Cohort 1 OHT: 2022-23 Year End Progress Report

Ontario Health Team (OHT) Name:	Middlesex London Ontario Health Team
Reporting Period:	Jan 1, 2023 to March 31, 2023

The Year End Progress Report consists of three components:

1) Narrative & Progress Update
2) TPA Performance Indicator Reporting
3) Financial Expenditure Statement

The Year End Progress Report is due on April 28, 2023 and should be submitted to Ontario Health at ontariohealthteams@ontariohealth.ca, copying your regional point of contact.

PART ONE: NARRATIVE & PROGRESS UPDATE

The Narrative & Progress Update provides the opportunity for your OHT to report back on progress against TPA outputs and milestones, specifically deliverables outlined in the Population Health Management and Equity Plan (or 'OHT Plan') submitted on July 29, 2022. Please ensure that narrative updates reflect any achievements or outcomes since the Mid-Year Progress report (April 1 to December 31, 2022).

There are no word limits to this component of the Year End Progress Report, but brevity is encouraged. **Please submit this component of the Report as a Microsoft Word document (please do not submit in PDF format)**. Please ensure your OHT name is included in the file name.

Collaborations

The Ministry of Health and Ontario Health are interested in learning more about how municipalities are engaged in OHTs. Your responses to the optional questions below may be shared with provincial stakeholders including the Association of Municipalities of Ontario (AMO).

	Response
OPTIONAL: Do you have one or more municipalities as signatory members of your OHT? If yes, please describe below the type of municipal representative(s) engaged in OHT decision-making and the services and/or programs they represent or administer.	☒ Yes ☐ No
City of London and County of Middlesex are represented on the MLOHT Coordinating Council as voting members. The City of London representative is the Deputy City Manager, Social Health and Development. The County of Middlesex representative is the Manager of Social Services at Middlesex County.	
OPTIONAL: If no, does your OHT have one or more municipalities engaged in another capacity (e.g., affiliate member)? If yes, describe below the type of municipal representative engaged in OHT activities, the services and/or programs they represent or administer, and the nature of their engagement in the OHT.	☐ Yes ☐ No
N/A	
OPTIONAL: If applicable, provide 1-2 examples of how municipal member(s) have been engaged in planning and delivering an OHT initiative.	
The City of London Director, Anti-Racism and Anti-Oppression has been engaged in the planning of the MLOHT Equity, Diversity and Inclusion Collaborative. The MLOHT Lead and several members of the MLOHT Operations Team have been engaged in the Whole of Community System response, a cross-sectoral response to address health and homelessness in London. This initiative included cross-sectoral health & homelessness summits that resulted in a System Response Plan that was	

endorsed by City of London Council. System governance model to support the implementation of the plan has been drafted and includes City of London Council, MLOHT Coordinating Council and staff from City of London, MLOHT and organizations across the health and homelessness sectors.

Access to Primary Care - Recruitment and Transition into Practice Program. Plan for creating a Middlesex London Recruitment and Transition into Practice Program was presented to the MLOHT Coordinating Council. City of London and County of Middlesex representatives have expressed interest in partnering on this initiative and may consider financially contributing to the program. The working group has presently been a partnership between the MLOHT, London Middlesex Primary Care Alliance, London Economic Development Corporation and Health Force division of Ontario Health West. The London Economic Development Corporation is a not-for-profit organization that is funded by the City of London through a Purchase of Service Agreement.

The MLOHT Lead actively participates in the City of London Community Safety and Wellbeing (CSWB) Advisory Committee and the County of Middlesex Social Services and Community Partners Network Meetings; we have found these connections very valuable for identifying shared priorities (e.g., connecting the County of Middlesex Navigator with our Health Care Navigation work, offering guidance for compensation processes for people with lived experience for CSWB work).

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

In *Ontario Health Teams – The Path Forward*, released by the Ministry of Health in November 2022, the phased introduction of integrated clinical pathways for OHTs to help deliver proactive, evidence-based care for patients with specific conditions was announced. OHTs working on the development and implementation of integrated care pathways for chronic diseases can report on this as part of TPA deliverables related to Priority 1.

	Self-reported progress (select from drop down)
Deliverable 1: Enhance care planning and delivery and outcomes for initial target population(s) based on local drivers.	**Yellow - Some Challenges**
a) Has your OHT implemented at least one improvement for your year one target population, as identified in your OHT plan?	☒ Yes ☐ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022- December 31, 2022).	

COPD & CHF Care Pathways - *Leading*
Standard care pathways for people living with COPD and CHF were developed with patients, caregivers and providers to ensure equitable access to a minimum standard set of activities, “always for everyone events”. MLOHT is now actively working with key early adopter primary care sites to implement pathway changes. Early adopter sites include a community health centre (LIHC) to ensure the pathway reduces health disparities.

Achievements since last reporting period include:
Since April 2022, clinical engagement of early adopter sites has begun.

- Co-design meetings are continuing with LIHC’s clinical teams to review pathway activities and identify areas for improvement.
- Victoria Family Medical Centre has completed the care pathway assessment; clinical team engagement will begin soon.
- Initial recommended focus at LIHC is on early identification and support for accessing community and specialist services.
- New project work focused on co-designing pathways for people using or at risk of using methamphetamine has started.
- New project work focused on lower limb preservation has started.
- HealthPathways Community (New Zealand-based model) is being explored and conditioned with local primary care stakeholders.

Early adopter sites are experiencing low capacity for change due to COVID recovery and HHR pressures. This is resulting in extended project timelines as the COPD/CHF Care Pathway project team has taken the approach of remaining flexible and adjusting project approach and timelines to meet the needs of the early adopter sites. The MLOHT is currently considering expanding its integrated care pathway work to new populations.

CHF QBP - *Partnering*
MLOHT is partnering with Huron Perth and Area OHT, LHSC, St. Joseph's Health Care London, Middlesex Hospital Alliance, Best Care, HCCSS SW, London InterCommunity Health Centre, TVFHT, OH West, South West Self-Management, 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 and better integrating and expanding current programs. 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 people living with CHF, their caregivers, 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.

Achievements since last reporting period include:

- Integrated model of care launched January 2023.
- Patient-reported outcome collection launched March 2023 .
- Education resources have been standardized to the Heart and Stroke heart failure packages.
- South West Self-Management courses have been promoted across the integrated model of care.
- Targets for improvement and an associated monitoring strategy have been established.
- Patient-reported experience measure has been identified.
- Clinical engagement with Middlesex Hospital Alliance is ongoing.

Individualized Care Plan (Phase 1) – *Supporting*
This work aims to better understand best practices for creating and sharing individualized care plans for patients. Through partnership with local researchers, this work aims to: i) understand how care plans are created and used for care planning, and ii) conduct co-design sessions with patients, caregivers and providers to gain consensus on what domains should be included in an individualized care plan and how the care plan could be better utilized in the system by all members of the care team. Achievements since last reporting period include:

- Interviews have been completed with system care managers and physicians. Recruitment of providers and older adults/caregivers is still ongoing.

Care Manager Model (Phase 1) – *Supporting*
In past research, we have learned that older adults and providers find our health care system complex. It is hard to find and access services. It is sometimes difficult to receive care when people need it the most. The OHT, in partnership with local researchers, are exploring the function and role of care managers across the health care system. The term care manager is sometimes used interchangeably with system navigators, transition facilitators or care coordinators. This work aims to understand: i) What factors facilitate or hinder the implementation of a care manager program in Middlesex London? 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.

Achievements since last reporting period include:

- Interviews have been completed with system care managers and physicians. Recruitment of providers and older adults/caregivers is still ongoing.

	Self-reported progress (select from drop down)
Deliverable 2: Design and implement population health interventions for additional target populations aligned with provincial direction and built on broadened OHT partnerships.	**Green - Progressing Well**
a) Has your OHT implemented an improvement for one or more additional population(s), as identified in your OHT Plan?	☒ Yes ☐ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022- December 31, 2022).	

Equity Deserving Co-Design:

First Nations Co-Design - *Partnering*
Middlesex London and Elgin Ontario Health Teams (OHT), along with other community partners, including St. Joseph's Health Care London (SJHC) and London Health Sciences Centre (LHSC), have been working with the local First Nation communities to understand health care experiences and opportunities for improvement through co-design sessions and individual conversations.
The team leading this work, and the partner organizations, are committed to building sustained, cooperative, mutually beneficial, and respectful relationships with local

First Nations communities. We will continue to actively listen and partner authentically to make improvements with the communities for better health and well-being.

Achievements since last reporting period include:

- Monthly consultation with Middlesex Hospital Alliance about partnerships with local First Nation communities regarding cultural healing room, Indigenous advocate roles and MLUs with urban indigenous organizations.
- Meet and greet with the executive director of the Southwest Middlesex Health Centre, to start to explore the idea of a healing space, reconciliation plan, and how to best support their indigenous clients.

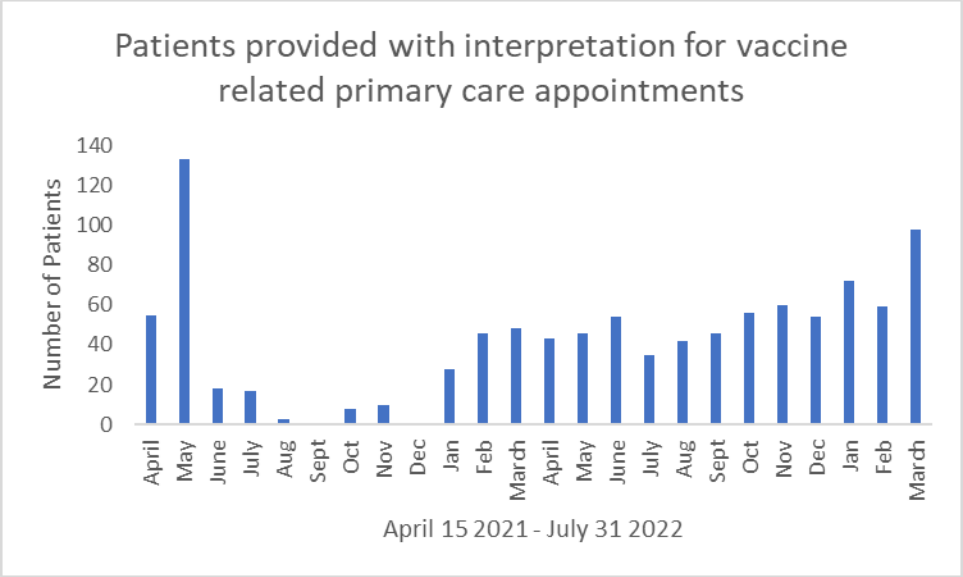
The next steps will be to continue to receive input at community sessions and work together on planning and implementing improvements that align with the community's priorities. There are no projects set at this time but, in the 2023-2024 year, projects will be mapped out and implemented.

On-Demand Virtual/Phone Interpretation Support (Voyce) - *Leading*
MLOHT is offering primary care providers funding and connection to on-demand virtual (video or audio phone) interpretation services to enable patients to receive care in their language of comfort. Last reporting period, MLOHT was awarded $43,393 from the Alliance for Healthier Communities to fund on-demand virtual interpretation services at Primary Care clinics to support vaccination discussions until March 30th, 2023.

Achievements since last reporting period include:

- Final report outlining 22/23 results was submitted to Alliance for Healthier Communities. Report included an analysis of experience to date, highlighting the benefits of on-demand virtual video & phone interpretation services:
    - offer interpretation via phone or app so no additional hardware required,
    - the service is easy-to-use with minimal training required,
    - on-demand - interpreter answered within 29 seconds (average for duration of project for Voyce interpretation service),
    - flexible - no need for pre-booking, can accommodate walk-ins and no-shows,
    - approximately 300 languages available, including sign language. Over the duration of the project, interpretation was provided for 36 different languages (29 languages this period),
    - depending on provider chosen, cost is $1-$2 per minute,
    - average service call for duration of project was 19 minutes per appointment.
- Since April 2022, through personal outreach, and communication through MLOHT and LMPCA newsletters, 2 additional clinics have been identified that service new immigrants and have been connected to Voyce to be set up with interpretation supports. This is in addition to the 5 clinics already using the service.

- Since April 2021, MLOHT has supported interpretation of 1031 primary care appointments. This includes 229 since December 31st (this reporting period).



cQiP – Improve access to community-based Mental Health and Addiction Services in Middlesex London - *Partnering*

Year 1 focused on two change initiatives that will be supported by the MLOHT:

1. **Increase awareness of and promote the use of additional crisis stabilization beds (16+) and crisis lines**

   Achievements since last reporting period include:
   - Crisis Centre and CMHA TVAMHS Services were promoted via existing annual events / promotion days:
     - Good Exposure with Social Media during Bell Let's talk, January 2023
     - Facebook – 8 posts – 93 engagements
     - Instagram – 10 posts – 76 Engagements
     - Twitter – 7 Tweets – 19 engagements

   From Jan 1st – March 31st use of service has increased:
   - # of Resident Admissions July 01 – Dec. 31
     - 2020 - 299
     - 2021 – 322 (7.7% increase from previous year)
     - 2022 – 488 (51.6% increase from previous year)
     - Jan 01 – Mar 31 2023 (3 months) – 241 (continues to maintain increase)
   - # of Visits To Crisis Centre
     - April 01 – June 30
       - 2021: 694
       - 2022: 647 (decrease – 6.8% from previous year)
     - July 01 – Sept. 30
       - 2021: 805
       - 2022: 934 (increase +16% from previous year)
     - Oct. 01 – Dec. 31
       - 2021: 673
       - 2022: 830 (increase +23.3% from previous year)

- Jan. 01 – Mar. 31 2023
  - 957 (increase)

- # of Visits Flagged as ED Diversion
  - April 01 – June 30
    - 2021: 295
    - 2022: 327 (increase + 10.9% from previous year)
  - July 01 – Sept. 30
    - 2021: 348
    - 2022: 399 (increase +14.7% from previous year)
  - Oct. 01 – Dec. 31
    - 2021: 286
    - 2022: 300 (increase +4.9% from previous year)
  - Jan. 01 – Mar. 31 2023
    - 355 (increase)

2. Evidence-based advocacy for affordable, accessible health and housing supports

London Middlesex is facing a crisis in its collective ability to provide timely and appropriate supports to people who are experiencing homelessness and impacts associated with homelessness (e.g., physical health issues, addiction challenges, mental health challenges). There is acknowledgement that the challenges can't be fully addressed by any one agency, by any single focused collaborative, or by any one sector alone. These are challenges that require a system-wide and whole of community response.

The City of London, London Health Sciences Centre, St. Joseph's Health Care, Canadian Mental Health Association, Middlesex-London Health Unit, Middlesex-London Paramedic Service and London Police hosted three Health and Homelessness summits, bringing everyone who is engaged in the work to address the challenges of health and homelessness together to develop a whole of community response to urgent issues related to homelessness, addictions, and mental health.

Achievements since last reporting period include:

- The Health and Homelessness Whole of Community System Response was finalized and endorsed by City Council.
- MLOHT provided a letter of support to City Council outlining its commitment to supporting the process in any way it can. This may include:
  - Co-design support/coaching,
  - the MLOHT Patient/Client, Care Partner Council informing a governance structure that empowers the voice of those with lived/living experience,
  - informing governance and decision-making structure that is grounded in trust, transparency, collaboration and health equity,
  - alignment with the Mental Health and Addictions Collaborative Quality Improvement Plan (cQiP), and
  - supporting the backbone structure.

- System Governance Model was drafted with input from the MLOHT Operations Team. The governance model includes a role for the MLOHT Coordinating Council.
- In response to City of London's draft Strategic Plan, the MLOHT partnered with Indwell, CMHA and London InterCommunity Health Centre in a Letter of Support to the City of London Mayor. In this letter we offered a recommendation to separate the Strategic Plan's unit goals for "supportive affordable" housing from "affordable" housing. Different than affordable housing, supportive housing offers people who have struggled to maintain stable housing an opportunity to find both stability and belonging. We also asked for further consideration to distinctly consider the needs of Indigenous People.
- MLOHT is participating in the Circle of Support program.
  The Circle of Support program aims to improve the social and health outcomes of the most marginalized people in London. The program is a collaboration between partner organizations; together, they create an individualized/person-centred network of supports, using collective system resources, to ensure that individuals receive what they need to move from crisis and deprivation of housing toward stability and thriving.
  This work is in pilot stage; next steps include evaluation, scaling and sustainability plans.

cQiP – Cancer Screening - *Supporting*
Year 1 focused on three change initiatives:

1. Increase cancer screening services for New immigrants to Canada, Indigenous and First Nations people
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.

Achievements since last reporting period include:

- Screening initiative specifically targeted to our Indigenous population: March 27 FIT Testing presentation during Oneida Women's Wellness day - 120 attendees.
- The South West Regional Cancer Program is collaborating with the Central East Regional Cancer Program to provide Pap smear educational sessions for community nurses and physicians. The educational opportunity will be held in a space outside of the hospital to avoid privacy and risk concerns and will not be conducted on patients.
  The session will be held in early June, with hopes that this will be a reoccurring opportunity. The Regional Colposcopy leads from each region will present on cervical screening & HPV, and then provide hands on training with silicone models.

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

MLOHT is establishing 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 people experiencing barriers to health.
The EDI Collaborative is an opportunity for Middlesex London partners to work together to improve the equity, diversity, and inclusivity of service delivery in social and health care environments across our community. By sharing and coordinating engagement and improvement efforts, we aim to go further faster, together, on our shared EDI journey.

The EDI planning group was established in October. It includes members from the Middlesex London OHT, St. Joseph's Health Care London, Western University, Thames Valley Family Health Team (TVFHT), City of London, Centre for Research on Health Equity and Social Inclusion (CRHESI) among others. The planning group did have one patient representative for three months, however she has resigned her position. We are currently recruiting another patient partner.

Achievements since last reporting period include:

- Work Breakdown Structure and Timelines Completed.
- Discussions to identify a partner to co-lead the EDI collaborative with MLOHT continue.
- The Vision was clarified.
- Many engagement meetings were held with interested agencies.
- Collaboration with the City of London Director of Anti-Racism and Anti-Oppression.
- Stakeholder list was drafted – to be reviewed with the City of London.
- Process drafted for coordinating engagement with populations experiencing barriers through the EDI collaborative.
- Kick off meeting agenda and plan developed, to be finalized once venue and date have been determined.

The EDI Collaborative kick-off event was postponed from a February event to May 2023

Let's Go Home – *Supporting*
Let's Go Home 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, and navigation/community connections with no financial barriers.
The new program went live December 5, 2022 and will support up to 12 patients/week (with a commitment to monitor and assess capacity). Ongoing evaluation of the program is underway.

Achievements since last reporting period include:

- The Let's Go Home program went live on December 5th and is being offered from specific units at St. Joseph's Healthcare London (Parkwood Institute), London Health Sciences Centre (Victoria Hospital and University Hospital) and Middlesex Hospital Alliance (Strathroy General Hospital)
- From December to March, LEGHO received 161 referrals for service, with volumes currently averaging 11 per week (target=12). Utilization is monitored closely, and service has expanded to include the Sub-Acute Medicine Unit at LHSC for the 2023-24 fiscal year.
- To date, patients of the LEGHO program have reported an average 13% improvement in quality of life. Ages ranged between 35 and 97, with the average age of 75.
- Feedback has been extremely positive:

  "I can't believe the amount of help he received, it made a huge difference for him, he is doing so much better, much more himself and it was scary for a while there, so we can't thank you enough -- it's a great program."

  "Thank you so much for visiting my father. As you could tell, he appreciated it immensely. Also, we wanted to thank you for the efforts that you are making on his behalf. We would never have been able to navigate these programs without your help."

Lower Limb Preservation – *Partnering*

Lower-limb amputation is one of the most feared complications of vascular disease and/or diabetes and is a devastating complication of non-healing wounds.
Peripheral vascular disease (PVD) and diabetes are significant risk factors that present in 94% of non-traumatic lower-limb amputations in Ontario, of which up to 85% have been estimated to be preventable.
In response to this, Ontario Health has developed a Lower-Limb Preservation Integrated Care Program with the following goals:

1. To reduce avoidable, non-traumatic major lower-limb amputations in Ontario.
2. To improve equitable access to high-quality best-practice early screening, cardiovascular risk factor modification, and integrated lower-limb wound care.

The Ministry of Health has approved funding the MLOHT and LHSC to advance lower-limb preservation (LLP) care in Ontario through the provision of person-centred, integrated, and coordinated care across the continuum for people with diabetes and peripheral vascular disease.

Through provincial stakeholder engagements and in alignment with the Ontario Framework for Lower-Limb Preservation, three priorities for action have been developed for this project:

1. Improve/ expand integrated, connected, collaborative care
2. Improve coordination and consistency of wound management
3. Improve early identification and preventative management

Achievements since last reporting period include:

- Successfully submitted the LLP Demonstration Program Action Plan
- Ministry of Health has approved funding for the 2022/23 fiscal year to advance lower-limb preservation (LLP) care in Ontario
- Planning Project Team has been established
- Project Manager has been assigned, from MLOHT
- Governance Structure Committee members recruited
- Project Contact list/Partner Engagement Plan developed and submitted, as required
- Driver Diagram, based on multiple engagement sessions with stakeholders, is drafted – documents are being reviewed by stakeholders for additional feedback
- Patient and caregiver recruitment is underway
- Current State Analysis collection initiated

	Self-reported progress (select from drop down)
Deliverable 3: Identify opportunities to expand care redesign efforts to serve the OHT's full attributed population.	N/A - Not Yet Started

Note: Cohort 1 OHTs are not required to report on this deliverable at this time.

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

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.

Currently, PHIPA does not directly address the type of information sharing that is necessary to realize a fully integrated model of health care delivery by Ontario Health Teams. This requirement for PHIPA modernization has resulted in an inability to develop an attributed population registry for all OHTs until PHIPA is modernized or OHTs are given the appropriate status and requirements to meet privacy, legal and security requirements for patient health information. Although the attributed population methodology has been better understood, the ability to utilize and apply to PHM is still not possible until PHIPA allows. Our Test of Change team through the OHT Coalition for Population Health Management is collaborating with OHTs from across the

province to inform requirements and establish the next steps to ensure that OHTs can understand the population they are legislated to manage.

Achievements since last reporting period include:

OHT Coalition for Population Health Management

In Summer 2022, Ontario Health (OH) requested Ontario Health Teams (OHTs) with Test of Change initiatives related to integrated care planning and population health management (PHM) come together to adopt a common vision for PHM in OHTs and outline the programmatic approach required to carry it out. Dr. Matthew Meyer (MLOHT) was invited to co-chair this group with Dr. Anne Wojtak (ETHP), and Gina Johar (FLAOHT).

Ontario Health indicated that they want to "sprint" to find a provincial solution(s) for Population Health Management and would like OHTs to wait to implement individually-developed solutions. OH, therefore, indicated that they will no longer fund individual OHT solutions and have provided funding for cross-OHT planning/collaboration under the OHT coalition for PHM. Seven OHTs were requested to participate in the working group initially based on their existing Test of Change funding for a PHM-relevant project: Downtown East Toronto (DETOHT), East Toronto Health Partners (ETHP), Frontenac, Lennox, Addington (FLA), Middlesex London (MLOHT), Sarnia Lambton (SLOHT), Southlake Community (SCOHT), West Toronto (WTOHT). Representation from Northern Ontario was also added. Ontario Health is now working with the Coalition to inform provincial planning to help OHTs with the tools needed to reach maturity and offer Population Health Management to our full attributed populations. The Coalition is completing their first report and will be seeking funding for FY 2023/24 to expand the work and form a more inclusive set of supports for PHM across OHTs in partnership with RISE and HSPRN.

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.

Achievements since last reporting period include:

Over the past three months, the Test of Change team has continued to engage and collaborate with partners from across the health system to further develop a Shared Care Record via Health Information Exchange (Interoperable Shared Care Record). Over the past three months, this project has focused on testing the sharing of artificial patient encounter information between vendor partners AlayaCare, Ontario e-hub Oracle Cerner HIE, QHR Technologies – Accuro (QHR-Accuro) EMR and Smile Digital Health. This partnership increased our understanding of how the potential provincial EHR – smileCDR can function as a health information exchange through the exchange of HL7v2 messages in a Proof of Technology. A Clinical working group

was developed to support the understanding of how encounter information could be utilized for care and the implication for presenting this information in the point of care system. A Population Health Management working group informed implications of privacy, data governance and population health management analytics.

Proof of Technology
In partnership with Smile Digital Health, a proof of technology (POT) was designed and implemented on an Azure non-production environment that would enable the bi-directional data sharing patient encounter information in the form of HL7v2 messages. Supported by the clinical working group, patient encounter use cases were developed to inform the encounter messages that would be tested within the POT. One focused use case was developed that resulted in three patient profiles registered in the non-production environments of AlayaCare, QHR – Accuro EMR and Ontario e-hub Oracle Cerner HIE. The integration testing resulted in successful inbound exchange of the encounter messages through Smile POT. However, outbound encounter messages from Smile CDR were only successful with AlayaCare signaling additional work to be done with receiving vendors to support these functions.

Clinical Working Group Stakeholder Engagement
Over the past three months, more than 50 clinicians and administrative users of the vendor partners contributed to the development of multiple use cases that utilize encounter information sharing in an interoperable shared care record. Ultimately, one use case that included three individuals was validated and developed into HL7v2 messages for the purpose of testing within previously mentioned POT. This working group also delivered requirements for how these patient encounters should be displayed and utilized in a user interface in each of the participating point of care systems. Ontario e-hub Oracle Cerner HIE demonstrated the ability of their user interface to display the encounters within their current user interface. Both Alayacare and QHR-Accuro were able to develop a mock-up of the expected workflow implication and how this may be presented in their point of care systems eventually.

Population Health Management Working Group
A population health management working group was established to understand the implications of an interoperable shared care record. The group is focusing on dependencies and barriers that will need to be overcome as OHTs mature towards a vision of PHM.

<u>Use Case</u>
An integral element of this work has been the development of Use Cases, Storyboards, and data flow diagrams to articulate the opportunities for further development. Through collaboration with stakeholders, the Test of Change team has developed dozens of use cases that articulate clinical opportunity and the application of population health management methodologies for patients and clinicians.

<u>Stakeholder Engagement</u>

Patient and clinician engagement has been integral to develop and guide our Test of Change work. On a regular basis, we have met with primary care partners, physicians, patients, care partners, administrators, and government partners to seek feedback and validate the direction of our work. Specifically, across Ontario Health, we have continued engagement with ongoing projects such as Ontario Patient Summary, Ontario Standards of Care and the Privacy Community of Practice to ensure provincial alignment in our work.

Indigenous/First Nations Engagements

During the past six months, our Test of Change project has had the opportunity to engage with stakeholders from local First Nation communities and leaders in the digital health space such as First Nations Digital Health Ontario (FNDHO), Indigenous Primary Care Health Council (IPHCC), and Chiefs of Ontario.

These engagements have informed the development of use cases and storyboards as well as design considerations for the Shared Care Record and PHM. Through these engagements, project leaders involved in this work have completed OCAP training that has enabled an understanding of data governance considerations for Indigenous/First Nations populations. OCAP represents key considerations related to the ownership, control, access, and possession of First Nations data.

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). This initiative is intended to facilitate transition of Primary Care Providers and Specialists to eReferrals.

Achievements since last reporting period include:

- As part of the sustainability plan, MLOHT is supporting discussions with hospital administration to enable eReferral adoption at LHSC, St Joseph's, and Middlesex Hospital Alliance. In addition, MLOHT supports connections to eCE for on-boarding more providers (senders and receivers) to eReferral.
- Since eReferral went live on January 25, 2023 at the LHSC General Surgery Department, the MLOHT is working closely and collaboratively with the hospital/project leads to support communication to primary care providers, and identify evaluation metrics.

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/clients,

care partners, and providers across the system, as well as detailed review of local and international best practices and tools.

Achievements since last reporting period include:

- Project is progressing well; collection of locally-used tools to screen for health and social needs is complete, and all tools have been aligned with the multiple domains of health.
- Discussions with interRAI have started to ensure alignment with provincially/internationally-used tools.
- Co-design invites have been shared to begin designing survey questions.

SCOPE (Seamless Care Optimizing the Patient Experience) - *Partnering*
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.

Achievements since last reporting period include:

- Partners from primary care, community care and hospital have continued to advocate to move this initiative forward and have proposed an initial focus of primary care access to Diagnostic Imaging with a goal of improving system navigation, ED avoidance, and decreasing administrative burden for primary care.
- $270,000 committed by LHSC to launch the SCOPE project.
- Meeting scheduling underway to establish working group for project moving forward.

Access to Primary Care – *Partnering*
Partnered with primary care sector to develop a driver diagram to identify change initiatives to improve access to primary care.
The following change initiatives were prioritized for implementation:

- Develop a Coordinated Recruitment/Transition into Practice Program
- Empower/enable people to work to full scope of practice (NPs, MDs, RNs, Medical Office Administrators and others)
- Decrease administrative burden through increasing awareness of digital tools that help improve capacity/reduce administrative burden

<u>Recruitment and Transition into Practice Program</u>
Data from 2022 estimates that over 65,000 residents of Middlesex London do not have access to a primary care provider. Middlesex London is not attracting enough primary care providers to provide primary care to its growing population let alone replacing the retiring physicians. Most other municipalities in Ontario have a recruitment program (of varying sizes and scope). Western has a medical school and trains new family physicians in Middlesex London. There is no proactive recruitment of family medicine residents to encourage them to set-up practices in Middlesex London.

The purpose of this project is to develop a recruitment, transition in to practice and retention program for Middlesex London.

Achievements since last reporting period include:

- Project planning in progress with core project team.
- Presented to Coordinating Council for feedback and next steps (multiple partners expressed interest in supporting).

Empowering PCP to Work to Full Scope

Empowering healthcare workers to work to their full scope of practice optimizes access to existing primary care resources within the community. By delegating practices to qualified healthcare staff, primary care providers could increase/improve patient rostering within their practices and increase primary care capacity. Empowering healthcare workers aims to also increase the healthcare providers' satisfaction and decrease the risk of burnout. This change initiative will be mainly focusing on 3 healthcare workers groups:

1. Medical Office Administrators (MOAs),
2. Nurse Practitioners (NPs),
3. Registered Nurses (RNs) & Registered Practical Nurses (RPNs)

There has also been a request from primary care providers to learn more about the role of Physician Assistants.

Achievements since last reporting period include:

- Project Lead and Sponsor identified.
- Clinical Lead identified.
- Project Initiation and Planning Charters drafted.
- Project team identified.
- A planning working group, with members from each of the determined healthcare workers groups, has been formed and met to brainstorm the deliverables of this project and to help build networks for more focused working groups.

Increasing Awareness of Technology to Reduce Admin Burden

To free up some capacity within existing practices, primary care clinicians need to understand how they can release time to care by implementing various technology enablers. The intended outcome of this project is by implementing various digital tools, existing HHR resources in primary care will be able to take 1 or 2 more patients into their practice.

The purpose of this project is to create a 'menu' of digital tools that exist so that a clinician can see what options are available in one location and make informed decisions about implementing digital tools in their practice.

A. Understand what technology exists
B. Potential cost and how much time is needed to implement tool
C. Resource that may help with implementation.

Achievements since last reporting period include

- The eEnabler Menu is close to being finalized. It was presented at the Patient, Client and Care Partner Council meeting on February 7th, 2023, for feedback and to gather experience with the various enablers. PCCP feedback is being incorporated into the Menu.
- Next steps include final vetting via Clinical Lead and Project Sponsor prior to building as an online tool.

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

Achievements since last reporting period include:

- The One Referral Form is being utilized across LHSC and with all Transitional Care partners.
- For the 25 restorative care beds at Kensington Village, there was an 84% occupancy for the 6-week period of January 29,2023 – March 11, 2023. One week (week of March 5) had an occupancy above 90%. For the 10 ALC beds at Kensington, occupancy for the same 6-week period was 97%. Parkwood ALC Surge program occupancy reached 89.7% in February.
- At LHSC, ALC Throughput Indicator for patients waiting for LTC tells us that the volume of ALC-LTC patients in hospital grew in both January (161 new cases vs 136 discharges) and February (161 new vs 151 discharged). March numbers are not yet finalized.

MLOHT Communications Plan *- Leading*
Raising awareness of the future vision and benefits of integrated care and population health management, highlighting the progress of ongoing projects and deliverables that the MLOHT leads, partners and/or supports, and how to get involved.

Achievements since last reporting period include:

- The MLOHT website content has been migrated to a new server successfully.
- Pull-up banners (EN/FR) designed and printed.
- Reached over 330 MLOHT Newsletter subscribers.
- Began utilizing Facebook to promote MLOHT.

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.
Funding has not yet been secured to launch this project.

	Self-reported progress (select from drop down)
Deliverable 4: Implement enhanced approaches to partnering with patients, families and caregivers in execution of the Population Health Management and Equity/OHT Plan.	**Green - Progressing Well**
a) Has your OHT implemented any changes to your approach for engaging with patients, families and caregivers?	☒ Yes ☐ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022- December 31, 2022).	

Patient Client Care Partner Council – *Leading*
The Patient/Client, Care Partner Council is reaching out across patient/caregiver/people with lived experience tables across Middlesex London. The purpose of the outreach is to strengthen the patient and caregiver voice across Middlesex London.

Achievements since last reporting period include:

- PCCPC learned about Use Cases and Patient Stories and how both can be used to elevate the patient/caregiver voice. Same presentation was provided to Coordinating Council and every effort is now made to reflect on a use case or patient story at each CC meeting that aligns with and enhances the understanding of decisions or discussions on the agenda.
- PCCPC supported Access to Primary Care Project (Increasing Awareness of Technology to Reduce Admin Burden) by sharing their experience with Digital Health Tools.
- PCCPC supported the co-design of the Healthcare Navigation Future State.
- PCCPC validated the “What Will Be Different” patient statements, to strengthen the shared MLOHT vision.
- PCCPC co-designed the Roles and Responsibilities of PCCP members on working groups and on projects .
- PCCP compensation model/process was reviewed and updated.
- Outreach Team presented the MLOHT and PCCPC to the South West Regional Cancer Program to strengthen the voice of patients/clients, care partners across ML.
- PCCPC Chair presented the Outreach Team’s presentation to the RISE Patient, Family and Caregiver Engagement and Partnership Community of Practice.

Patient, Client, Care Partner Network - *Leading*
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)

Achievements since last reporting period include:

- PCCP Network Onboarding and Engagement process was mapped and validated with PCCPC.
- PCCPC provided input on the PCCP Network Recruitment Poster and Handbook.
- PCCPC Outreach Team drafted a high-level concept/proposal focusing on developing a comprehensive MLOHT PCCPC network – a Shared Registry that enables "voices" to be shared across various health and non-health sectors. This future state vision was reviewed with PCCPC for feedback.

a) Describe how your OHT is measuring and evaluating clinical improvements in population health including tracking self-selected indicators aligned to the Quintuple-AIM Framework.

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 steps were taken:

- 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. 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.
- 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 experiences (PROM/PREM) for patients living with COPD and CHF, and

Access to Primary Care to understand the overall impact of our collective work on the health equity-driven quadruple aim.
- Project charters/workbooks are developed that include outcome measure metrics: quantitative and qualitative measures that are used to verify and validate project outcomes.

PREM/PROM Data Collection
PREM/PROM data collection was initiated with early adopter sites. Process included early adopter sites identifying patients in the EMR with COPD and CHF, emailing patients a PREM/PROM survey and sharing anonymized data with MLOHT. Survey included a question where patients provided consent to share anonymous data with MLOHT.

Lessons Learned from initial data collection process:
- Low response as only through email.
- Disconnect from routine workflows contributes to low survey response rate.
- Labour intensive process to search EMR for COPD and CHF.
- Not equitable for clients and people without internet access/email.
- Anonymized data is being shared with the MLOHT Q&A coordinator via email. This is not the optimal method of data sharing, especially with a large number of survey responses expected in the future.
- Data is stored on the MLOHT's MS Teams platform. This limits the capacity to process and use data for decision-making.

Discussions are under way with partners and subject matter experts to develop a multi-pronged data collection, sharing, and storage process that is scalable and sustainable. This has proven more complicated than initially anticipated resulting in extended timelines. The following short- and long-term PREM/PROM data collection strategy is being explored:

Short Term PREM/PROM Data Collection strategy
- Multiple programs are collecting PREM and PROM but the questions are not standardized. Work with Quality and Analytics group to develop a standard for PREM, PROM and provider experience data questions that can be implemented across sectors in Middlesex London.
- The Quality and Analytics Advisory Group met to discuss standardizing sociodemographic questions in Middlesex London. Having standardized sociodemographic questions helps us to know the people we serve better and supports equity in care.
- Use multiple existing channels to collect data: Best Care, Frail Senior's strategy, early adopter sites.
- Include in-person surveying of patients to address equity.

Such multipronged non-centralized data collection will have limitations as to understanding who gets surveyed and how often same patients may get surveyed.

Long Term PREM/PROM Data Collection strategy

- Utilize population registry (when available)
  - to enable and track who gets surveyed and frequency of surveys.
  - to enable PREM/PROM responses to inform Population Health Management.
- Utilize patient portal (when available) to distribute survey.
- Include in-person surveying of patients to address equity.
- Create standardization and integration with existing clinical workflows to streamline data collection at our system partners (e.g., early adopter sites).

Supports Needed

- Developing a scalable and sustainable PREM/PROM data collection process is a complex endeavour and volume of responses to report to Ministry is expected to be low for some time. We appreciate Ontario Health's patience along the way.
- We recognize that Ontario health is moving towards the standardization of system-level performance indicators to develop more integrated and coordinated care across OHTs. It would be helpful for OHTs to know what the standardization could look like in terms of data management, including the use of standard measurement tools, data platforms, etc.

OPTIONAL: Does your OHT currently have the ability to identify and report on how many patients are directly impacted by your OHT's clinical initiatives (e.g., number of patients enrolled in a clinical pathway)?	☐ Yes ☒ No

Priority Area 2: Patient Navigation and Digital Access

Background - Patient Navigation

Key Definitions

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

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

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

At a minimum, OHTs should aim to provide OHT-level support 7 days per week, ensuring daytime and evening coverage. After hours and holidays, Health811 may supplement the OHT-level navigation support. In these cases, there should be a mechanism in place for the Health811 service to link the OHT-level navigation support (i.e., ability for Health811 to book a call for the patient with the OHT-level navigation supports if required). This mechanism will be co-designed over time with OHTs.

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

As outlined in the TPA guidance (issued May 2022) the deadline for implementation of 24/7 navigation supports for Cohort 1 OHTs is March 31, 2023. If your OHT has discussed an extension for this deliverable with your Ontario Health regional contact for navigation, please note this in your response.

Digital Navigation

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

In the fall of 2022, following an assessment (by OH and an external consultant) of the synergies between the Multitenant Navigator (MTN) and Health811 (i.e., business requirements, vendor capabilities, costs, and timelines), and subsequent OH MTN-Health811 steering committee recommendations, MOH has indicated their support for leveraging Health811 as the provincial platform to surface OHT content and services, including OHT portal integration needs and access to the provincial patient data viewer. The extensive effort, feedback, and requirements to date that informed the MTN initiative will be incorporated into the Health811 implementation. OH will work with OHTs to onboard to the Health811 platform, which will allow for patients to be served local-level content and service information, as well as access to their digital health data.

	Self-reported progress (select from drop down)
Deliverable 1: Implement patient navigation supports and report on patient utilization[1].	**Green - Progressing Well**

[1] **Note:** Cohort 1 OHTs are **not required** to report on patient utilization as part of this TPA deliverable. Teams can instead consider reporting on patient experience.

a) Have improvements to patient-facing navigation services and supports been implemented?	☒ Yes ☐ No

If yes, describe.

In October 2022, the Middlesex London Navigators Collaborative was started. It has met three times in the past months with an average of 40 individuals attending representing 25 different agencies. The purpose of the collaborative is to increase collaboration and communication between community organizations located in Middlesex London. Understanding each others work better allows each organization to navigate for their patients/clients and/or care givers/care partners in a more effective way. This results in improved patient facing navigation.
In addition to the Collaborative, MLOHT is currently working on the Localized Navigation Model. We have named Home and Community Care Support Services South West (HCCSS SW) as our lead agency in this work. The decision was made based on intensive discussions, engagement with other OHTs, co-design sessions with stakeholders, and one-to-one interviews with different navigation agencies (211, healthlince.ca, Community Support Services and HCCSS). In February 2023, the Coordinating Council members voted and approved HCCSS SW as leading agency for Middlesex London. The tentative implementation date for Front Door model with HCCSS is June 2023. As per information shared by OHW the final date of implementation for this model is September 30th.
A multidisciplinary team was formed to support this work. The team meets weekly, chaired by the MLOHT Navigation Lead, and includes members from HCCSS SW, Huron-Perth OHT, and Elgin OHT. The objectives of this team are to:

- Develop a Screener/Intake Tool
- Map out initial intake processes, pathways, standard operating procedures
- Development of the team
- Plan the execution and evaluation of the model and Evaluation plan.

Starting April 1st, HCCSS has decided to dedicate the working group to focus on developing/planning the model for MLOHT.

In addition to the above, the MLOHT has been working with the neighboring OHTs to develop a consistent navigation resource page within the OHTs' websites. These navigation resources will support the service delivery and linkage to Health811.
The Consolidated Self Management Website is intended to be one of the resources available for patients/clients, caregivers/care partners and providers on this page.

Consolidated Self Management Website *- Leading* Self-Management Programs Network (selfmanagementprograms.ca) was launched on March 31st 2022, consolidating information on self-management programs and workshops in the West region. Since launch until January 2023 (approximately 1 year period),9,000 visits are reported to the website.
The MLOHT continues marketing self-management programs through the MLOHT and LMPCA newsletters and by distributing posters to local clinics.

If no, describe challenges or barriers.

N/A

b) Have improvements been made to coordination of existing navigation services?	☒ Yes ☐ No

If yes, describe.

The Navigators Collaborative has improved coordination by allowing for and facilitating knowledge exchange between different community agencies. We are using the Collaborative to introduce agencies and the services they provide, within the group. Each meeting has two to three agencies present their roles and services to the whole group. Moreover, we have created a shared space on MS Teams and are currently developing a contact list that shall facilitate the communication between the community agencies. Better understanding of the different roles and criteria for services, allows each organization to coordinate and request services in a more effective way. This results in improved coordination of services.

If no, describe challenges or barriers.

N/A

c) Does your OHT have any existing plans in place to measure these improvements?	☒ Yes ☐ No

If yes, describe.

In your response, reflect on how your OHT is collecting data on the navigation service and evaluating the navigation service [including what component of the service is being evaluated (i.e., uptake of services, wait times, experience with navigator, etc.]

An evaluation survey was created and sent to all Middlesex London Navigators Collaborative Members to understand how effective the collaborative has been so far in improving patient facing navigation and coordination of services. Of those that responded:

- 70% strongly agreed/agreed that the collaborative had improved the effectiveness and quality of their ability to navigate for their patients/clients and/or caregiver/care partner.
- 50% had already made new connections because of the collaborative.
- 75% agreed that the collaborative had increased their awareness of community supports available in the Middlesex London area.

The evaluation plan for the Localized model is under development by the project team. The metrics to be measured have been identified. These metrics include call volumes, location of caller, number of warm transfers, language of caller, Francophone calls, Indigenous callers, types of services requested, and any follow up calls made. The

methodology of evaluating those metrics is being discussed. These data points are taken into considerations while developing the Screener/Intake Tool. We are waiting for Ontario Health to share their template for the Patient Reported Outcome Measures and the Patient Reported Experience Measures so that we can align our work with Ontario Health.
If no, describe challenges or barriers.
N/A

Background – Patient Portals

In the Fall of 2022, the decision was made by OH with the support of the MOH to leverage Health Connect Ontario as the provincial platform to surface OHT content and services, as well as OHT portal integration needs and access to a provincial patient data viewer. HCO will act as the digital front door for patients, leveraging provincial digital identity standards and streamlining access to their provincial health data and services, including the provincial patient viewer. Ontario Health is in the process of procuring a provincial clinical viewer for patients and providers to view electronic health data.

In light of this new direction:

- Cohort 1 OHTs are **not** required to include a plan or progress update in their Year End Report related to patient portals.
- OHTs should not invest in procuring net-new or further expansion of existing patient portals (as it relates to the access to patient health data) at this time.
- Further detail will be shared in the coming months as the procurement process wraps up and a vendor for the viewers is finalized.

	Self-reported progress (select from drop down)
Deliverable 2: Develop and implement a patient portal that gives patients access to their health information.	N/A - Not Yet Started
Note: Cohort 1 OHTs are not required to report on this deliverable at this time.	

	Self-reported progress (select from drop down)
Deliverable 3: Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings.	**Green - Progressing Well**
a) Has your OHT improved access to OAB to additional primary care settings?	☒ Yes ☐ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
If yes, describe the process and outcomes.	

Online Appointment Booking (OAB) - *Supporting*
Online Appointment Booking was not among the initial priorities identified through community 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.
With additional information presented to the OHT in early spring, an expression of interest was sent to primary care providers to inform of funding/change management support opportunities, with a clear indication that the OHT/Digital Initiatives may move 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 provider organizations (requiring 82 licences) expressed interest in the one-time OAB funding opportunity.
Due to lag in implementation (deployment plan), some primary care organizations priorities changed and withdrew from the OAB opportunity.

Achievements since last reporting period include:
The implementation deadline for Online Appointment Booking was March 31st.
Original expression of interest yielded the potential implementation of 81 licenses. The majority of OAB licenses for MLOHT were implemented in this reporting period.
Total Live Licenses: 56 licenses deployed from January 1 – March 31st

- London Family Health Team & Family Health Organization: 30 Licenses
- Southwest Middlesex Health Centre: 19 Licenses
- Wolseley Family Care Centre, 1 License
- Old South Maternity, 5 Licenses
- MD Pediatrics, 1 License

The eServices Program at the eHealth Centre of Excellence is to provide the MLOHT with a report the week of April 17th. This should include those who might have an opportunity

to scale existing schedules, an OAB resource package, and OHT specific cumulative metrics summary (our OHT will have limited data due to the late deployment for teams in our catchment area). Of Note: Most of the sites noted above will not be required to submit monthly reporting for their 9 month cost coverage as originally stated due to their late deployment, unless the OHT would like them to report & offer them the support and follow up to do so.

	Self-reported progress (select from drop down)
Deliverable 4: Report on enhancing virtual care maturity and access.	**Green - Progressing Well**
a) Has your OHT completed a virtual care assessment (of your members)?	☒ Yes ☐ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
b) Has your OHT developed a virtual care plan based on this assessment?	☐ Yes ☒ No ☐ No change since last reporting period *(April 1, 2022 – Dec 31, 2022)*
If yes to the above (b), describe the virtual care plan.	
Virtual Care Maturity Model Assessment – *Supporting* The LHSC/St. Joseph's Health Care London Virtual Care Team has conducted 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. Initial recommendations include: • Enhancing equitable access to virtual care for patients, caregivers and providers • Change management and adoption support for providers • Development of a quality and evaluation framework to assess value and impact • Creation/adoption of information and communication technology to enable shared care across partner organizations The MLOHT Digital Health Team has completed their review and the report is now in its final stages of editing with the Operations Team & Partners.	

	Response
OPTIONAL: Does your OHT have a digital strategy or plan? If yes, provide a link or attach a copy to your submission and provide details below. If no, identify any challenges or barriers.	☐ Yes ☒ No
	Link:

We have Population Health Management and Equity Plan and digital strategies in service to that plan.	
OPTIONAL: Has your OHT made progress on any other digital or virtual care priorities, including activities related to data governance and privacy, including expanding/revising your existing Harmonized Information Management Plan?	☒ Yes ☐ No
If yes, describe.	

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

Remote Care Management/Surgical Transition - *Supporting*
MLOHT supported a remote care management/surgical transition funding proposal with regional 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. All three funding proposals were successful.

Achievements since last reporting period include:

- LHSC surgical transition project launched January 2023.
- Middlesex Hospital Alliance project launched March 2023.
- Evaluation plans have been developed.
- Home and Community Care Support Services withdrew their application for funding due to project delays putting volume targets at risk

Virtual Urgent Care/Episodic Access to 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. Paediatric patients requiring non-life threatening care benefit from the virtual assessment and may be referred to their primary care physician or ED to address their acute care need. This virtual service is also effective at diverting some visits from the ED; according to data from September, 2022, 62% of patients using VUC would have gone to their local ED if VUC wasn't available.

Achievements since last reporting period include:

- Planning to transition from a physician model to an NP model; aiming to hire NPs this summer.
- Aiming to gradually shift from 1-5 pm, M-F to 1-9 pm, 7 days/week.
- Working through how Health811 will connect with Episodic Access to Care.

On Demand Virtual/Phone Interpretation Support (Voyce) – *Leading*, *see priority 1, deliverable 2*
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*, *see priority 2, deliverable 1*
MLOHT is supporting the Ministry in the development of the provincial Health Care Navigation Service (HCNS) digital platform.

Consolidated Self-Management Website *– Leading, see priority 2, deliverable 1*
The consolidated self-management website includes access to information to virtual self-management programs and workshops**.**

Re: Activities related to data governance and privacy, including expanding/revising your existing Harmonized Information Management Plan
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 of 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).

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

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

	Self-reported progress (select from drop down)
Deliverable 1: Implement an enhanced governance model and processes that align with provincial direction.	**N/A - Not Yet Started**
Note: Cohort 1 OHTs are not required to report on this deliverable on this time.	
OPTIONAL: If applicable, describe any key changes or achievements related to governance or membership since the last reporting period (April 1, 2022 – December 31, 2022).	

- Governance Sub-Committee Co-Chairs identified. Co-Chairs include the Executive Director of the London InterCommunity Health Centre and the Senior Director, Health System Partnerships of London Health Sciences Centre, who is also a member of the MLOHT Operations Team.
- Coordinating Council Terms of References were reviewed and updated by the Governance Sub-Committee and approved by Coordinating Council
- One-Page Summary document created to support Coordinating Council cluster representatives in informing and accurately representing the voice of their cluster.

MIDDLESEX LONDON
Ontario Health Team

MLOHT UPDATE TO CLUSTER

FEB 23RD COORDINATING COUNCIL MEETING FOCUS

Budgeting for 23/24

Seeking input on budget planning for Fiscal Year (FY) 2023-24, with a particular focus on potential for in-kind contributions to the MLOHT from partners.

Healthcare Navigation

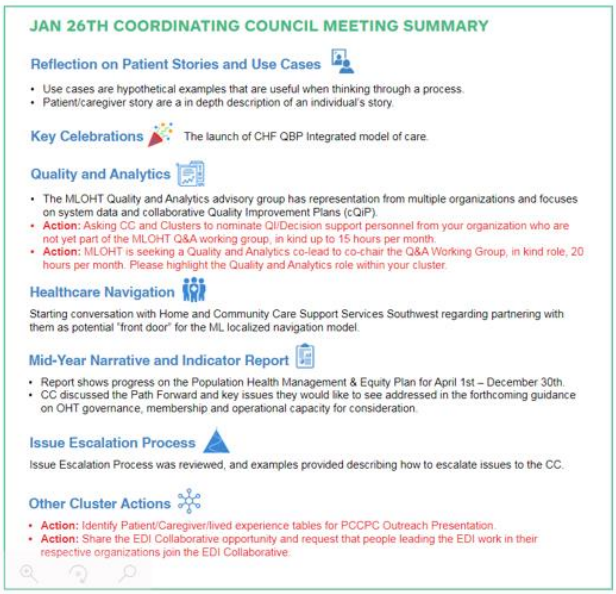
Asking the Coordinating Council to approve and name Home and Community Care Support Services South West (HCCSS SW) as our Front Door Lead Agency for our Local Navigation Model.

Referral Management

Informing and updating the Coordinating Council regarding the outcomes and the evaluation results of the eReferral via eFax project.

How are we progressing re: Improving care for people living with COPD/CHF

Updating the Coordinating Council (CC) on the progress of improving care for people living with COPD and/or CHF including lessons learned, aligned projects, and future directions.



JAN 26TH COORDINATING COUNCIL MEETING SUMMARY

Reflection on Patient Stories and Use Cases

- Use cases are hypothetical examples that are useful when thinking through a process.
- Patient/caregiver story are a in depth description of an individual's story.

Key Celebrations The launch of CHF QBP Integrated model of care.

Quality and Analytics

- The MLOHT Quality and Analytics advisory group has representation from multiple organizations and focuses on system data and collaborative Quality Improvement Plans (cQiP).
- **Action:** Asking CC and Clusters to nominate QI/Decision support personnel from your organization who are not yet part of the MLOHT Q&A working group, in kind up to 15 hours per month.
- **Action:** MLOHT is seeking a Quality and Analytics co-lead to co-chair the Q&A Working Group, in kind role, 20 hours per month. Please highlight the Quality and Analytics role within your cluster.

Healthcare Navigation

Starting conversation with Home and Community Care Support Services Southwest regarding partnering with them as potential "front door" for the ML localized navigation model.

Mid-Year Narrative and Indicator Report

- Report shows progress on the Population Health Management & Equity Plan for April 1st – December 30th.
- CC discussed the Path Forward and key issues they would like to see addressed in the forthcoming guidance on OHT governance, membership and operational capacity for consideration.

Issue Escalation Process

Issue Escalation Process was reviewed, and examples provided describing how to escalate issues to the CC.

Other Cluster Actions

- **Action:** Identify Patient/Caregiver/lived experience tables for PCCPC Outreach Presentation.
- **Action:** Share the EDI Collaborative opportunity and request that people leading the EDI work in their respective organizations join the EDI Collaborative.

OPTIONAL: Does your OHT have a plan to include additional groups (e.g., home and community care providers, mental health and addictions providers) in OHT decision-making?	☐ Yes ☒ No
If yes, describe.	
Home and Community Care and Mental Health and Addictions Clusters are already represented on the MLOHT Coordinating Council as voting members.	
OPTIONAL: Does your OHT have an existing or planned policy or agreement to manage risks associated with OHT initiatives?	☐ Yes ☒ No
If yes, would you be willing to share your experiences with OH and MOH? *(Teams may be contacted for follow up).*	☐ Yes ☐ No
Comments:	

	Self-reported progress (select from drop down)
Deliverable 2: Report on progress implementing Patient, Family and Caregiver Strategy.	Green - Progressing Well
a) Has your OHT implemented the planned engagement approaches as outlined in your Patient, Family and Caregiver Strategy?	☒ Yes ☐ No ☐ No change since last reporting period (April 1, 2022 – Dec 31, 2022)
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022 – December 31, 2022).	
Achievements since last reporting period include: • PCCPC learned about Use Cases and Patient Stories and how both can be used to elevate the patient/caregiver voice. Same presentation was provided to Coordinating Council and every effort is now made to reflect on a use case or patient story at each CC meeting that aligns with and enhances the understanding of decisions or discussions on the agenda. • PCCPC co-designed the Roles and Responsibilities of PCCP members on working groups and on projects	

- PCCP compensation model/process was reviewed and updated
- PCCP Network Onboarding and Engagement process was mapped and validated with PCCPC
- PCCPC provided input on the PCCP Network Recruitment Poster and Handbook
- PCCPC Outreach Team drafted a high-level concept/proposal focusing on developing a comprehensive MLOHT PCCPC network – a Shared Registry that enables "voices" to be shared across various health and non-health sectors. This future state vision was reviewed with PCCPC for feedback.

c) Describe how First Nation, Inuit, Métis, urban Indigenous, Francophone populations and/or other equity-deserving populations (including Black and racialized communities, 2SLQBTQIA+ communities, and people with disabilities) have been represented and engaged in your clinical improvement work.

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. The co-design findings and ongoing active participation of patients/clients/caregivers/care partners guide project prioritization; 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.

We intentionally have and continue to aim to diversify representation at PCCPC.

Equity-deserving populations that have been represented and engaged through your clinical improvement work include:

- First Nations Communities
  We continue partnering with the three local First Nations Communities to better understand the needs of these community members and co-design healthcare improvements.
  - Connected local First Nation health directors with local hospice building team to provide a two-eyed seeing approach to the design of the new hospice.
  - Built partnership between a First Nation and Southwestern Middlesex Health Centre to support First Nation on employing an Indigenous primary care physician.
  - Coordinated the purchase of a vehicle by the Elgin OHT for Chippewas of the Thames First Nation Health Centre Crisis Response Team, to support the transportation and mental health and addictions challenges identified as priorities by the community.

- Persona interviews completed with Elgin OHT with Indigenous people living with COPD for journey mapping.
- Lunch & Learn with HIV/AIDS connection, Ontario Aboriginal HIV/AIDS Strategy (OAHAS), Chippewas of The Thames Health Centre to continue to build a partnership.
- Continuing to work alongside LHSC's Indigenous Health Senior Director to support writing of an Indigenous Medicine Policy for LHSC.
- First Nations representatives are participating in the Lower Limb Preservations Project and on the Equity, Diversity and Inclusion Collaborative – Planning Team.
- Test of Change steering committee and working groups included members and contributors from First Nation Digital Health Organization (FNDHO).

- Francophone Populations
  - The team lead for Access Franco-Sante London has been an active member on the 24/7 navigation project team and supporting the Middlesex London Navigators Collaborative.
  - Carrefour Communautaire Francophone de London supported the development of the Navigation Support Needs Model.
  - Francophone representative is participating on the Equity, Diversity and Inclusion Collaborative – Planning Team and the Navigation Localized Model planning team.
  - Since April 2021, MLOHT has supported French interpretation of 55 primary care appointments. This includes 8 since December 31st (this reporting period).

- People who are marginalized (example, people experiencing homelessness, new immigrants, low-income families)
  - We supported the London InterCommunity Health Centre to lead Co-Design Discovery interviews with people who are marginalized. Four interviews were held through the Health Outreach program which focuses on people requiring addiction, harm reduction, housing, or employment support. Four interviews were held through the Newcomer Clinic for individuals who have moved to Canada recently.
  - The MLOHT has advocated for the inclusion of people with lived experience throughout the governance structure for the Health and Homelessness Plan– Whole of Community Response. The MLOHT has also advocated for grounding the Whole of Community Response in co-design.
  - The Equity, Diversity and Inclusion Collaborative Planning Team has reached out to an African Caribbean Black Advisory committee to request input in the planning of this collaborative.

Co-design participants have included rural populations, various income levels, various genders, care partners, people without access to personal transportation and people with various states of disease severity.

Health Equity Matrix
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.

Priority Area 4: Primary Care Engagement and Leadership

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

	Self-reported progress (select from drop down)
Deliverable 1: Implement a model and process(es) to enable primary care providers to have a collective voice in OHT activities and at OH tables.	**Green - Progressing Well**
a) Does your OHT have a primary care network, physician association or similar structure in place?	☒ Yes ☐ No ☐ No change since last reporting period (April 1, 2022 – Dec 31, 2022)
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022 – December 31, 2022).	

We value 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.

Achievements since last reporting period include:

- MLOHT Clinical Leads meet 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.
- 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.); acknowledging that the LMPCA communication channels only capture a portion of primary care, we also leverage OMA and London and District Academy of Medicine communication channels as appropriate (which reaches specialists as well)
- Supporting the LMPCA's development of a Network of Networks engagement strategy with practicing primary care providers in the region.
- Primary Care physicians (3-10 physicians per group) continue to be engaged in the Test of Change Steering Committee, Attributed Population Registry working group, Health Information Exchange working group, Access to Primary Care and EMR vendor working groups.

- Hired a Clinical Project Assistant to support the MLOHT Clinical Leads (Primary Care and Specialty Care) and the London Middlesex Primary Care Transformation Lead.
- Reviewed, updated and mapped the provider compensation process.
- The MLOHT Primary Care Clinical Lead was appointed as the Sponsor of the Access to Primary Care projects.
- Identified physician/clinical leads for the Access to Primary Care Projects streams of Empowering Health Care Workers to Work to their Full Scope and Reducing Administrative Burden via Digital Tools to support a co-leadership approach.
  Each MLOHT project includes a Project Lead (the doer, that drives the project and is responsible for project management activities) and a Clinical Lead (a subject matter expert responsible for the content and quality of deliverables).
  The Clinical Lead responsibilities include:
  - Provides guidance and subject matter expertise to project lead and project team throughout project planning, execution and closeout
  - Sets priorities, monitors progress to achieve project team objectives, contributes to project monitoring and reporting
  - Champions project and engages with physician groups, leaders and peers where an outcome or solution results in or requires a change in practice.
  - Reports progress and barriers to the Project Sponsor and Project Manager; troubleshooting and providing strategies to overcome barriers to implementation
- The MLOHT consistently compensates physicians for participation in our work at a rate of $165/hour.

Deliverable 2: Implement a plan to connect additional primary care providers and clinicians to the OHT.	**Yellow - Some Challenges**
Has your OHT connected additional primary care providers and clinicians to the OHT?	☒ Yes ☐ No ☐ No change since last reporting period (April 1, 2022 – Dec 31, 2022)
If yes, describe the approach and outcome.	
Achievements since last reporting period include: • With ongoing communication through existing networks (i.e. LMPCA, MLOHT Newsletter, physicians/clinicians involved in working groups, we have continued to see a gradual increase in the number of primary care providers and clinicians involved in our work. We are starting to leverage other channels such as social media to try and target a broader engagement.	
OPTIONAL: Does your OHT have a process for measuring and reporting on the level of engagement of primary care physicians and other clinicians in your primary care network or equivalent structures? If so, please describe.	☐ Yes ☒ No

We track the primary care providers and clinicians who have participated in our engagement sessions and working groups. However, we do not have a mechanism to track the percentage engagement across our OHT.

Priority Area 5: COVID-19 Response and Recovery

	Self-reported progress (select from drop down)
<u>Deliverable 1:</u> Implement a plan for COVID-19 response and recovery in alignment with provincial direction.	**N/A - Not Yet Started**
a) Has your OHT collaborated with your local Public Health Unit(s) to coordinate the administration of COVID-19 and flu vaccines?	☒ Yes ☐ No
b) Describe any achievements related to this deliverable since the last reporting period (April 1, 2022 – December 31, 2022).	

Achievements since last reporting period include:

COVID-19 Response
In the SW sub-region, each OHT geography previously had a triad of COVID response support that includes representatives from at least primary care, hospital and long-term care that met bi-weekly to weekly. In Middlesex London, this "triad" has continued to meet biweekly and consists of representation from the MLHU, HCCSS, Hospital, MLOHT Lead and MLOHT Clinical Lead for Primary Care. MLOHT has provided ongoing support to the COVID Clinical Assessment Centres into COVID, Cold and Flu Clinics.

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. Additionally, the MLOHT Lead has been designated the Tier 2 key contact in the OH West-designed Incident Management System.

MLOHT participates in monthly meetings with the Middlesex London Health Unit and London Primary Care Alliance to stay aligned in COVID-19 response and recovery and offer support where needed.
MLOHT will continue offering support when and where needed. This reporting period, the MLOTH funded Taxi Vouchers (through Alliance for Healthier Communities Funds) for families whose children need vaccination to meet the school mandate.

To support equitable access to vaccine, MLOHT continues offering on-demand video & phone interpretation services to primary care providers, facilitating vaccination (including COVID-19) discussions and care in language of their comfort. This reporting period, MLOHT has supported interpretation of 197 primary care appointments, *see priority Area 1, question 2.*

The MLOHT financially supports the MLOHT Clinical Lead – Primary Care to engage with the London Middlesex COVID Response Triad and resultant work. The majority of his work this period was related to expansion of the local CAC model to a COVID, Cold, and Flu Care Clinic (CCFCC) model and the recent planning for closing the local CCFCC.

COVID-19 Recovery
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, deliverable 2*
- **cQiP – Cancer Screening** - *Supporting, see priority Area 1, deliverable 2*
- **cQiP – ALC** – *Supporting, see priority Area 1, deliverable 3*

Support Requests

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

- Immediate information regarding operational funding for Cohort 1 OHTs beyond September 30/23
- 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 and home and community care.
- To advance the implementation of integrated pathways, financial support to implement Community HealthPathways
- 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)
- Establishment and sharing of an overall, provincial digital health architecture, roadmap, and playbook that works backward from a PHM point-of-care solution; 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 next steps for Test of Change projects, including approval of additional project funds.
- Confirmation of next steps for the OHT Coalition for PHM.
- 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.
- Access to individual-level data from Ontario MD and eCE re: local digital health progress across primary care partners (e.g., who is actively using online appointment booking and what platform, who is on HRM, etc.) This information is key for understanding peer-to-peer change management opportunities, building and strengthening positive relationships with primary care, and future digital health planning.
- Base funding for Best Care.
- Establish transparent process for evaluating bright spot programs across the province to determine what makes local programs expandable, scalable and

sustainable (e.g., clear criteria, path for scale and spread, timely access to sustainable funding).

- Accelerate modernizing Health Care Connect Program/Process to facilitate equitably connecting patients with a primary care provider
- Establish and enforce standards for EMR vendor interoperability and point-of-care population health management functionality.
- 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.
- Clear articulation of expectations and deliverables and timely access to documentation, data, and tools to help facilitate TPA deliverables (example Healthcare Navigation, CHF-QBP, Lower Limb Preservation)
- Consistent key contact/liaison for each project and/or establish diad model of key contact and/or standardize and document communication processes (to minimize impact of turnover of OH staff).
- Modernization of funding processes to align with local priorities and enable sustained and strengthened relationships with partners (e.g., longer timelines to collaboratively apply for funding, shorter timeline between approval of funding and distribution of funds, better balance between non-prescriptive and prescriptive funding opportunities, increase in non-competitive funding opportunities – e.g., LEGHO funding allocation was based on population size).
- Provincial plan for primary care practice facilitation, to enable primary care (particularly those working in non-team based models) to actively participate in system improvements.
- Provincial financial support for Primary Care Leadership (e.g., to support active participation in local Primary Care Alliance meetings and work)
- Standardized PREM/PROM and provider experience data collection across multiple projects
- We recognize that Ontario Health is moving toward the standardization of system-level performance indicators to develop more integrated and coordinated care across OHTs. It would be helpful for OHTs to know what the standardization could look like in terms of data management, including the use of standard measurement tools, data platforms, etc.
- Access to individual level (not just aggregate level) data in real- or near real-time and infrastructure support, including databases, software applications, etc.
- Provincial guidance on Data Sharing Agreements at OHT level.
- Access to Provincial Client Registry and the Provincial Provider Registry to inform local planning based for our attributed population and associated providers.
- Establish equitable plan for expanding equitable access to team-based primary care.
- Establish strategy for coordinating/collaborating across multiple OHTs (who is leading in what areas and who is learning from others in what areas?)

PART TWO: TPA PERFORMANCE INDICATOR REPORTING

Please use the template shared with you for the Mid-Year Report and complete column H “Year-End Report” and K “Year-End Report.” Please ensure your OHT name is included in the file name.

PART THREE: FINANCIAL EXPENDITURE STATEMENT

Please complete and attach the ‘Financial Expenditure Statement’ template to your submission. Please ensure to include OHT name in file name.