferral. Informed by our co-design findings, funding application was submitted, approved and projects launched to support the implementation of a Shared Care Record and Population Registry as proof of concept projects. The Shared Care Record and Population Registry projects are transformational and will greatly improve coordination of transitions between providers in the future. However, these are long-term project and will not result in change to patient care by March 31st 2022.

Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.	**Yellow - Some Challenges**	Informed by our co-design findings, funding application was submitted and approved for the Patient Navigation and Healthcare Navigation System OHT Alignment and Planning Resource. Successful Navigation Planning Lead candidate joined the MLOHT on secondment on November 15, 2021. We partnered with Oxford and Area and Elgin OHTs to create a triad model across our shared geography, including a Primary Care and First Nations/Indigenous Lead. We experienced a delay in hiring the First Nations/Indigenous Lead role. Project is progressing well but timelines across the region have been adjusted with a plan for implementation for 22/23. Phase 1 of work completed and final reports and data collection has been submitted to OH. Lack of clarity regarding ongoing funding is proving challenging to continuation of Phase 1 and expansion into Phase 2, from a human resources planning perspective. This uncertainty is unfortunate as we are gaining great traction with partners and it would be unfortunate to lose this momentum. The Middlesex London Strategic Direction Council (and associated Strategic Direction Office) is exploring system navigation for mental health and addiction as their 22/23 strategic priority. The MLOHT is actively partnering to ensure alignment of work and avoid duplication.
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.	**Yellow - Some Challenges**	Informed by our co-design findings, funding application was co-submitted with South West Self-Management to develop a self-management website that consolidates self-management workshop offerings across the West region. Application was approved and project launched in December 2021. Consolidated Self-Management website was successfully launched on March 31st, 2022. https://selfmanagementprograms.ca/ This website will expand and ease equitable and timely access to self-management workshops.
More patients in the OHT's priority population(s) are: • accessing care virtually • accessing their health information digitally • booking appointments online	**Yellow - Some Challenges**	MLOHT will participate in the West Region Patient Portal initiative. In the meantime, the MyChart portal is already in place and will continue supporting patients until the implementation of the West Region Patient Portal Initiative. The self-management website will increase access to virtual self-management workshops. Booking Appointments online and virtual primary care was not among the co-design themes and therefore not prioritized for implementation leadership by the MLOHT, although, we have requested/expressed interest in being advisory to the OH West Online Appointment Booking work .

More providers in the OHT are accessing provincially funded digital health solutions (e.g., provincial clinical viewers, Health Report Manager, eServices). *Note: Although not a listed milestone, the commitment to adopt core provincial digital health services is a pre-condition of using implementation funding on digital health, information management, and virtual care implementation activities) per page 23 of the TPA.*	**Yellow - Some Challenges**	Referral Management Project Phase 1 was launched and executed resulting in a co-designed standardized eReferral template. This template will support e-referrals/e-fax to specialists that don't have a referral form on the Ocean eReferral platform, enabling primary care providers to use the eReferral platform for all their referrals regardless of destination. Central Waitlist Management funding application co-submitted with the London Middlesex Primary Care Network, to support the implementation of electronic referrals and eFax (Phase 2). Application was approved in January 2022. This delay in funding has resulted in delay in launch of eFax functionality and thereby delay in transitioning providers to Ocean eReferral.
Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.	**Yellow - Some Challenges**	The MLOHT has committed to assisting and supporting the LMPCA as it works on engaging with primary care to participate and become formal members of the MLOHT. Some steps of work explored include working with OMA Legal to ensure that the agreements will work for physicians and other primary care providers. This approach ensures that the approaches taken in MLOHT are consistent with other OHTs provincially. We have recently had 3 different physicians reach out requesting information about OHT membership and plan to engage with each to share information about how to get involved with the MLOHT and the LMPCA. By partnering closely with LMPCA in this work we are ensuring that engagement is meaningful and relevant to primary care, and that we are building the foundations for sustainability.
Information about OHT member service offerings is readily available and accessible to the public, e.g. through a website.	**Green - Progressing Well**	The MLOHT website (Home - Middlesex London OHT (mloht.ca)) was launched February 2022 and the Western OHT was rebranded as Middlesex London OHT. MLOHT monthly membership newsletter is circulated to all MLOHT members and interested stakeholders, a current mailing list of 222 contacts, and shared on the MLOHT website.
Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.	**Green - Progressing Well**	COPD and CHF care pathway mapping via our co-design work with patients/clients/care partners and providers is complete and findings have been verified through a Delphi survey; the 'always for everyone events' embedded in the pathway will contribute to reducing inappropriate variations in care. Early adopter primary care sites have been identified and implementation plans are being developed.

The OHT's performance has improved on measures of access, transition, coordination of care, and integration.	**Yellow - Some Challenges**	Change opportunities have been defined that are ready for implementation early 2022/2023. This includes standardized care pathway for COPD and CHF, improved referral management (eReferrals/eFax) and improved access to self-management. Early adopter sites have been identified and plans are in place to initiate collection of baseline data. Extension has been received to start submitting baseline data by May 30th 2022. Projects with the greatest potential to impact coordination of care and integration are the Shared Care Record/HIE project and Attributed Population Registry Project. These are transformational projects with longer timelines. As indicated in our Q3 report, measurable improvements of access, transition, coordination of care, and integration will not be achieved by March 31st 2022.

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
Human Resources	The ongoing COVID response may continue to slow progress with advancing the work of our initial priority population of focus	Continue to approach the Middlesex London OHT work with a spirit of flexibility, adjusting timelines in light of the competing time demands of the COVID response
Partnership Risks - Governance	The global models of health teams that achieve improved health results for people have a plan that connects resources and accountability through robust governance – absence of this robust governance diverts resources from health/care activities to managing the complex governance	Develop a future state governance model/principles that act as a beacon or lighthouse, with support and collaboration from other OHTs, OH West and OH
Human Resources	With multiple competing priorities for OHTs, existing local human resources with strong relationships and expertise in digital health, change management, quality improvement (South West Partnering for Quality) may be diverted to regional digital health implementation efforts. The lack of access to these local human resources will negatively affect the ability of our OHT to make improvements and support COVID recovery in a timely way.	Advocate to Ontario Health West to maintain Partnering for Quality as a local resource for multiple OHTs.

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.
• Execute Referral Management Project Phase 2 – Test eFax functionality and facilitate transition of primary care providers and specialists to eReferrals • Market the consolidated Self-Management website to raise awareness and improve equitable, timely access to self-management programs across the West region. • Begin building a Community of Practice for Navigators for the Middlesex London area. Finalize the project team members including any stakeholders that want to be involved. Continue engagement focusing on patient, family and community engagements. • Confirm partnership with smileCDR and validate its ability to support a Shared Care Record according to the detailed requirements • Confirm partnership with the Provincial Client Registry and explore opportunities to create an Attributed Population Registry according to the detailed requirements. • Develop collaborative Quality Improvement Plan and start collecting baseline metrics for all of our Key Performance Indicators. • Care Pathways for COPD/CHF – implement care pathway across early adopter sites and apply continuous improvement through PDSA approach (Plan-Do-Study-Act). • Support Patient Portal West Region Initiative • Support COVID-19 response and recovery • Continue to build our OHT 'backbone' structure • Recruit Patients, Clients and Care Partners to join and strengthen our PCCP Council and Network • Transition from current Middlesex London OHT Clinical Lead role to a Clinical Lead – Specialty Care and a new Clinical Lead – Primary care • Continue to partner with each of the three local First Nation communities to plan co-design sessions across these 3 themes: MHA support for trauma, virtual care, and health system navigation • Engage with stakeholders to inform the 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.