

Population Health Management and Equity Plan (OHT Plan) Template Version 1.0

Ontario Health Teams Division, Ministry of Health
Population Health and Value-based Care, Ontario Health

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Overview of Template

Background

Cohort 1 Ontario Health Teams (OHTs) that have Transfer Payment Agreements (TPAs) for Continued Implementation Funding must complete a series of deliverables and reporting requirements. The first submission to the Ministry of Health (ministry) is the completion of an OHT Population Health Management and Equity Plan (referred to as 'OHT Plan' in this document).

Cohort 1 OHTs must submit their OHT Plans to the ministry by July 29, 2022. This submission will be shared with Ontario Health (OH).

Please use this template for your submission. OH has released a companion document (*'Cohort 1 Ontario Health Teams TPA Deliverable Guidance'*) that provides guidance for teams as they develop each section of their OHT Plan.

Purpose

The OHT Plan is an operational blueprint for how teams will achieve their required TPA deliverables across five priority areas and advance their OHT more broadly over the course of the agreement. The Mid-Year, Year End and Final Reports provide the opportunity for teams to report on their progress against the OHT Plan.

The Ministry and OH will use the information in this Plan to identify potential supports needed and best practices within select priority areas, in order to support teams in the achievement of their deliverables.

Expectations

The development of the OHT Plan must involve meaningful engagement and partnership with patients, families, caregivers, and communities, as well as other OHT members (including primary care providers and clinicians), as key stakeholders in system transformation.

Brevity is encouraged. Although there are no word limits to the OHT Plan template, please aim to be concise.

The ministry and OH recognize that certain planning or implementation activities may require adjustment as new information becomes available (e.g., funding opportunities, further guidance, etc.).

If your team has already completed deliverables included in this TPA or already has work underway, you may reference that work in this template.

Baseline Update

The following questions confirm important baseline information about your team.

A. OHT Profile

OHT Name	Middlesex London Ontario Health Team
Transfer Payment Recipient Name	
Website Updates: Please review the ministry's OHT website to ensure your team's name, URL, and location of providers is up to date.	<i>List any required updates here:</i> <ul style="list-style-type: none"> • Name is 'Middlesex London Ontario Health Team' • www.mloht.ca
We would like to follow you! If your OHT is active on social media, the ministry would be grateful for the opportunity to follow you and hear about your work in real time!	Twitter: @ML_OHT LinkedIn: https://ca.linkedin.com/company/middlesex-london-oht Instagram: Other:

B. Confirming OHT Membership

Your ministry point of contact has shared with you the membership records we have on file for your team. Please validate the list per the instructions included in the provided spreadsheet.

Membership and entry criteria are defined by each OHT through their Collaborative Decision Making Arrangements (CDMAs) or other governing instruments. Some teams may use different nomenclature to describe the range of involvement that an organization or provider has with the OHT (e.g., affiliate, observer, collaborator, member, core member, partner, etc.). To help the ministry and OH better understand your team, please provide a brief summary of the terms used to describe your membership structure. The terms listed below should align with what is provided back to the ministry in your membership spreadsheet.

OHT Involvement/Membership Type/Role	Definition
Coordinating Council Member	Voting or Non-Voting Member of Coordinating Council
Membership Agreement Signatory Member	Health Care Organization or Community Organization or Individual or Cluster that has signed a Membership Agreement
Participatory Partner	Broad term to describe anyone/any organization who/that has actively participated in the work of the OHT since our approval as an OHT; participation may be via co-design, working group, or project team participation; inclusive of Coordinating Council Members and Membership Agreement Signatory Members

Please also provide information on how your OHT is engaging clinicians, specifically in terms of:

1. Number of primary care providers¹ (physician, NP, other provider) involved² in the OHT.

We partner very closely with the London Middlesex Primary Care Alliance, which represents primary care providers, including many physicians and nurse practitioners. Additionally, we have two Clinical Lead positions embedded in our Operations Team (one Primary Care), 2 Primary Care physicians on our Coordinating Council, and 1 COVID Primary Care Lead. Over 60 different primary care providers (including approximately 48 physicians) have participated in various working/project groups to date.

2. Number of other clinicians (specialist physicians, other clinicians) involved in the OHT.

We have one Clinical Lead (Specialty Care) role embedded in our Operations Team. Additionally, outside of primary care, we estimate that over 50 clinicians (25 specialists and approximately 30 other clinicians from across the system, excluding primary care) have participated across co-design activities, working groups, and project teams.

¹ Primary care providers, who include family doctors, general practitioners, nurse practitioners, and other health care providers, are often Ontarians' first point of contact with the health system.

² For the purposes of this Plan and associated reporting, "Involved" means: Any level of participation (this is not a formal/provincial definition but a way for OHTs to self evaluate).

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

Priority Area 1 Deliverables	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 deliverable and projected timing for completion.
<p>Enhance care planning and delivery and outcomes for initial target population(s) based on local drivers.</p>	<p>Green - Progressing Well</p>	<p>COPD & CHF Care Pathways - <i>Leading</i> Standard care pathways for people living with COPD and CHF were developed with patients, caregivers and providers to ensure equitable access to minimum standard set of activities. Upcoming Milestones:</p> <ul style="list-style-type: none"> • Confirm shared vision, identify early adopter sites and champions – August 31, 2022 • Kick Off Events – Sept 30, 2022 • Care Pathway Assessment with early adopters – Nov 31, 2022 • PDSA/Testing of Select Opportunities Initiated – Jan 1, 2023 <p>MLOHT Evaluation Framework - <i>Leading</i> Key Performance Indicators were defined and data collection process initiated. Upcoming Milestones:</p> <ul style="list-style-type: none"> • Multipronged data collection process in place – Sep 30, 2022 • Q&A Working Group establish what we want to monitor at population level/measurement plan/dashboard – Jan 30, 2023 <p>CHF QBP - <i>Partnering</i> Spoke-Hub-Node model embedding an established community-initiated integrated disease management program (Best Care HF) in primary care practices. Upcoming Milestones:</p> <ul style="list-style-type: none"> • Governance structure established – Aug 31, 2022 • Care pathway developed – Oct 31, 2022 • Project launch – November 30, 2022 <p>Individualized Care Plan (Phase 1) – <i>Supporting</i> Phase 1 background/foundational work to: i) further understand best practices for individualized care planning, ii) revisit past discovery phase data, and iii) conduct co-design sessions to gain consensus on what should be included in an individualized care plan. Upcoming Milestones:</p> <ul style="list-style-type: none"> • Launch project - TBD <p>Care Manager Model (Phase 1) – <i>Supporting</i></p>

		<p>Phase 1 background/foundational work to understand: i) What factors facilitate or hinder the implementation of a care manager program in ML? ii) What providers, patients, and caregivers believe should be included in a care manager model; and iii) explore similarities and differences between navigation, care management, and care coordination roles.</p> <p>Upcoming Milestones</p> <ul style="list-style-type: none"> • Launch project - TBD
<p>Design and implement population health interventions for additional target populations aligned with provincial direction and built on broadened OHT partnerships.</p>	<p>Green - Progressing Well</p>	<p>Equity Deserving Co-Design:</p> <p>First Nations Co-Design - <i>Partnering</i> Health representatives from the 3 local First Nation communities shared their priorities with MLOHT Leadership last summer and identified 3 specific streams of work:</p> <ul style="list-style-type: none"> • Virtual Care in First Nation Communities • Improving Access to MHA Supports for Trauma in Communities • Health Care Navigation Current State Analysis and Future State Options <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Community Engagement Sessions – July 21 and Aug 4, 2022 to further understand current experiences and prioritize opportunities for improvements. Future work will include co-designing solutions for implementation • Hiring of Indigenous Health Improvement Facilitator Role – Sept 30, 2022 <p>Newcomers/Refugee Co-Design - <i>Leading</i> Partner with Cross Cultural Learner Centre (CCLC) to facilitate co-design sessions with a newcomer/refugee population prioritized by CCLC. Some discovery phase interviews have been completed with individuals attending newcomer primary care clinics.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Engage Stakeholders – conduct more exploratory interviews with clients, caregivers and providers to ensure broad representation – Dec 31, 2022 • Initiate Project – prioritize findings and with partners, determine next steps – Feb 15, 2023 <p>On Demand Virtual/Phone Interpretation Support (Voyce) - <i>Leading</i> Provide on-demand virtual and phone interpretation services to enable patients to receive care in a language of their comfort.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Assess experience to date – Sept 2022 • Expand use through targeted outreach to primary care clinics supporting newcomers – Oct 2022

		<p>cQiP –Improve access to community-based Mental Health and Addiction Services in Middlesex London - <i>Partnering</i></p> <p>Year 1 focuses on two change initiatives that will be supported by the MLOHT:</p> <ul style="list-style-type: none"> • Increase awareness of and promote the use of additional crisis stabilization beds (16+) and crisis lines • Evidence-based advocacy for affordable, accessible health and housing supports <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Establish Working Groups – Aug 30, 2022 • Develop Project Plans – Oct 30, 2022 • Initiate Plans – Nov 15, 2022 <p>cQiP – Cancer Screening - <i>Supporting</i></p> <p>Year 1 focuses on three change initiatives:</p> <ul style="list-style-type: none"> • Increase cancer screening services for New immigrants to Canada, Indigenous and First Nations people • Increase system capacity to complete PAPs by training RNs to perform PAPs in Primary care. • Develop a strategy for people that do not have primary care provider to have cancer screening. <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Establish Working Groups – Aug 30, 2022 • Develop Project Plans – Oct 30, 2022 • Initiate Plans – Nov 15, 2022 <p><i>Equity, Diversion, Inclusion (EDI) Collaborative – Partnering</i></p> <p>Establish a Middlesex London Equity, Diversity, and Inclusion (EDI) Collaborative to facilitate the connection between EDI Leads/Groups to efficiently collaborate on shared priorities and initiatives, including coordinated engagement with equity-deserving populations.</p> <p>Upcoming Milestones</p> <ul style="list-style-type: none"> • Launch project - TBD <p><i>LEGHO (Let’s Go Home) – Supporting</i></p> <p>LEGHO is intended to support providers and patients by removing non-clinical barriers to discharge/community stabilization (legislated co-pay for CSS services, coordination between multiple CSS providers, alignment of clinical & community supports). Through bundled services, patients and care partners will have coordinated access to meals, transportation, homemaking, wellness checks, navigation/community connections with no financial barriers</p> <p>Upcoming Milestones</p> <ul style="list-style-type: none"> • Launch project - TBD <p><i>Individualized Care Plan (Phase 1) – Supporting, see priority 1, deliverable 1</i></p>
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		<p>Care Manager Model (Phase 1) – Supporting, see priority 1, deliverable 1</p>
<p>Identify opportunities to expand care redesign efforts to serve the OHT’s full attributed population.</p>	<p>Green - Progressing Well</p>	<p>Healthcare Navigation – Leading, see priority 2, deliverable 1</p> <p>Consolidated Self-Management Website – Leading, see priority 2, deliverable 1</p> <p>Shared Care Record - Leading Designing and implementing a Health Information Exchange (HIE) solution that would give providers access to information from other systems.</p> <p>Upcoming Milestones (timelines dependent on Provincial, MOH, OH work):</p> <ul style="list-style-type: none"> • Pending smile CDR agreement with OH; establish work plan to develop API integration requirements with selected EMR - July 31, 2022 • Data definitions for core information established and confirmed with local and provincial dependencies – Sept 30, 2022 • API Integration requirements with EMR established – Sept 30, 2022 • Privacy Framework Established – Sept 30, 2022 • Azure cloud/smileCDR partition established for OHT – Sept 30, 2022 • Final version use cases published – Sept 30, 2022 • Work plan established to launch selected use cases in Q3/Q4 – Sept 30, 2022 <p>Attributed Population Health Registry - Leading Establishing a registry with individual-level patient/client information to support population health management.</p> <p>Upcoming Milestones (timelines dependent on Provincial, MOH, OH work):</p> <ul style="list-style-type: none"> • Establish privacy working group with other OHT to address PHIPA barriers and requirements – July 31, 2022 • Establish proxy population for application of use cases – Aug 31, 2022 • Data definitions established and confirmed with local and provincial dependencies – Sept 30, 2022 • Establish attributed population registry framework with provincial asset dependencies (Provincial Client Registry linkages) – Sept 30, 2022 • Establish workplan to launch use cases on acquired proxy population – Sept 30, 2022 <p>Referral Management through Ocean eReferrals and eFax - Partnering “eReferrals via eFax-Initial Phase” was launched on May 24th, 2022. This initiative is intended to facilitate transition of Primary Care Providers and Specialists to eReferrals.</p>

		<p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Evaluation Plan – Oct 31, 2022 • Continuous spread and scale of eReferral in the region – Dec 31, 2022 <p>Wholistic Needs Screen <i>Leading</i> A “wholistic needs screen” has been proposed through co-design to support proactive identification and management of health and social determinant needs.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Review existing assessments and screening tools – Oct 31, 2022 • Co-Design and validate wholistic needs screen tool – Mar 31, 2023 <p>SCOPE (Seamless Care Optimizing the Patient Experience) - <i>Partnering</i> SCOPE supports Primary Care Providers and their patients through an integrated platform across the continuum of care that makes services comprehensive and responsive to patient needs. Launch of this project is pending funding.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Secure funding – TBC (joint proposal submitted) • Launch Project – TBC (pending funding) <p>Access to Primary Care – <i>Partnering</i> Partner with primary care sector to draft a driver diagram to identify change initiatives to improve access to primary care.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Establish an Access to Primary Care Working Group – July 31, 2022 • Develop driver diagram outlining challenges and change ideas – Sept 30, 2022 • Select change initiatives and develop plan for implementation – <i>TBD pending results of driver diagram and LMPCA recommendation</i> <p>cQiP – ALC - <i>Supporting</i> Support partners to Improve overall access to care in the most appropriate setting.</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Consider how LEGHO CSS work can support a reduction in ALC rates as part of LEGHO planning work – Sept 30, 2022 • ALC working group to determine plan for ALC improvement – Sept 30, 2022 <p>MLOHT Communications Plan - <i>Leading</i> Raising awareness of the future vision and benefits of integrated care and population health management, highlighting the progress on ongoing projects and deliverables that the MLOHT leads, partners and/or supports, and how to get involved.</p>
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<p>Implement enhanced approaches to partnering with patients, families and caregivers in execution of the OHT Plan.</p>	<p>Green - Progressing Well</p>	<p>Patient Client Care Partner Council – <i>Leading</i> Outreach and Collaboration across Patient Tables in Middlesex London</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Create list of patient, caregiver and lived experience tables in ML – Aug 15, 2022 • Plan engagement – Aug 30, 2022 • Update PCCPC Terms of Reference – Aug 30, 2022 • Initiate meetings with tables – Sep 30, 2022 • Together define benefits for collaboration across patient tables – April, 2023 • Develop resulting strategy and plans – June 30, 2023 <p>PCCPC Onboarding and Orientation Process</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Develop Orientation Package and Onboarding Process – Sept 30, 2022 <p>Patient, Client, Care Partner Council and Network Recruitment</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Develop Long Term Recruitment Process – Aug 30, 2022 • Initiate Long Term Recruitment Process – Sept 30, 2022 <p>Patient, Client, Care Partner Network - <i>Leading</i> Formalize PCCP Network to broaden patient, client, care partner involvement in project teams and co-design activities</p> <p>Upcoming Milestones:</p> <ul style="list-style-type: none"> • Develop Network Operating Guidelines – Nov 30, 2022

1. Describe what activities your team is pursuing to better understand your OHT’s attributed population, including your use of available data sources. In your response, please identify how you are seeking to understand health disparities and equity considerations in the communities your OHT serves.

Population Data

The Middlesex London OHT has leveraged a wide variety of data holdings and reports to gain understanding of our population. These include reports on our attributed populations provided by the MoH, Ontario Health, Inspire, the Health System Performance Network, and Integrated Decision Support. We have also leveraged information from agencies including Statistics Canada, the Canadian Institute for Health Information, and the Institute for Clinical Evaluative Sciences plus local data holdings and research. While all helpful, the breadth of information and the lack of consolidated data has been a challenge. Therefore, we have adopted a two-fold strategy for better understanding our population. First, we have actively engaged our partner organizations and members of our population to guide us towards local challenges and opportunities for improvement (see Co-Design). We have also launched a Test of Change project aimed at supporting improved access to individual-level information for all OHTs that we believe will be necessary for all OHTs to effectively support PHM.

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.

To better understand our attributed population, a co-design process is being used to collect individuals' experiences, and co-design and implement system improvement strategies. Discovery interviews were completed with patients/clients, care partners and providers to understand current health system experiences and opportunities for change.

In Q3 2021, 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

The co-design themes guide project prioritization and co-design is embedded in each project, where solutions to identified challenges are co-designed and co-developed with patients, clients, care partners and providers.

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.

Equity Deserving Co-Design

We continue partnering with the three local First Nations Communities to better understand the needs of these community members and co-design healthcare improvements.

Additionally, MLOHT plans to initiate discovery interviews and co-design sessions with other marginalized populations such as newcomers in FY 2022/2023.

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 in 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).

We continue partnering with the London InterCommunity Health Center as an early adopter of the COPD Care Pathway. The scope of the COPD Care Pathway project includes recognizing and supporting people in overcoming equity barriers.

Population Registry and Shared Care Record

To better understand our attributed population and enable effective population health management, we are working with partners at Ontario Health and in other OHTs to establish attributed population registries for each OHT, and establish the digital foundation to support a provincial shared care record. Our Attributed Population Registry Working Group co-designed the following vision “In order for an OHT to support equitable access to well-connected and integrated care, the OHT must have enough information about each member of their attributed population to identify them and connect with them as appropriate.” Our OH-funded Test of Change project has allowed us to explore a process for creating OHT registries leveraging the OH-procured smileCDR and the provincially-held Provincial Client Registry. This project is dependent on finalization of the OHT population attribution methodology, modernization of PHIPA, and continued development of the Ontario Patient Summary; therefore, members of our team will be supporting these initiatives. [See question 3C for more detail.](#)

2. Based on your understanding of your OHT’s attributed population, please describe your initial target population(s) to date and any additional populations you plan to target. Please describe the segmentation/stratification approaches, equity approaches, and data sources you used/will use to identify these populations.

During our OHT’s formation, we undertook a population prioritization exercise with key partners that recommended an initial priority population of 2,000-3,000 people living with advanced COPD and/or CHF, who are in need of system-level care coordination or navigation, with a special emphasis on those at risk of institutionalization. With our early adopter sites, patients living with COPD and CHF are now being identified in their EMR. A process is underway to measure baseline patient experience and outcomes. Care pathways are being co-designed and implementation and will include the development of a toolbar that (using EMR data) identifies patients at risk of COPD and/or CHF early, to enable appropriate intervention to prevent and/or better manage disease progression. Patient experience and outcomes will be regularly collected to track the impact of our pathway develop and support ongoing quality improvement.

Additional priority populations the MLOHT aims to target include equity deserving populations (e.g., First Nations, newcomers/refugees, people living with mental health and addictions challenges).

Our OHT has intentionally focused our effort on ultimately being accountable for our full attributed population. An example of how we have committed to this effort is our co-design approach that has intentionally reflected the diversity of our community (we have been tracking the diversity of co-design voices using a matrix approach where we have specifically asked individuals to share total family income before taxes last year (in addition to several other questions about sexual orientation, birth country, racial or ethnic group, preferred language, etc.)). As our Quality and Analytics group helps evolve our evaluation framework, we’ve committed to capturing and using data to inform Health Equity and have, to date, considered the data captured by the Toronto Central LHIN as our gold standard for equity-relevant data. However, we’re working with various partners to ensure we get this right.

Other examples of work focused on our ultimate goal of supporting our full attributed population include our Test of Change work to establish an Attributed Population Registry and development of a wholistic needs screen which, once fully implemented, will help identify health and social needs across our full attributed population.

3. Using population health management and equity approaches describe the steps you will take to enhance care delivery and service integration, and/or redesign care pathways for the following:

- A. Initial target population(s)
- B. Additional target population(s)
- C. Your OHT's full attributed population (identify future opportunities)

In your answer, please identify how you will:

- Engage and partner with patients, families and caregivers, and communities (including First Nations, Inuit and Métis, racialized communities, and Francophones) to co-design interventions
- Incorporate data, best evidence, and lessons learned to date
- Evaluate the impact of care transformation/redesign efforts in alignment with the Quadruple Aim
- Apply an equity lens to reduce health disparities

MLOHT's work is guided by co-design and impact on our health equity-driven quadruple aim. When prioritizing new projects for implementation, the MLOHT Decision Tool is used to assess each opportunity for alignment with our co-design themes, (i.e how it addresses needs identified through co-design interviews), expected positive impact on our health equity-driven quadruple aim, and degree of effort required (time, cost). High impact (and preferably lower effort) opportunities are prioritized for implementation.

Each initiative/project is informed by data and best practice evidence and solutions/deliverables are co-designed with patients/clients, care partners/caregivers, and providers. In addition to hosting co-design sessions, the MLOHT strives to include patients and/or caregivers as part of each core project team to further ensure the voice of patients & caregivers remains at the core of everything we do.

Project charters/workbooks are developed that include outcome measure metrics: quantitative and qualitative measures that are used to verify and validate project outcomes. MLOHT's Key Performance Indicators have been defined and measurement initiated to understand the overall impact of our collective work on the health equity-driven quadruple aim.

We developed a Health Equity Matrix to ensure our engagement reflects the diversity of our community and supports the development of a culturally appropriate health system that effectively reduces health disparities to become a truly equitable health care system.

A. Initial target population (s).

Co-Design discovery interviews were completed with people living with COPD/CHF, caregivers/care partners supporting that population, and caregivers and providers supporting that population. Co-design sessions took place to review, validate and prioritize themes, with the following themes initially prioritized:

- Access to and Awareness of Services
- Sustained Care Relationships

Projects were launched to co-design solutions:

COPD & CHF Care Pathways - *Leading*

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 evidence based, standard care pathways for people living with COPD and CHF to support:

- Equitable access to care – ensure equitable access to minimum standard set of activities

- 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. Early adopter sites include a community health centre to ensure pathway reduces health disparities.

MLOHT Evaluation Framework - *Leading*

To establish an evaluation framework which is in line with the principles of a Health 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.
- 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
- Data collection strategy was drafted and initiated to measure patient outcomes and experience (PROM/PREM) for patients living with COPD and CHF, and Access to Primary Care.

Work is underway with early adopter sites to develop an enhanced, multi-pronged data collection process, that includes online, phone and in person surveying of patients with COPD and CHF. As the group evolves, our Q&A Working Group will serve to identify additional measures to be monitored at population level and develop a measurement plan and/or dashboard.

CHF QBP - *Partnering*

MLOHT is partnering with LHSC, St. Joseph's Health Care London, Middlesex Hospital Alliance, Best Care, HCCSS SW, London InterCommunity Health Centre, TVFHT, OH West and the LMPCA to develop a Spoke-Hub-Node model by embedding an established community-initiated integrated disease management program (Best Care HF) in primary care practices. The proposed model of care leverages current programming like the Advanced Heart Failure Clinic, CC2H, COACH, Telehomecare, Best Care, primary care, and South-West Self Management and seeks to expand program offerings across Middlesex London, expand eligibility criteria, and create formal partnerships between programs to support transitions in care and maximizing scope of practice. This is a system integration project that is expected to benefit patients and caregivers with CHF, providers, and the system as a whole. Expected outcomes include reducing hospital admissions, readmissions, length of stay, and ED revisits, as well as improving patient-reported outcome and experience measures.

Individualized Care Plan (Phase 1) – *Supporting*

Phase 1 background/foundational work to: i) further understand best practices for individualized care planning, ii) revisit past discovery phase data, and iii) conduct co-design sessions to gain consensus on what should be included in an individualized care plan.

Care Manager Model (Phase 1) – *Supporting*

Phase 1 background/foundational work to understand: i) What factors facilitate or hinder the implementation of a care manager program in ML? ii) What providers, patients, and caregivers

believe should be included in a care manager model; and iii) explore similarities and differences between navigation, care management, and care coordination roles.

B. Additional target population(s)

Equity Deserving Co-Design - *Partnering*

First Nations Communities

Health representatives from the 3 local First Nation communities shared their priorities with MLOHT Leadership last summer and identified 3 specific streams of work:

1. Virtual Care in First Nations Communities
2. Improving Access to MHA Supports for Trauma in Communities
3. Health Care Navigation Current State Analysis and Future State Options

Co-design sessions will take place in partnership with First Nations communities to confirm themes and co-design solutions.

Newcomers

Co-design activities are planned for newcomers/refugees in FY 22/23

On Demand Virtual/Phone Interpretation Support (Voyce) - *Leading*

MLOHT is offering primary care providers funding and connection to on-demand virtual and phone interpretation services to enable patients to receive care in a language of their comfort.

cQiP - Mental Health and Addictions - *Partnering*

MLOHT is partnering with healthcare and community organizations to Improve access to community-based Mental Health and Addiction Services in Middlesex London.

Year 1 focuses on two change initiatives:

1. Increase awareness of and promote the use of additional crisis stabilization beds (16+) and crisis lines
2. Evidence-based advocacy for affordable, accessible health and housing supports

cQiP – Cancer Screening - *Supporting*

MLOHT worked with partner organizations to coordinate/design Quality Improvement initiatives and strategies, using a driver diagram approach to Increase overall access to preventative care in Middlesex London.

Year 1 focuses on three change initiatives:

1. Increase cancer screening services for specific (target) population: New immigrants to Canada, Indigenous and First Nation
2. Increase system capacity to complete PAPs by training RNs to perform PAPs in Primary care.
3. Develop a strategy for people that do not have primary care provider to have cancer screening.

The regional cancer care centre will be leading this initiative.

Equity, Diversion, Inclusion (EDI) Collaborative – *Partnering*

Establish a Middlesex London Equity, Diversity, and Inclusion (EDI) Collaborative to facilitate the connection between EDI Leads/Groups to efficiently collaborate on shared priorities and initiatives, including coordinated engagement with equity-deserving populations.

LEGHO (Let's Go Home) – *Supporting*

LEGHO is intended to support providers and patients by removing non-clinical barriers to discharge/community stabilization (legislated co-pay for CSS services, coordination between multiple CSS providers, alignment of clinical & community supports). Through bundled services, patients and care partners will have coordinated access to meals, transportation, homemaking, wellness checks, navigation/community connections with no financial barriers

Individualized Care Plan (Phase 1) – *Supporting*

See Section A

Care Manager Model (Phase 1) – *Supporting*

See Section A

C. Full Attributed Population

Many of the projects and initiatives launched as a result of initial co-design interviews and cQiP requirements will benefit the full attributed population:

Healthcare Navigation – *Leading*, see priority 2, question 1

Consolidated Self-Management Website – *Leading*, see priority 2, question 1

Attributed Population Registry - *Leading*

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. Work under way for this fiscal year include engagement of the OHT Leads community of practice to ensure pan-provincial input and support, development of an OHT Digital Health Coalition for PHM to guide visioning around the digital needs of OHTs related to PHM, commitment to work with OH and MoH staff to explore and address barriers to sharing of PHI with and within OHTs for the purposes of PHM, and work with partners across the system to explore opportunities to identify a sub-population from which the functionality of an Attributed Population Registry can be explored.

Vision - Our Attributed Population Registry Working Group co-designed the following vision “In order for an OHT to support equitable access to well-connected and integrated care, the OHT must have enough information about each member of their attributed population to identify them and connect with them as appropriate.”

Use Cases - To support work towards our vision, use cases are being co-designed to illustrate how population identification, population observation/monitoring and population engagement (in-reach and out-reach) could be made possible via an Attributed Population Registry. Use cases have been developed into storyboards and data flow diagrams to articulate how the data will utilize current provincial digital assets and databases to establish an attributed population registry for Ontario Health Teams and support them to carry out PHM.

Population Identification – Maintaining an up-to-date list of the individuals for which the OHT is accountable. Utilizing the attributed population methodology, our OHT will be able to understand basic demographic information of those in our OHT and those attached to primary care. Our current understanding of the attributed methodology through recent engagements suggests that changes may be required to equitably address those requiring health services in our OHT.

Population Observation/Monitoring – Assess changes in our population over time and inform detailed regional public health interventions. Population monitoring/observation will utilize a team of Population Health Management analysts to track changes over time in their Attributed Population’s demographics such as age, gender, rural/urban mix, and attachment to primary care. These analysts will use this information to chart trends over time to inform local planning and generate an automatically updated OHT dashboard and customized reports as required.

One specific opportunity is the development of risk scores, which could be generated by Ontario Health and distributed to our OHT at the individual level. This would allow our OHT to stratify our population according to risk, compare changes across strata over time, and compare our population in relative terms to those attributed to other OHTs. Another example would focus on establishing the ability to identify the most significant clinical problem facing a patient. Through a focused

identification and monitoring of different disease states such as COPD/CHF, would allow for an understanding of those specific individuals to inform planning and resource allocation across the OHT.

Population out-reach – Use individual-level information like name, address, gender and age to inform targeted service awareness campaigns, pro-active healthcare education, targeted health screening, and individualized data collection.

Population in-reach – Allow people to contact the OHT directly and effectively support triage, follow-up, and documentation of the interaction

Shared Care Record Via Health Information Exchange - *Leading*

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.

The foundation of population health management is promoting positive experiences at the point of care. This requires effective sharing of information between patients/clients/caregivers and their care teams. Improved communication between patients and providers was also noted as an area of improvement by our co-design discovery phase. It is our firm belief that improved interoperability between clinical systems is required to make this happen and that, if done properly, elements of this coordinated data can serve as the foundation for effective system planning and evaluation.

Therefore, the second portion of our Test of Change project focuses on exploring real-time sharing of key information between Primary Care EMRs, Home and Community Care CISOs, and Hospital HISs. This work will also leverage the OH-procured smile CDR and will work in partnership with other data integration efforts including the hospital collaboratives and work by the e-Health Centre of Excellence.

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.

Next phase of the project include working with the OH-procured smileCDR to test data interoperability between Primary Care, Home and Community Care, and Hospital information systems, detail data flow requirements, privacy and legal concerns, roles based access, and technical requirements between systems leveraging existing opportunities wherever possible (eg. smileCDR partnerships with EMR vendors and hospital HIS collaboratives, PHIPA modernization) With our Shared Care Record working group, use cases are being developed to illustrate examples of information needs and data flow that could be supported by a Shared Care Record. These use cases include:

1. Patient File Creation and Update

Leverage centralized data holdings to allow for automatic entry of patient demographic information into charts when a new file is being created and to support automatic updated where appropriate when changes are made. This will reduce the administrative burden for clinical teams and improve the accuracy of information.

2. Appointment Tracking

Facilitate the sharing of appointments between patients/clients and members of their care team. This will support better understanding of a patient's care plan and care team. It can also serve to support system-level care management.

3. Improved Prescribing

Sharing of information on medications between clinical systems will allow patients' and their physicians to better understand medications prescribed in different settings to improve patient safety etc.

4. Improved Care Experiences

Physicians have told us that a consolidated version of key clinical notes would improve their ability to manage a patient. Patients have told us that the ability to share an 'about me' summary of what

matters to them with all care providers they may encounter would help set the stage for improved care experiences. We are exploring how these 2 data elements could be developed and shared.

Referral Management through Ocean eReferrals and eFax – Partnering

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 for patients.

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) and was successful in securing Central Waitlist Management funding.

To simplify workflow, a standard, generic referral form was co-designed with providers. This form has become the standard referral form to be used provincially by all specialists onboarding to Ocean eReferral.

“eReferrals via eFax- Initial Phase” went live May 24th, 2022. This initiative (efax functionality) enables primary care providers to send more referrals through Ocean eReferral regardless of specialist registration. An internal Directory of Specialists in Middlesex London Region was created and their listings in Ocean were updated.

Remaining work:

- Ongoing engagement with primary care providers and specialists through townhalls, newsletters and personal reach out. This shall support and facilitate the transition of Primary Care Providers and Specialists to eReferrals.
- Detailed evaluation plan, along with data analysis, shall be executed in Q2, 2022 in partnership with eCE

Wholistic Needs Screen - Leading

A “wholistic needs screen” was proposed through co-design to support proactive identification and management of health and social determinant needs. This tool is intended to be applied to the full attributed population as a quick, proactive screen for health and social determinant needs, with clear next steps on how to link people with the supports needed. Planning will involve significant co-design with patients, care partners, and providers across the system, as well as detailed review of local and international best practices and tools.

SCOPE (Seamless Care Optimizing the Patient Experience) - Partnering

SCOPE provides an integrated platform across the continuum of care that makes services comprehensive and responsive to patient needs. Primary Care Providers can connect to services through a single point of access (SCOPE+ Line), such as:

- Internist On-call for immediate consultation and urgent assessment and management of their patient’s medical conditions.
- Home & Community Care Coordinator - facilitates access to home and community resources for patients with complex or chronic care needs
- Nurse Navigator - provides general advice and assistance navigating hospital, community, and SCOPE+ services/resources for your patients.
- Diagnostic Imaging - answers questions about different tests and results, escalates urgent imaging requests, and can refer directly to the radiologist on-call.

Model will be co-designed to meet local needs. Launch of this project is pending provincial funding and/or confirmation of a local partner that can contribute resource to this work.

Access to Primary Care – Partnering

MLOHT engaged with primary care providers to define “Access to Primary Care” and determine data sources for the indicator at the London Middlesex Primary Care Alliance (LMPCA) meetings. Next, we will work with our primary care sector to draft a driver diagram to suggest change initiatives to help achieve the target.

cQIP – ALC - Supporting

MLOHT worked with partner organizations to coordinate/design Quality Improvement initiatives and strategies, using a driver diagram approach, to positively impact the cQIP indicators

London Health Sciences Centre, Home and Community care, Kensington Village, SJHC (Parkwood Institute), LTC facilities, Middlesex Hospital Alliance, and Community Support Services will work together to Improve overall access to care in the most appropriate setting. Year 1 focuses on developing and reviewing a collaborative (one form) referral form and process to optimize transitional bed usage across Middlesex London.

MLOHT Communications Plan - *Leading*

A need has been identified to enhance communication to stakeholders about the MLOHT. This includes raising awareness of the future vision and benefits of integrated care and population health management, highlighting the progress on ongoing projects and deliverables that the MLOHT leads, partners and/or supports, and how to get involved. The communications plan will include expanding the MLOHT website with additional info on the future vision and work taking place toward that vision. Other methods will include (but not limited to) MLOHT newsletter, email blasts, flyers/brochures and social media.

Clarification of the long-term vision for OHTs is needed so we can better understand and communicate our future vision, see section at end of document on supports/resources needed.

Learning Collaborative – *Leading*

Establish a Learning Collaborative to provide education and training to partners to establish a shared understanding of our vision and pathway to population health management and person-driven, integrated, wholistic care.

Priority Area 2: Patient Navigation and Digital Access

Priority Area 2 Deliverables	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 deliverable and projected timing for completion.
Implementing patient navigation supports and report on patient utilization.	Green - Progressing Well	Healthcare Navigation Service Phase 2 - <i>Leading</i> 24/7 navigation supports model that facilitates awareness and navigation of available services. Upcoming Milestones: <ul style="list-style-type: none"> • Co-design sessions with different populations including two Indigenous co-design options – Dec 31, 2022 • Middlesex London Navigation Collaborative Kick off -Oct 30, 2022 • Collaboration with Navigation Leads from some of the neighboring West OHTs (Sarnia/Lampton OHT, Huron/Perth OHT etc.) – Oct 30, 2022 • Initiate conversation between 211, Healthline.ca and ConnexOntario regarding information exchange - March 31, 2023 • Supporting OH West with Multi-Tenant Navigator Platform go live - March 31, 2023 Consolidated Self Management Website - <i>Leading</i> Self-Management Programs Network (selfmanagementprograms.ca) was launched on March 31st 2022, consolidating information on self-management programs and workshops in the West region. Upcoming Milestones: <ul style="list-style-type: none"> • Website Participant Registration Report – every quarter • Activity & Expenditure Reports for Marketing the Self-Management Programs Network Website – every quarter
Give patients digital access to their health information through a patient portal or similar access channel, in alignment with provincial direction).	N/A - Not Yet Started	<i>Dependency on Shared Care Record Project and West Region Patient Portal initiative</i> MLOHT participates 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. In addition, LHSC/St. Joseph's are implementing the Cerner patient portal functionality to align with the West Region Patient Portal strategy.
Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings.	Yellow - Some Challenges	Online Appointment Booking - <i>Supporting</i> Upcoming Milestones: <ul style="list-style-type: none"> • Confirm Primary Care providers wanting to implement OAB through one time funding (to date, 8 clinics for a total of 75 licenses identified)- July 31, 2022 • Connect Primary Care providers with eCE to support with OAB implementation – Sept 30, 2022

<p>Report on progress enhancing virtual care maturity and access.</p>	<p>Green - Progressing Well</p>	<p>Improve access to virtual care in First Nations Communities – <i>Partnering</i>, see priority 1, deliverable 2</p> <p>Remote Care Management/Surgical Transition - Supporting MLOHT is supporting a remote care management/surgical transition funding proposal with regional partners. Upcoming Milestones:</p> <ul style="list-style-type: none"> • Funding decision – Aug 30, 2022 <p>Virtual Urgent Care - PAEDS – <i>Supporting</i> LHSC is leading the sustainability of the Pediatric Virtual Urgent Care clinic and has begun engaging with Primary Care (LMPCA Co-Chair) re: opportunities for improving the coordination of patient care between Primary Care Providers (PCP), Emergency Department (ED) and the Virtual Urgent Care (VUC). Upcoming Milestones:</p> <ul style="list-style-type: none"> • Sustain current model until September 30/22 • Weave ideas discussed for improving connections across the patient journey into considerations for our Improving Access to Primary Care Working Group – Sep 30, 2022 <p>On Demand Virtual/Phone Interpretation Support (Voyce) – <i>Leading</i>, see priority 1, deliverable 2</p> <p>Healthcare Navigation Services Online Platform – Supporting MLOHT is supporting Ministry in development of the provincial online Health Care Navigation Service (HCNS). Upcoming Ministry Milestones:</p> <ul style="list-style-type: none"> • Initiate conversation between 211, Healthline.ca and ConnexOntario regarding information exchange by March 31st, 2023. • Supporting OH West with Multi-Tenant Navigator Platform go live March 31st, 2023. <p>Consolidated Self-Management Website – <i>Leading</i>, see priority 2, deliverable 1</p> <p>Virtual Care Maturity Model Assessment – <i>Supporting</i> Conduct an environmental scan, leveraging the provincial Virtual Care Maturity Model, to establish the current state of virtual care operations across Middlesex London health care partners, and to determine key priorities/targets to advance virtual maturity across the MLOHT. Upcoming Milestones</p> <ul style="list-style-type: none"> • Launch project - TBD
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1. Describe the steps your team has taken and/or will take to implement 24/7 patient navigation supports for your attributed population by fiscal year 2022-2023.

Healthcare Navigation Services - *Leading*

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

Phase 1 of this project was supported by HCNS one-time 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 a First Nations/Indigenous Lead to ensure appropriate focus on these two key stakeholder groups.

To date, the following problem statements have been identified

- Although there are many phone numbers and websites to find health care services, community agencies, providers, and primary care practitioners may not always know who or where to go to for help.
- The model of care that a primary care practitioner practices in may impact the ability to navigate supports for their patients.
- There are persistent issues with internet connectivity for rural county areas.
- Individuals often need to lead their own advocacy and repeat their stories due to the lack of "true" warm transfers between sectors (e.g., primary care and community services) and sometimes, within sectors (e.g., primary care).
- High proportion of patients/clients, caregivers/care partners have low digital literacy
- The COVID pandemic impacted the ability to connect with many partners; engagement will need to continue.

Phase 2 of the project is to focus on how to improve awareness of and access to services for patients/clients, caregivers/care partners, providers and to improve the care journey by facilitating seamless transitions. This is to be achieved by the following:

1. Provide patients/clients, caregivers/care partners and providers with 24/7 navigation supports that facilitate access to care by:
 - Supporting the provincial Health Care Navigation Service (HCNS) digital platform
 - Creating & implementing a local (non-digital) navigation support model for marginalized patients/clients, caregivers/care partners.
2. Continue to strengthen and expand effective representative engagement of patients/clients, caregivers/care partners, providers in the planning, design, delivery and evaluation of OHT implementation activities.

Consolidated Self-Management Website - *Leading*

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, MLOHT 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 was co-designed with patients, clients, care partners and providers and launched on March 31st 2022: <https://selfmanagementprograms.ca/>

Marketing of the website and individual self-management programs is ongoing.

3. Describe the steps your team has taken and/or will take to enable patients in your attributed population to digitally access their health information (e.g., through a patient portal or other access channel). As part of your response, identify what steps will be taken to continually expand access (e.g., to more patients, to more information, etc.).

The MLOHT is leading proof of concept projects implementing a shared care record and attributed population registry. The patient portal will need to integrate effectively with the resulting shared care record. Because of this dependency, patient portal is not in scope of this first phase of work.

In the meantime, MLOHT participates in the West Region Patient Portal initiative to stay informed of and provide advice to the regional direction. Furthermore, the MyChart portal is already in place and will continue supporting patients until the implementation of the West Region Patient Portal Initiative. In addition, LHSC/St. Joseph's will be implementing Cerner's patient portal to support advanced functionality for patients receiving acute care services. The self-management website will increase access to virtual self-management workshops.

4. Describe the steps your team has taken and/or will take to expand access to Online Appointment Booking (OAB) for your attributed population in primary care settings. As part of your response, identify how many primary care providers who are members of your OHT currently do and do not offer OAB.

Booking Appointments online was not among the co-design themes and therefore not prioritized for implementation by the MLOHT leadership.

The MLOHT is leading proof of concept projects implementing a shared care record and attributed population registry. The OAB solution will need to integrate effectively with the resulting shared care record. Because of this dependency, OAB is not in scope of this first phase of work, but will be included in continued planning.

In the meantime, we have requested/expressed interest in being advisory to the OH West Online Appointment Booking work.

We have also shared the one-time OAB funding opportunity with primary care providers, with clear acknowledgement that we may be moving to a standard OAB solution in the future. Providers understand that they can implement the OAB of their choice but depending on which OAB solution becomes the standard, they might be required to transition to a different OAB in the future. Eight primary care providers (requiring 75 licences) have expressed interest in the one-time OAB funding opportunity.

5. Describe the steps your team has taken/will take to enhance its virtual care maturity and access to virtual care for your attributed population. As part of your response, provide a baseline assessment of your OHT's virtual care maturity.

The MLOHT Coordinating Council reviewed the virtual care survey and agreed for the Operations Team to determine how to best implement to add value for our local partners, which may include a sampling approach with primary care. The LHSC/St. Joseph's Health Care London Virtual Care Team has offered to deploy the Virtual Care Maturity Model Assessment across Middlesex London health care partners, determine priorities based on results, and develop and implement a plan for supporting organizations in advancing their maturity, with support from the MLOHT Operations Team. Deployment of the assessment is tentatively planned for this fall, following which we will better understand our baseline maturity.

Virtual care and projects to enhance and optimize virtual care in MLOHT include:

Improve access to virtual care in First Nations Communities – *Partnering*

Three local First Nation communities identified improving access to virtual care as one of their priority themes. Co-design sessions will take place with First Nations communities to understand current state of virtual care in First Nations Communities, opportunities for improvement, and develop implementation plan.

Remote Care Management/Surgical Transition - *Supporting*

MLOHT is supporting a remote care management/surgical transition funding proposal with regional partners. MLOHT is currently working with partners including OH West, Middlesex Hospital Alliance, London Health Sciences Centre, St. Joseph's Health Care London, and Home and Community Care Support Services to collectively apply for funding to sustain and scale programs that provide remote care management to priority, vulnerable and surgical patients to enable clinical monitoring in the home and community. Projects are pending funding.

Virtual Urgent Care - PAEDS – *Supporting*

Children's Hospital at LHSC launched virtual urgent care as a means to provide patients and caregivers with an opportunity to receive timely and convenient access to urgent health care from a regional Pediatric Emergency Department physician. Hospital EDs who receive patient referrals from the Virtual Urgent Care benefit from the virtual assessment and are better prepared to address the acute care need when the patient arrives.

On Demand Virtual/Phone Interpretation Support (Voyce) – *Leading*

MLOHT is offering primary care providers funding and connection to on-demand virtual and phone interpretation services to enable patients to receive care in a language of their comfort.

Healthcare Navigation Services – *Supporting*

MLOHT is supporting the Ministry in the development of the provincial Health Care Navigation Service (HCNS) digital platform.

For information on the MLOHT Healthcare Navigation Project, see *priority 2, question 1*

Consolidated Self-Management Website – *Leading, see priority 2, question 1*

The consolidated self-management website includes access to information to virtual self-management programs and workshops.

Virtual Care Maturity Model Assessment – *Supporting*

Conduct an environmental scan, leveraging the provincial Virtual Care Maturity Model, to establish the current state of virtual care operations across Middlesex London health care partners, and to determine key priorities/targets to advance virtual maturity across the MLOHT.

Virtual Care Maturity Model Assessment – Supporting, Pending CC Approval

Conduct an environmental scan, leveraging the provincial Virtual Care Maturity Model, to establish the current state of virtual care operations across Middlesex London health care partners, and to determine key priorities/targets to advance virtual maturity across the MLOHT.

6. Describe key planned activities related to data governance, privacy, and the development of harmonized information management policies and practices. This can include expansion or revision of existing Harmonized Information Management Plans.

Clarification of the long-term vision for OHTs is needed to determine data governance and privacy strategies, see section at end of document on supports/resources needed.

Data Governance

Data governance policies will be developed in conjunction with our project partners to ensure patient health information is protected. Through the development of use cases and data flows, data governance requirements will be established and validated by the appropriate parties. Through our OHT Test of Change projects, an initial understanding of First Nations principles of OCAP has taken place. It is the intention of the project team to continue fruitful engagement with local First Nations partners and ensure appropriate training on the OCAP principles is completed.

Privacy

In addressing current privacy requirements and next steps to move our OHT forward, a couple avenues are being explored. Through our Test of Change projects, storyboards and data flow diagrams are in development to understand how Population Health Management activities will require modernization updates to PHIPA legislation. In collaboration with Ontario Health and other identified OHTs, a privacy committee will be formed to identify recommendations for changes that will enable key PHM activities to be put into practice to support better health for all members of our attributed population. Also, our OHT will be looking to utilize privacy templates developed by other OHT partners to ensure privacy implications are assessed at multiple points of a project.

Harmonized Information Management Plan

The pending 2023/24 updated HIMP for the MLOHT will be centred around standardization of tactics/strategies within the OH West Digital priorities., and key strategic projects supported by OH (including Tests of Change and Clinical Services Renewal).

7. If your team is pursuing any digital health or virtual care priorities not already noted above, please describe them here.

N/A

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

Priority Area 3 Deliverables	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 deliverable and projected timing for completion.
Develop and implement an enhanced governance model and processes that align with provincial direction (when available).	Green - Progressing Well	<ul style="list-style-type: none"> • Simplify Membership Process – Oct 30, 2022 • Establish Governance Sub-Committee to focus on the implementation of the enhanced governance model – Oct 30, 2022 • <i>Identify additional milestones pending provincial direction</i>
Report on progress implementing Patient, Family and Caregiver Strategy.	Green - Progressing Well	<ul style="list-style-type: none"> • With PCCPC, select evaluation tools for patient/client, caregiver engagement and incorporate them into operations – Oct 30, 2022 • With PCCPC, review number of patients, clients and care partners engaged (co-design sessions, projects, PCCPC), compare with Health Equity Matrix and identify gaps in our engagement – Nov 30, 2022

1. Please **briefly** describe your team’s existing collaborative governance structures and processes (diagrams may be appended). Identify any progress, achievements, or innovations to date regarding your team’s governance structures or processes that you would like to highlight. Challenges may also be identified. This information is being collected for informational purposes only and will be used to support the ministry and OH in better supporting OHTs.

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. Clarification of the long-term vision for OHTs is needed to further determine governance requirements, see section at end of document on supports/resources needed.

Cluster Representation Model

The MLOHT is founded on voluntary collaborative decision-making arrangements; it is essential to implement mechanisms to provide representation from health and key stakeholder sectors while constraining the number of Coordinating Council voting members to a manageable number. Hence, the Coordinating Council is structured on the cluster representation basis.

To provide representation across its members, the MLOHT has recognized the following Clusters:

- Patients/Clients and Caregivers,
- Primary Care,
- City of London,
- Community Support Services,
- Home and Community Care,
- Hospitals,
- Indigenous Community,
- Long Term Care,
- Mental Health/Addictions,

- Middlesex County,
- Middlesex-London Health Unit,
- Middlesex-London Paramedic Service

Decision-Making Framework

The Middlesex London Ontario Health Team (MLOHT) decision making framework describes the MLOHT’s decision-making process. This framework 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.

Table shows Decision Levels:

MLOHT Lead
<ul style="list-style-type: none"> • Quarterly Reports • Cost items that fall within approved budget lines up to \$10,000
Operations Team
<ul style="list-style-type: none"> • Requests for MLOHT support and Decisions to submit MLOHT funding proposals <ul style="list-style-type: none"> o Cost estimate <\$10,000 within existing budget, and o MLOHT hours of effort <100 within existing human resources, and o Low impact on existing MLOHT deliverable timelines o Low impact across system (multiple sectors) • Decisions in line with transfer payment agreement, work plans and priorities
Coordinating Council
<ul style="list-style-type: none"> • Letters to Ministry on behalf of Coordinating Council • MLOHT budget • Strategic Plan • Requests for MLOHT support and Decisions to submit MLOHT funding proposals <ul style="list-style-type: none"> o Cost estimate >\$10,000 within existing budget, or o MLOHT hours of effort >100 within existing human resources, or o Med-high impact on existing MLOHT deliverable timelines o Medium to High impact across system (multiple sectors) • Prioritization of Projects • MLOHT Policies and Governance Documents • Project Charters for Significant Change Projects
Coordinating Council – Requires consult with cluster
Decisions brought forward to Coordinating Council that have medium to high impact on respective cluster members

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 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:

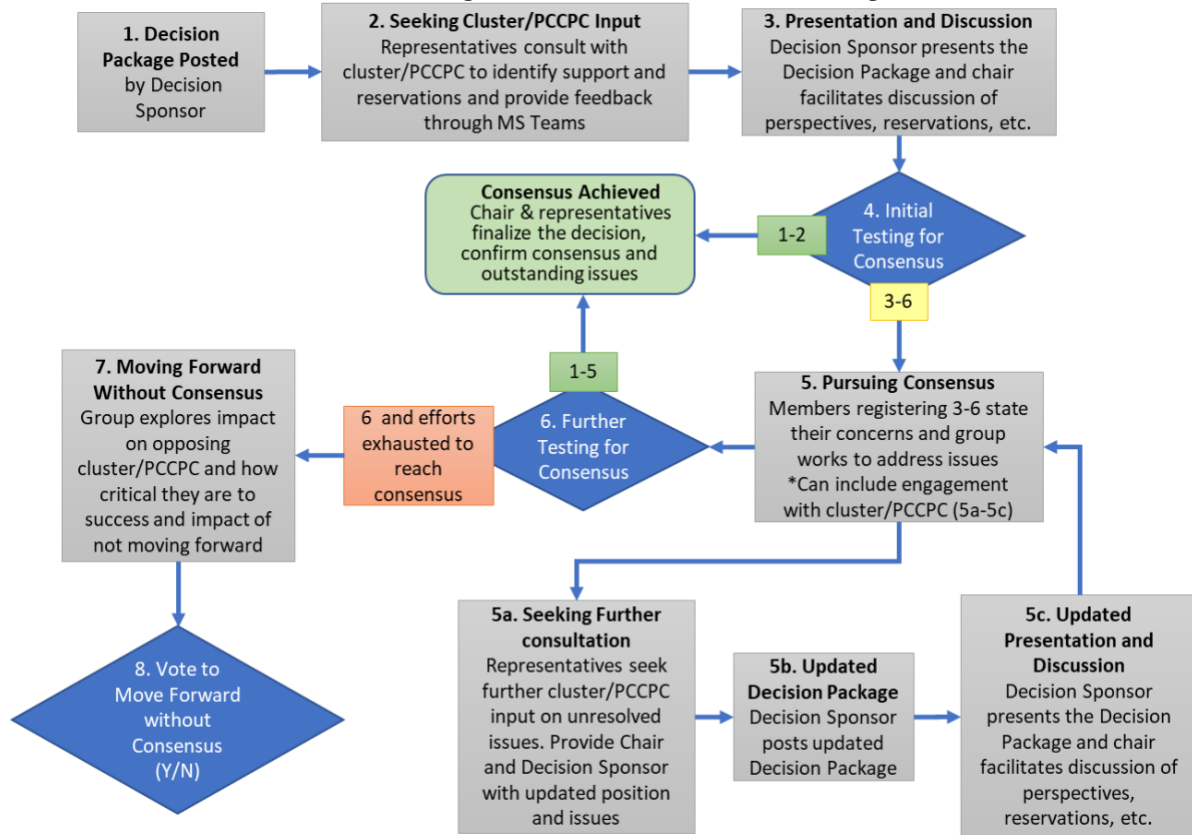
- Assessing requests for MLOHT support,
- Seeking funding for MLOHT initiatives/launch of projects, and
- Prioritizing projects based on estimated impact and effort associated with our purpose, goals, and commitments

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

Flowchart and Table shows resulting Process and Matrix for Seeking Consensus:



Consensus Position Level Matrix

Level	Position	Support for Decision	Reservations about the Decision or its implications.	Likely to Participate in its Implementation
1	Strongly Agree	My cluster (organization)/PCCPC strongly agrees with this decision.	No outstanding reservations.	Cluster/PCCPC supports participation as appropriate.
2	Agree	My cluster (organization)/PCCPC agrees with this decision.	No outstanding reservations.	Cluster/PCCPC supports participation as appropriate.
3	Agree with Reservations	My cluster (organization)/PCCPC agrees with this decision with some reservations.	Have one or more reservations.	Cluster/PCCPC supports participation as appropriate.
4	Disagree, but will go along with the majority	My cluster (organization)/PCCPC disagrees with this decision, but will go along with the majority	Have one or more reservations but willing to allow the group to go ahead with decision.	Cluster/PCCPC supports participation as appropriate.
5	Disagree and won't be involved in implementation	My cluster (organization)/PCCPC disagrees with this decision, and won't be involved in implementation	There are outstanding concern(s) that need to be addressed.	Will not participate unless outstanding concern(s) are <u>addressed</u> , but won't work against implementation.
6	Opposed and will work to block	My cluster (organization)/PCCPC opposes this decision, and will work to block implementation	Have fundamental objections to the decision.	Will oppose and work to block implementation.

Any representative wishing to abstain from the process will be given the chance to do so and this will be recorded in the meeting minutes.

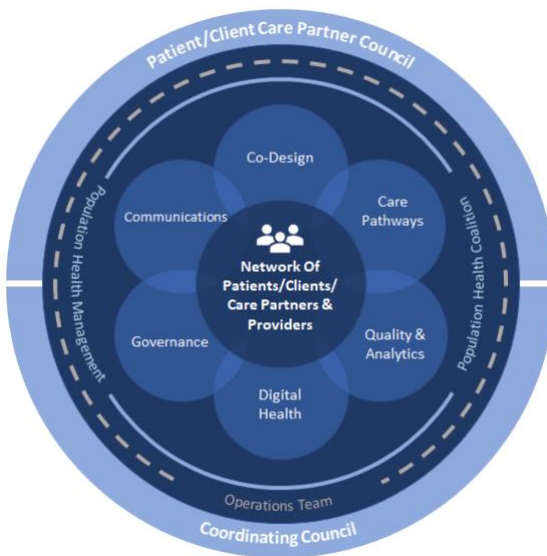
2. Describe the processes and structures your OHT has put in place to date to implement the engagement domains and approaches identified in your OHT's Patient, Family and Caregiver (PFC) Partnership and Engagement Strategy.

At Middlesex London Ontario Health team, we apply a health equity, quality improvement, population health, and co-design approach to everything we do.

Patient/Client/Care Partners are embedded in the MLOHT governance structure:

Patient/Client/Care Partners Council (PCCPC)

Our structure values patients, clients, and care partners. We consider our local network of patients, clients, care partners, and providers at the centre of everything we do. This is exemplified by the value we place in our Patient/Client and Care Partner Council (PCCPC).



PCCPC plays a key role in supporting patient/client and caregiver health system governance, accountability and stewardship toward 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. In January 2022, the MLOHT worked with the PCCP Council to further define the role of the PCCP Council and the role of the PCCP Network, honouring the interest and capacity of the PCCP Council members and our Patient, Family and Caregiver Partnership and Engagement Strategy commitments.

PCCP Council responsibilities include:

- Co-Chair Coordinating Council
 - PCCPC chair serves as a Coordinating Council Co-Chair
- Represent patient/caregiver voice on 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).
 - PCCPC Report is a standing agenda item at Coordinating Council meetings and Coordinating Council Report is a standing agenda item at PCCP Council.
- Represent patient/caregiver voice on Operations Team
- Receive updates on Operations Team progress
- Engage in policy development, strategy and system level discussions
- Provide input on MLOHT Decisions
 - The PCCPC actively uses the consensus decision making tool in their meetings to come to agreement on topics. The results of PCCPC consensus votes informs Coordinating Council discussions and decisions.
 - PCCPC meets prior to each Coordinating Council meeting to review and discuss upcoming Coordinating Council decisions to support their two Coordinating Council voting members in effectively representing the patient and caregiver voice.
 - MLOHT's Decision Tool to evaluate all requests from partners for MLOHT support and prioritize new projects includes a check box to track whether PCCPC has been informed/involved/has supported the request.
- Develop and maintain PCCPC structure (ToR, policies and practices)
- Support Evaluation/Continuous improvement of patient/client, caregiver engagement process
- Participate in Rise - Patient, Caregiver Community of Practice
- As PCCP Council members are also part of the PCCP Network, they have the option of also participating in co-design activities, project teams, working groups and interview panels.

Patient, Client, Care Partner Network

The Patient, Client, Care Partner Network represents a broader pool of patients, clients and care partners that are engaged for the following purposes:

- Co-Design Activities
 - Represent patient/caregiver voice through discovery interviews and co-design sessions
- MLOHT Project Working Groups
 - Represent patient/caregiver voice on MLOHT Project Teams and Working Groups
- Participation on Interview Panels (for hiring of MLOHT staff)

MLOHT is exploring the possibility of setting up an engagement software platform, in the future, to obtain ongoing and regular input from the Middlesex London community.

MLOHT is committed to Co-Defining issues and Co-Designing Solutions with Patient, Client, Care Partners and Health Care Providers:

- Meaningful engagement and co-design is featured as a foundational value of our OHT. We work with patients/clients, care partners, and providers to co-define the problems that we need to focus on and co-design the solutions for improved care. Partners are not only engaged in discovery and co-designing of solutions but also during implementation and evaluation.
- When prioritizing new projects for implementation, the MLOHT Decision Tool is used to assess each opportunity for alignment with our co-design themes, (i.e how it addresses needs identified through co-design interviews) and expected positive impact on our health equity-driven quadruple aim. Project deliverables are co-designed with patients/clients, care partners/caregivers, and providers. In addition to hosting such co-design sessions, the MLOHT strives to include patients and/or caregivers as part of each core project team to further ensure the voice of patients & caregivers remains at the core of everything we do.
- Informed by PCCPC, the MLOHT developed a framework for effective engagement and co-design. This includes interview guides to support discovery phase, co-design onboarding materials, co-design session slide decks, pre-event materials, and session facilitator guides.

MLOHT is committed to a population health management approach that focuses on patient/client-driven care, with an emphasis on patient/client empowerment at point-of-care:

- Projects launched to support population health management approach include the Attributed Population Registry and Shared Care Record
- Projects completed that support patient/client-driven care, with an emphasis on patient empowerment include the Consolidated Self-Management Website. Additionally, new projects to be launched FY 2022/2023 include Individualized Care Planning and Care Manager Models.

Priority Area 4: Primary Care Engagement and Leadership

Priority Area 4 Deliverables	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 deliverable and projected timing for completion.
Develop and implement a model and process(es) to enable primary care providers to have a collective voice in OHT activities and OH tables.	Yellow - Some Challenges	<ul style="list-style-type: none"> Hire MLOHT Clinical Lead (Primary Care) – September 30/22 (Primary Care Clinical Lead posting published – July 14, 2022)
Develop and implement a plan to connect additional primary care providers and other clinicians to the OHT.	Yellow - Some Challenges	<ul style="list-style-type: none"> Activate Primary Care Digital Health Advisory Group – September 30, 2022 Hire Clinical Improvement Project Support role to support clinicians ‘on the ground’ to participate in OHT improvement work and to release more time of Clinical Leads to engage with peers and– September 30, 2022 Simplify Membership Process to more easily enable clinicians to affirm and document their support/involvement with the OHT – Oct 30, 2022

1. Provide an overview of the overall implementation approach and methods for physician, primary care provider and other clinician involvement in the OHT including: communication, involvement in OHT decision making, leadership roles, and provider experience (if available). In your response, please identify how you used data to inform your approach (e.g., INSPIRE primary care reports)

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 (2 physicians and 1 administrator) and thereby 3 votes
- MLOHT Coordinating Council is co-chaired by 1 primary care administrator (and 1 caregiver)
- 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

- MLOHT calls to action are communicated via LMPCA newsletter (e.g., co-design session recruitment, Townhalls, onboarding to eReferral recruitment, self-management website poster for clinics, etc.)
- 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 and several specialists participated in Referral Management Co-Design Sessions
- 7 primary care providers participated in Co-Design sessions, validating and prioritizing co-design themes
- Actively recruiting second Clinical Lead who will represent primary care
- Financially supporting a portion of the London Middlesex Primary Care Transformation Lead role to signal the value that the OHT places on the organization of and partnership with primary care

2. Identify activities that the OHT is undertaking to involve primary care providers and other clinicians in clinical pathway redesign and supporting clinical care planning.

- Working with Thames Valley Family Health Team (TVFHT) and London Intercommunity Health to identify early adopter clinical teams to implement COPD and CHF care pathways; leveraged lessons learned and clinical expertise of Best Care program
- Leveraging work between TVFHT, St. Joseph's Health Care London and LHSC Mental Health Care Programs to develop a collaborative mental health and addictions care pathway for lessons learned and opportunities for alignment and integration
- Pulling primary care partners into discussions regarding Pediatric Virtual Urgent Care
- Including primary care partners in the development of our local Community Support Services (CSS) Let's Go Home (LEGHO) model

3. Describe existing and planned OHT activities to strengthen and expand primary care provider and other clinician leadership, including emerging models such as physician associations, primary care councils and networks.

- Continuing to explore opportunities for MLOHT support of leadership activities of London Middlesex Primary Care Alliance
- Planning a Town Hall for early fall focused on engagement of community specialists
- Preliminary discussions underway for opportunities to engage a broader sector of community and hospital physician leadership on 2-3 times per year to provide updates on OHT and other regional activities and look at opportunities for collaboration and integration

Clarification of the long-term vision for OHTs is needed, in particular clarification of accountability for an integrated primary care system, see section at end of document on supports/resources needed.

Priority Area 5: COVID-19 Response and Recovery

Priority Area 5 Deliverables	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 deliverable and projected timing for completion.
Develop and implement a plan for COVID-19 response and recovery in alignment with provincial direction.	Green - Progressing Well	MLHU, LMPCA, MLOHT meeting to support COVID-19 response – Aug 10, 2022 cQiP –Improve access to community-based Mental Health and Addiction Services in Middlesex London – <i>Partnering</i>, see priority Area 1, deliverable 3 cQiP – Cancer Screening - <i>Supporting</i>, see priority Area 1, deliverable 3 cQiP – ALC – <i>Supporting</i>, see priority Area 1, deliverable 4

1. Please outline the activities the OHT is currently planning to undertake to mobilize OHT members to support COVID-19 preparedness, response and recovery through the integrated and co-ordinated delivery of services, in alignment with provincial direction

COVID-19 Response

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 participates in monthly meetings with the Middlesex London Health Unit and London Primary Care Alliance to stay aligned in COVID-19 response and offer support where needed. MLOHT has provided administrative support to these meetings since January 2022.

MLOHT will continue offering support when and where needed, this may include:

- Partner to plan and execute cultural community COVID Vaccine clinics
- Support the MLHU by distributing through our communication channels, calls for clinical staff, vaccinators and volunteers to expand the capacity of their mass vaccination sites.
- Provide N95 mask fit testing for community-based staff across the healthcare system
- Support care pathways and planning for regional COVID-19 response programs

To support equitable access to vaccine, MLOHT continues offering virtual & phone interpretation services to primary care providers and home and community care (servicing temporary foreign agricultural workers), facilitating Covid-19 vaccination discussions and care in language of their comfort.

MLOHT continues offering bus tickets to Vaccination Clinics, primary care providers, and community resource centres to distribute to people needing support in accessing the COVID-19 vaccine.

The MLOHT financially supports a primary care representative to 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.

COVID-19 Recovery

To support COVID-19 recovery, MLOHT plans to develop and manage an MS Teams site where leaders of each organization across our region can share resources, discuss issues (including lack of Health Human Resources) and share ideas for recovery (how to support staff, etc.)

To support COVID-19 recovery, MLOHT brings together partners to develop yearly collaborative Quality Improvement Plans (cQiP) and supports implementation of change initiatives:

- **cQiP –Improve access to community-based Mental Health and Addiction Services in Middlesex London – *Partnering*, see priority Area 1, question 3B**
- **cQiP – Cancer Screening - *Supporting*, see priority Area 1, question 3B**
- **cQiP – ALC – *Supporting*, see priority Area 1, deliverable 4, question 3C**

Other Implementation Updates

Recognizing that teams have been advancing the OHT model in ways that may not be captured within the above five priority areas, if there are any other achievements or leading practices that your OHT would like to share please include them below:

Strengthening our shared vision of Population Health Management and Integrated Care

On June 8th, the MLOHT Operations Team met for a full day retreat to:

- Understand where we are in our journey toward population health management and integrated care
- Identify gaps in current work and opportunities to strengthen current activities and/or add new activities/projects/initiatives

In preparation for the retreat, the team reviewed the key frameworks which we are aligning our work with, including:

- OHT TPA Priorities 2022/23
- MLOHT Co-Design Themes
- International Foundation for Integrated Care (IFIC): Pillars of Integrated Care
- Rapid-Improvement Support and Exchange (RISE): OHT Building Blocks

The Operations team explored: “Once we have achieved our vision of Population Health Management and Integrated Care, what will be different?” Achievements and work underway to support that vision were listed, and gaps/opportunities identified.

On June 23rd input was sought from the Coordinating Council and on July 7th input was sought from the Patient, Client Care Partner Council to further envision what will be different once we have achieved our vision of Population Health Management and Integrated Care for patients, clients, care partners, front-line providers, organizations and boards. Input has also been sought from one First Nations leader to date.

Our shared vision includes: *Seamless integrated, coordinated care focused on what matters to the patient/client, person-driven, Kindness, respect and value for care providers. Inclusive Healthcare available and accessible to all. Social services, municipalities and traditional health care services work together, wrap services around the patient/client. Police and Mental Health workers work together. Wholistic support for people with MHA challenges. Better communication between providers and less administrative burden. Expectation of boards and leaders to be good partners and march together to support an integrated system.*

Prioritization of New Projects

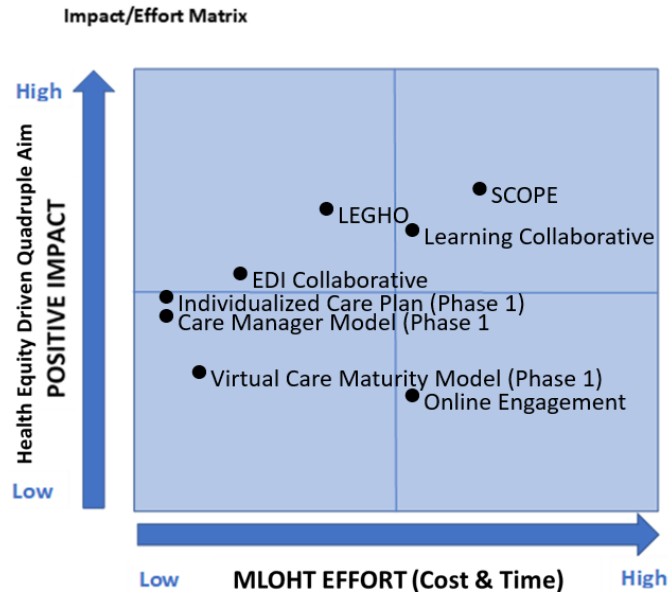
Operations Team members reviewed the gaps/opportunities identified to support our vision. I.e. what work needs to be done to achieve our vision of PHM and Integrated Care, that is not yet underway/planned. The gaps/opportunities were themed/grouped, and either added to the scope of existing projects or positioned as new projects for consideration. Our Decision Tool was completed for each new potential project to describe the opportunity and assess alignment with our co-design themes, impact on our health equity driven quadruple aim, effort of implementation, risk considerations, etc.

New projects for consideration include:

- Individualized Care Plan (Phase 1)
- Care Manager Model (Phase 1)
- Learning Collaborative
- Equity, Diversion, Inclusion Collaborative
- Virtual Care Maturity Model (Phase 1)
- Online Engagement (Bang the Table)
- LEGHO (Let's Go Home)

- SCOPE (Seamless Care Optimizing the Patient Experience)

On July 13th, the Operations Team reviewed each decision tool and together mapped each new project on an impact/effort matrix. The team compared the projects on their estimated positive impact on the health equity-driven quadruple aim (patient experience, patient outcomes, provider experience, value) and effort required of the MLOHT Operations team to implement (cost, time). Estimates are best guess.



Recommendation:

Considering MLOHT’s budget and Operations team capacity, the Operations team agreed on the following recommendation for prioritization of new projects:

New Projects Prioritized for Initiation:

- LEGHO – MLOHT to Support
- Individualized Care Plan Phase 1 – MLOHT to Support
- Care Manager Model Phase 1 – MLOHT to Support
- EDI Collaborative – MLOHT to Partner
- Virtual Care Maturity Model Phase 1 – MLOHT to Support

New Projects Prioritized for Initiation if/when project funding and/or sufficient in-kind partner support is secured to reduce impact on MLOHT capacity:

- SCOPE – MLOHT to Partner
- Learning Collaborative – MLOHT to Lead/Partner

Operations Team recommends holding off launching Online Engagement Project until MLOHT’s Communications Strategy is further along, and potential, perceived reputational risk is reduced.

Creating a Culture of Celebration

Our MLOHT strives to create a culture of celebration. The MLOHT Operations Team considered 3 types of celebration and has started to identify strategies for celebration.

Personal Celebration

Purpose: To ensure people feel valued and are recognized for their efforts.

MLOHT Internal Celebration

Purpose: Team building, maintain strong connections and trust, and create a joyful work environment

MLOHT External Celebration

Purpose: As part of change management, celebrate the small wins, this approach helps us and our partners maintain momentum and interest (especially important for long term projects) and helps build interest and trust in the MLOHT. This helps to promote goal setting and achieving those goals.

- At the June Operations Team Retreat, the team identified celebratory milestones for each project.
- Strategies are being developed for how to celebrate such milestones outwardly such as recognition in the MLOHT Newsletter, MLOHT Milestone Marker email blast, Milestone Marker celebrations on Coordinating Council and Operations Team agenda.



What supports and/or resources would help you with completion of your deliverables?

- Clarification of the long-term vision for OHTs including details on the expectations for “clinical and financial accountability of for our attributed population” and the anticipated financial and capital supports that will be made available to OHTs in support of this vision. Desire for consistency and alignment across OHTs.
 - In particular, clarification of accountability for an integrated primary care system.
- Sustainability of the OHT Impact Fellows model/program (funding for and opportunity to hire another Fellow in time to replace our current Fellow team member)
- Acceleration of the provincial Remote Care Monitoring platform procurement process – the recent recommendation to “pause further enrollment in your RCM program as soon as necessary to enable patients to complete their pathways” is not a feasible mitigation strategy for us in Middlesex London where our Telehomecare RCM program was confirmed as a key, positive program to support our initial population of priority during co-design discovery discussions with our community. We are requesting that Ontario Health reconsider their position that “there will not be a new provincial vendor for RCM programs in place by December 31, 2022”. Our community would highly value a reprioritization of activities to achieve the procurement a new provincial Remote Care Management (RCM) solution before December 31, 2022. The risk of not having standardized digital health solutions will impact quality of care and sustainability to fund the solutions.
- Establishment and sharing of an overall, provincial digital health roadmap that works backward from a PHM point of care solution and accompanying architecture; we would be more than happy to participate in provincial digital health planning events
- Equitable access to base funding for SCOPE models beyond the Greater Toronto Area
- Confirmation of support for our Test of Change projects, including approval of additional project funds and approval of contract for smileCDR.
- Acceleration of modernizing the Attributed Population methodology to ensure that the methodology is appropriate for the purposes of engaging individual members of the population (example, geographical and care location context) and ensures inclusion of all Ontarians.
- Acceleration of PHIPA modernization to enable OHTs to have PHI transparently shared to advance the health of the population through population health management.
- Greatly expand the OH West funding envelope for CSR projects as preparation step for successful point of care PHM.
- Establish and enforce standards for EMR vendor interoperability and point of care population health management functionality.
- Greater clarity of roles of OHTs in regional/cross-OHT initiatives. Example: Frail Seniors Strategy, Ontario Structured Psychotherapy.
- Supporting education and training regarding “Structural Inequity” and support strategy/initiatives to address it.
- Support from Ontario Health to allow for the integration of the databases of 211, ConnexOntario, and thehealthline.ca. This would improve the provider experience as it regards to updating each site to ensure current information.
- Provincial financial support for Primary Care Leadership (e.g., to support active participation in local Primary Care Alliance meetings and work)

- Regular updates on the formation of the multi-tenant navigator, including timelines and clearly identified deliverables and expectations for the OHTs to ensure the work of the OHT aligns with Ontario Health.