OHT Implementation Funding Final Report (Cohort 1)

Ontario Health Team (OHT) Name:	Cambridge North Dumfries OHT
Reporting Period:	November 2020 to June 30, 2022

The Final Report consists of three parts:

1) Narrative Summary
2) TPA Performance Indicator Reporting
3) Financial Expenditure Statement

The reporting period for this Report is the entirety of the OHT Implementation Funding Transfer Payment Agreement (TPA), November 2020 to June 30, 2022.

The Final Report is due to your Ministry of Health (ministry) point of contact by **July 29, 2022**.

PART ONE: NARRATIVE SUMMARY

The Narrative Summary provides the opportunity for your OHT to report back on implementation throughout the term of the TPA, including highlighting key achievements, successes, challenges, and lessons learned.

The Final Report is **retrospective** and focuses on the term of the first TPA. Cohort 1 OHTs will also be submitting their Population Health Management and Equity Plan (or 'OHT Plan') on July 29, 2022, as part of their new Continued Implementation Funding TPAs. In contrast to the Final Report, the OHT Plan should be considered prospective (forward looking).

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

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Section A: Showcasing OHT Success

This section requests your OHT to highlight key achievements and successes that occurred throughout the term of the Implementation Funding TPA.

OHTs may consider using this section as a way to report back to their communities about their progress. The ministry encourages OHTs to answer these questions in a manner that can be shared broadly, and to consider making the answers available to patients, providers, and the public, as appropriate.

The ministry may use these responses to report on successes and accomplishments achieved to date, including through public communications pertaining to OHTs.

When answering the following questions, please reflect on how your OHT's activities are reflective of achieving the quadruple aim of better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value. Where possible, please outline what the OHT as a collective has done to support these activities (as opposed to individual OHT members).

What is your biggest success in improving the patient and caregiver experience?
Examples may include improvements or innovations in care delivery that are making a difference to patients. The first phase of OHT implementation has largely prioritized setting the foundation for improvements in care delivery, in addition to consistently pivoting to respond to immediate community needs related to COVID-19. The strengthening of collaborative relationships and new, innovative ways of working together across Members has provided models for sustainable care transformation that is anticipated to accelerate in 2022-2023. Particularly through the COVID-19 pandemic response, the CND OHT demonstrated the ability to efficiently and effectively provide direct service provision to respond to evolving needs. For example, the OHT successfully collaborated to support several COVID-19 vaccination clinics including a Primary Care vaccination clinic for the 80+ year old population and a CND OHT vaccination clinic that ran from April 20 to May 28, 2021 where a total 4,488 vaccines were administered to community members. The clinics were staffed by clinicians from CND OHT Members and Affiliate Members. Planning for these clinics was spearheaded by a group of committed CND OHT front-line clinicians, physicians and primary care leaders. This collaboration demonstrated the strong partnerships and trusting relationships that have been developed through the course of the pandemic. Similar models for shared clinician-led co-design are being applied to care delivery transformation in the CND OHT. Family physicians, nurse practitioners and nurses are chairing the CND OHT Connecting Care Co-Design Groups, initiating several change concepts that will improve care delivery for CND OHT priority populations. Advanced implementation of provincially procured digital health solutions is also having an impact on the patient and caregiver experience. The CND OHT made a one-time digital health grant available to primary care providers who made investments in digital health or virtual care this year. This has

resulted in 17 responses supporting a total of 97 clinicians in Cambridge and North Dumfries. These funds were used for reimbursement of investments made in digital health solutions enabling:

- Existing Online Appointment Booking through Pomelo's Healthmyself (11 clinicians) and Veribook (17 clinicians)
- Virtual Visits through Telus EMR Virtual Visits (29 clinicians), Think Research's VirtualCare (9 clinicians), and QHR's Medeo (1 clinician)
- Secure Communications through Hypercare (5 clinicians)
- Patient Engagement through Ocean Tablets, Kiosks, Webforms, and Patient Messaging and Reminders (55 clinicians)

The CND OHT has implemented a virtual care patient experience survey that has informed investments in this space. We continue to monitor and analyze feedback to ensure that CND OHT approaches respond directly to the needs and preferences of our attributed population.

What is your biggest success in improving patient and population health outcomes?

The CND OHT Connecting Care Co-Design Advisory Committee was able to effectively establish a population health approach to diagnosing our current health system to identify and understand who patients are, how they access care, where they access care, what they need in terms of supports, and who is involved in their healthcare journey across the continuum. Through this we have established processes to begin to understand the gaps in care and services available to patients within the CND community. We are actively working towards understanding what programs are available that are effective in supporting patients within each of our priority population health segments, how we might start to consider spread of these programs, and what tools or services can improve and integrate the communication and connect care planning amongst multi-organizational care teams to effectively wrap all care providers around patients in a one team approach. The goal will be to reduce the number of times a patient must tell their story, ensure no cold hand offs are occurring through patient transitions so patients are receiving the right care, at the right time, in the right place, as well as enable all providers' ability to inform patient care plans and understand what each patient's unique needs are.

While the work that has happened in 2021/2022 remains in the understanding, problem solving and system redesign change concept development phases, once the work shifts into implementation (2022/2023) it will have a dramatic effect on patients' experience by improving how they are accessing services in an equitable and seamless manner. We aim to equip our providers with the tools that will allow them transparency into all community-based programs that may support their patients, including case finding to support care pathways that will result in a stronger approach to prevent treatment plans.

As an initial change concept, the Complex Medical work stream began developing an algorithm that can be integrated into all primary care databases to use patients' medical records to flag 'risk of frailty' within each level of the population health pyramid from health, to rising risk, all the way up through high risk and high-end users. This will enable primary care providers to refer patients through a frailty screening program and pathway to support preventative treatment and supports at all levels of the population health pyramid. This will improve a patient's ability to remain independent in the community for longer, improve quality of life, and potentially increase the time that a patient remains in the healthy or rising risk categories before advancing to the high risk and high-end user segment based on advancement of their frailty.

What is your biggest success in improving value and efficiency?

Increased coordination and collaboration of CND OHT Members has improved value and efficiency through the optimization of services and resources. The CND OHT Co-Design Groups have increased local service provider understanding of services through facilitated activities to identify gaps and opportunities in the system for priority populations. Town Halls, email blasts and informal sharing of information through peer networks in Primary Care in particular have resulted in increased awareness of available services within Cambridge and North Dumfries, optimizing the uptake of existing programs and increasing access to these services for CND OHT attributed populations.

What is your biggest success in improving the provider experience?

The OHT has played a critical lead role in coordinating COVID-19 response activity across system partners, thereby facilitating a unified and enhanced response in times of challenge. The OHT's leadership in this regard includes, but is not limited to, their commitment to timely and comprehensive sharing of information, shared problem solving and co-ownership of intractable problems, particularly those experienced by any one member of the OHT. The CND OHT has meaningfully demonstrated to providers that they can rely on the OHT to be a hub to access support and information. For example, the CND OHT partnered with Region of Waterloo Public Health to host an urgent COVID-19 Town Hall for Primary Care on December 22, 2022. Over 80 participants joined the webinar and received critical updates on changes to case and contact management, vaccine distribution, updates to the clinical assessment centre and other Omicron near real-time information. Feedback from participants indicated that they appreciated a dedicated forum for primary care that brought them directly together with Public Health, with the opportunity to ask questions, review specific scenarios and receive clarification on directives. Similarly, the CND OHT heard from primary care clinicians that there were challenges in accessing mask fit testing, and in response within one week a mask fit testing clinic was provided free of charge to primary care providers across CND. The Town Halls and other activities have built trust and credibility with primary care, setting the foundation for ongoing engagement with the CND OHT.

What is your biggest success in addressing the needs of equity-deserving populations? (e.g. Indigenous, Francophone, racialized and other priority populations)

The CND OHT is in the early days of addressing the needs of equity-deserving populations, and is taking a co-design approach to this work. Consultations with these groups have indicated that engagement and co-design will rely heavily on building understanding amongst those in power positions and developing trusting relationships with clear accountabilities for work in this space. As a result, the focus of the first phase of this work has been on training and meaningful engagement and includes:

- Indigenous Cultural Safety Training offered to all CND OHT Steering Committee and staff support team members
- Monthly engagements with Entité to build an understanding of the Francophone population in Cambridge and North Dumfries

- Regular engagements with Region of Waterloo Indigenous Liaison Lead and key stakeholders such as Southwest Ontario Aboriginal Health Access Centre to build relationships and identify and implement collaborative activities.

COVID-19 provided an opportunity to rapidly co-design and implement improvements in service delivery for equity-deserving populations. The CND OHT collaborated with the local Cambridge Gurdwara to provide two culturally appropriate vaccination clinics, including immunizers who could communicate with the community. The CND OHT also provided critical COVID-19 materials translated in the five top-spoken languages in CND communities as per census data and connected directly with cultural leaders across Cambridge North Dumfries (including church and cultural leaders) to ensure awareness of these resources.

What accomplishment is your OHT most proud of?
The CND OHT is most proud of the trusting relationships that have been built across Member organizations, clinicians and within the CND communities. The COVID-19 pandemic provided the opportunity to build credibility and awareness of the OHT, setting the foundation for accelerated and sustainable change in the next phase of our work. This was accomplished while making meaningful impact including improvements in digital health and care coordination.

SECTION B: OHT CHALLENGES AND LESSONS LEARNED

This section asks OHTs to reflect on the OHT building blocks and highlight any notable challenges and lessons learned. Please refer to Appendix A in the OHT Guidance Document for more details on the OHT building blocks. Answers will not be shared beyond the ministry and Ontario Health. Responses will help inform continued advancement of the OHT model.

Building Block[1]	Challenges and Lessons Learned
1. Patient Care and Experience and Service Delivery	**Challenge:** The ability to maintain and build on excellence in patient care delivery has been notably compromised by health human resource challenges and significant capacity limitations related in part to the impact of the pandemic and the aging workforce. In addition, many members of our community did not access medical/clinical care as needed during the first two years of the pandemic and are now significantly deconditioned or experiencing medical complications which has put them at higher risk of poor health. This further burdens healthcare providers at a time when they are increasingly limited in their resourcing.

[1] Please note that the titles of the building blocks have been slightly revised since the release of the 2019 Guidance Document, however the order in this Template aligns with Appendix A of the 2019 Guidance Document.

	Lessons Learned: There is opportunity to share resources across system partners, consolidate roles, and tighten integrative processes in order to optimize current resourcing and empower all roles to be working at maximum effectiveness. Crisis response activity during the pandemic demonstrated our ability to work collectively to better support communities in need, despite resource limitations.
2. Patient Partnership, Community Engagement and Equity	**Challenge:** The CND OHT has invested significant resources in building understanding and engagement with local communities. Overall, there is a lack of awareness of Ontario Health Teams. Further provincial communication around Ontario Health Teams will support local efforts to build credibility and clarify roles and expectations of OHTs with stakeholders. **Lessons Learned:** Through engagements with leaders in equity-deserving communities, we have learned that a co-design approach is critical to this work. Particularly with Indigenous communities, we have discovered that there is a desire to build relationships and understanding and create space for sovereignty in care design and delivery. These approaches are challenging to navigate in more familiar change management approaches in healthcare because they take time and do not follow a linear approach to planning and implementation.
3. Defined Patient Population Towards Population Health Management	**Challenge:** The CND OHT is committed to a population health management approach to care transformation. We have invested in training co-design groups in population health management and have designed work plans aligned with population health practice best practices. We are challenged in applying these approaches given the lack of understanding around what exactly the attributed population for our communities is. Segmentation for priority populations was conducted based on community and primary care stakeholder experience and understanding of need, however a more concrete understanding (including individual-level data) will provide a more precise and data-driven approach to transformation. **Lessons Learned:** Population health management approaches take time and will not result in quick wins for the community or providers. To support change management, the CND OHT has ensured that we clearly communicate with stakeholders about our work in both the long term and short term to manage expectations and maintain engagement.
4. In-Scope Services	**Challenge:** Primary Care is the foundation of the healthcare system, and the CND OHT is fortunate to have innovative, passionate and engaged physicians and nurse practitioners in the design and implementation of the OHT. However, there is a significant disparity between the vision for integrated care and the siloed primary care practice model in the current system. Current payment models are a barrier to increasing integration of care and do not align with a vision for a system providing comprehensive, accessible team-based preventative care. For example, a family physician in CND highly trained in obesity medicine is interested in expanding access to his services to the broader community. However, negation and compensation (including availability of preventative care billing codes) have prevented the expansion of his practice to provide this care for the community. A commitment by the province to reduce these barriers would

	facilitate local collaboration amongst primary care to ensure the community has access to critical preventive care services.
5. Leadership, Accountability and Governance	**Challenge**: There is consistent tension between collaborative decision making and efficiency in OHT co-design, strategy and decision-making. As per the Collaborative Decision-Making Agreement, the CND OHT is committed to engaging all Members in decision making. Current OHT governance structures reflect this commitment, including a Joint Board Committee and Steering Committee that include one voting representative from each Member organization. As the OHT continues to mature and grow membership, these governance structures will need to evolve to ensure functioning and efficiency. Practically, it will likely not be possible to have a fully shared-governance model with over 25 Member organizations. As a result, we are exploring best and emerging practices that balance collaborative decision making with the potential for representative decision making. This may take the form of sector representative governance, for example. However, the success of the CND OHT to date has been in providing all Members, including smaller organizations, with an equal voice in decision making. There is a concern that moving away from shared governance to representative governance could dilute engagement and collaboration. **Lessons Learned:** Member organizations value shared decision making in the OHT and the opportunity for all Members to have an equal voice in decision making.
6. Performance Measurement, Quality Improvement, and Continuous Learning	**Challenge:** As our OHT works towards maturity, one of the challenges we have encountered has been formalizing a performance monitoring framework and embedding quality improvement in the CND OHT. This requires us to build relationships and trust with key stakeholders to support collaboration and promote a culture of quality. We have identified this work as a priority for our OHT and have hired a Performance Monitoring and Quality Lead to support acceleration of this work. **Lessons Learned:** There is a mutual benefit to integrate academia into planning around performance monitoring. As we establish the CND OHT performance monitoring framework, we are committed to proactively identifying and hard-wiring indicators that will allow us to evaluate impact and improvement in both the short and long term.
7. Funding and Incentive Structure	**Challenge**: There is a lack of clarity around expectations for when OHTs may be expected to take on fiscal responsibility for the attributed population. Similarly, it seems that the infrastructure to manage this level of accountability has moved from LHINs to Ontario Health West. Clarity around timing and infrastructure expectations related to funding would be helpful to set the foundation for this accountability in the future. **Lessons Learned:** Trusting relationships and a shared vision are critical to support collaboration in the absence of funding or an incentive structure.
8. Digital Health and Information Sharing	**Challenge**: There is a gap in the CND OHT for required work in privacy, security and legislative and regulatory compliance related to information sharing and governance. This has significantly limited progress in this space locally.

	Engagement with frontline healthcare organizations for digital health initiatives, especially primary care, has been limited by higher priority expectations such as pandemic response and recovery. Despite encouragement to apply for funding in alignment with pre-existing local priorities and work, the real impact has been that these opportunities overshadowed and pushed out smaller local work not eligible for any funding but still a priority for the local community. The biggest barrier to progressing digital health maturity continues to be the lack of operational or base funding available to cover licencing and administrative fees. This is felt particularly in primary care, long term care, and community support services sectors. **Lessons Learned:** Recognition by the OH region that some digital health initiatives and projects would benefit from a regional approach and taking the lead to coordinate and align multiple OHTs was very successful and appreciated.

Are there any other challenges or lessons learned not highlighted above that your team would like to share?
A lesson learned is the criticality of having primary care leadership on OHT activities. From the launch of the CND OHT, clinicians were well represented on Co-Design Groups, but early on in planning it was identified that there was an opportunity to strengthen engagement. Clinicians are now the chairs of the Co-Design Groups and Work Streams. This has increased ownership on planning and projects. We anticipate that this approach will continue to ensure that planning is centred around primary care and that it contributes to change management excellence as we begin to implement change concepts across CND communities. A lesson learned has been the value of communication across OHTs to share learnings and identify opportunities for alignment where it is sensible to do so to be responsive to the needs of patients and providers. The CND OHT continues to identify an appropriate balance of responding directly to the needs of local providers and the attributed population while maintaining alignments with neighbouring OHTs to ensure that we reduce potential fragmentation while building local OHT digital and service infrastructure.

SECTION C: OHT SUPPORTS

This section asks OHTs to comment on the supports offered by the ministry, Ontario Health and/or the OHT Central Program of Supports. Your responses will help to inform the improvements of supports offered to OHTs. Responses will not be shared beyond the ministry and Ontario Health.

Please highlight any supports and resources, including the Communities of Practice, offered by the ministry, Ontario Health and/or the OHT Central Program of Supports that your team used to support implementation activities over the term of your TPA. How could these supports be improved to best support your needs? Please be specific where possible.
Examples include, but are not limited to, Rapid Improvement Support and Exchange (RISE) Population Health Management coaching and webinars, Accountability, Shared Leadership and Governance Program (ADVANCE) leadership workshops, Public and Patient Engagement Collaborative (PPEC) Engage with Impact Toolkit, Health System Performance Network (HSPN) webinars, digital health playbook, etc. The CND OHT has actively engaged with Communities of Practice and Central Program of Supports. This has assisted our OHT to build capacity of leadership and staff support and co-design group members through learning opportunities (ADVANCE, webinars) and coaching (population health management). The challenge with leveraging these tools and activities is the very limited capacity of OHT stakeholders. The CND OHT staff support team, including the Transformation Lead, sit on several provincial and OH West communities of practice and webinar lists resulting in at least 8-10 hours per month of meetings. Certainly, the connections are helpful, but it does take away resourcing to respond directly to local needs. Ideally, there will be an ongoing dialogue around the right balance of support to ensure that these resources are appropriate given the very limited backbone support within OHTs. A transition to more direct support, particularly in specialty areas (coaching, consultation) for this next phase of work would be more valuable to our team than tools and webinars. For example, a provincial or regional privacy or finance resource who could be reached for support and questions would be extremely valuable.

Has your OHT used any other supports, and if so, how have you used them? What additional supports would your OHT have found helpful throughout the term of your TPA?
CND OHT planning would have benefited from a longer-term TPA, or ideally a commitment to sustained funding. Building out a team and programs to support long-term population health management and a transition for funding accountability while working on shorter-term project-based resourcing is extremely challenging.

PART TWO: TPA PERFORMANCE INDICATOR REPORTING

Please use the template shared with you for the Year-End Report and complete column L “Final Report” and R “Final Report.”

PART THREE: FINANCIAL EXPENDITURE STATEMENT

Please see attached template.