## Introduction:

* The Progress Report is intended as an addendum to the Self-Assessment Form submitted by teams to the Ministry of Health in May 2019.
* The report provides an opportunity for teams to demonstrate the progress they have made towards meeting the Ontario Health Teams readiness criteria since their self- assessment submissions*.*
* The Progress Report will be considered by the Ministry with the original Self- Assessment that your team submitted to inform an assessment of the readiness of your team to submit a comprehensive Full Application.
* The next round of teams invited to submit a Full Application will be announced in early March 2020.

**Guidance for Completing the Progress Report:**

* Please refer to the *Ontario Health Teams: Guidance for Health Care Providers and Organizations* document*,* your *Self-Assessment* submission and feedback letter, and preliminary data package, to complete this report.
* This form should be signed by the primary contact of your team on behalf of all of the members of your team and any new members who were not signatories to the team’s initial Self-Assessment.
* Submit the Progress Report to [OntarioHealthTeams@ontario.ca](mailto:OntarioHealthTeams@ontario.ca) by: January 20, 2020.
* Please contact [OntarioHealthTeams@ontario.ca](mailto:OntarioHealthTeams@ontario.ca) or your ministry point of contact for any inquiries regarding this Progress Report

**Please note:**

* Please submit the form only in the fillable word document provided to allow the ministry to extract the information provided for analysis purposes and ensure that word count limits are observed.
* Up to 10 pages of additional supplementary documentation are permitted. Please include any visuals, charts, or diagrams as supplemental information. This information may be considered by the ministry in its review of the progress report.
* Although the core components of the model will remain in place, over time, expectations will be adjusted to support learning and improvement at each stage of the process. Lessons learned by the first cohort of named Ontario Health Teams will inform refinements to the model and implementation approach and provide valuable information on how best to support subsequent teams.
* This Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the organizations identified in this progress report or anyone else.
* All Progress Reports submitted to the Ministry are subject to the public access provisions of the *Freedom of Information and Protection of Privacy Act* (FIPPA). If you believe that any of the information you submit in connection with your application reveals any trade secret or scientific, technical, commercial, financial or labour relations information belonging to you, and you wish that this information be treated confidentially (subject to applicable law) by the Ministry, you must clearly mark this information “confidential” and indicate why the information is confidential in accordance with s. 17 of FIPPA.
* Progress reports are accepted by the Ministry only on condition that the team members submitting this report thereby agree to all of the above conditions and agree that any information submitted may be shared with any agency of Ontario or delivery partner within the OHT Central Program of Supports:<http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx#supports>

**Proposed name of the Ontario Health Team**

**Part I: Defined Patient Population and Priority Year 1 Population(s)**

**KW4 Ontario Health Team**

**Reflecting on your team’s self-assessment response for Model Component 3: Defined Patient Population, please provide the following additional information.**

**What did the attributed population data reveal about the population accessing care from partners in your team? Please note that while the attribution data may be used to identify potential partners, it is not prescriptive. Teams are encouraged to partner with individuals and organizations they deem appropriate.**

**Response** *(750 words maximum)*

The Ministry of Health (MOH) feedback from the KW4 OHT original expression of interest included the recommendation to better analyze demographic and service usage data on the proposed year one target populations, and develop methodology to capture and track these populations. The two MOH data sets have supported better understanding of the KW4 OHT population at maturity; and the provider network information has confirmed many of our year one provider-partners. We have additionally engaged with provider-partners not included in the MOH data set, yet important to the proposed year-one targets; and we have been undertaking compliimentary analyses to support planning.

Attributed Population

* + KW4 OHT’s attributed population is 397,627.
  + One fifth (58,000) of our geographic population accesses services outside KW4 OHT, and a comparable number of non-residents is accessing care within our OHT region (For example, we have 15,792 individuals accessing healthcare who reside in neighbouring Cambridge- North Dumfries, an OHT with whom we are liaising about how our adjacent OHTs will coordinate to ensure continuity of care across OHT boundaries. (In addition to patients, we share many regional and municipal service partners that will have to be considered as planning for both OHTs matures).

Work is underway to design integrated care for our proposed year one target populations, with specific focus areas to be determined. The attributed population data has supported

better understanding of some basic demographic data. For example, 15.8 % of the attributed population is over 65 years. Provincial data on prevalence of health conditions reveals that the KW4 attributed population presents with respiratory diseases, gastrointestinal, musculoskeletal and infectious conditions more commonly than other conditions (i).

Information is being complimented by contracted analyses to understand demographics, service usage, health and wellness profiles, and opportunities for implementing integrative activities.

**KW4 OHT Provider Network**

The 18 primary care provider groups identified in the first MOH data set are either signatories to the KW4 OHT’s initial self-assessment, or family health organizations targeted in the primary care engagement strategy described in Part 2 of this progress report. However, the MOH data set does not include data from additional KW4 OHT primary care partners including:

* + Kitchener Downtown Community Health Centre (KD CHC),
  + Woolwich Community Health Centre (Woolwich CHC), and
  + Waterloo Region Nurse-Practitioner Led Clinic (Kitchener site).

The percentage of primary care visits made by the KW4 attributed population outside of the enrolling group was 15.4%, lower than the provincial average of 22.6%. The rate of CTAS IV/V ED visits per 1,000 enrolled population was also lower in KW4 at 78.2, compared to

140.2 provincially (ii). Unscheduled ED visits by the attributed population is also lower than the provincial average at 19.4% versus 24% (iii). This data supports and positions the provider network in KW4 OHT to continue providing excellent continuity of care in the community, while supporting the ministry’s mandate to end hallway medicine.

Additional Analyses and Patient Tracking

In addition to reviewing the MOH attributed population data, we have been conducting our own analyses and developing baseline population health profiles for our community and the proposed year one target populations (Appendix A); mapping all signatory organizations’ work to our year one target populations; working with our local WW LHIN to understand hospital usage patterns for our year one target populations; and continuing with planning for year one and KW4 OHT at maturity.

We have been working with the two hospital signatories and six primary care signatories to the KW4 OHT self-assessment to understand their respective rosters, EMRs and how their patients move between primary and acute care. We will be building on this work to develop

our OHT proposal later in 2020 (with a focus on tracking year one target populations through primary care).

Next Steps

As noted in our proposed priority year one target populations described later in this section, we are conducting qualitative studies for each proposed target population to further our year one planning and to support decision-making. As we work towards a future state and mature KW4 OHT, we plan to engage and involve all additional primary care and healthcare providers in our OHT region, including those not reflected in the initial MOH data set, which includes the 2 KW4 CHCs and NPLC noted earlier, and approximately 150 solo primary care practitioners and specialists known to the KW4 OHT. This is further described in Part Two.

## How has or how might these data be used to inform your planning to achieve quadruple-aim metrics related to your patient population?

**Response** *(750 words maximum)*

The data has provided baseline information on important performance indicators and comparisons to Ontario, which will be beneficial for monitoring purposes as we move forward. The data is reflect in the quadruple-aim as noted below:

Better patient and population health outcomes

The data on the health conditions and rankings provided insights on the prevalence of health conditions within our patient population. This type of information is useful for prioritizing services that will improve care delivery and positively impact health outcomes. Taking a comprehensive approach to disease promotion, prevention and management supports better outcomes for local residents. A regional quality improvement example would be the recognition that diabetes and cardiovascular issues are ranked in the top 20 most prevalent conditions, however only 44% of patients with diabetes and 16.9% of those with congestive heart failure have a flow sheet completed.

Understanding resource use patterns for the population also permits planning for the most appropriate level and type of care, including non-medical supports. The data provided illustrated some patterns of acute care use that will need to be considered as a means to reduce hallway medicine:

* + 16% of total inpatient hospital days in a year (excluding newborns and stillbirths) were for adult mental health
  + 14% of acute inpatient days (excluding newborns and stillbirths) were ALC days

Better patient, family and caregiver experience

The data provided indicated that the percentage of patients who were able to schedule same day/next day appointments when sick, has been consistently lower for our network compared to Ontario (34.9% in our network vs. 44.7% for Ontario, Q4 17/18). The data further highlighted potentially avoidable ED usage:

* + 25% of all ED visits were CTAS Level IV & V
  + 5.7% of the attributed population had 2-4 ED visits
  + 0.7% had 5+ ED visits

Challenges in accessing care when needed affects the patient experience of healthcare, and this experience is critical to informing plans for accessible services. Numerous local and provincial evaluations on access to team-based care and integrated care models; has demonstrated a positive outcome in patient experience with the health care system (for example Health Links and Advancing Access to Team Based Care). KW4 OHT will position the patient at the center of its care model, co-designing the system with patients, families and caregivers, and continuously seeking quality improvement in the areas of patient reported outcome and experience measures.

Better Provider Experience

The Institute for Healthcare Improvement (IHI) has examined the importance of including the provider experience in the quadruple aim for healthcare systems. Although data on provider experience is limited, we acknowledge that in moving forward building clinician resiliency, reducing burnout and addressing health human resource gaps is of utmost importance in the delivery of safe, patient-centered, high quality care. Future plans for integrated care delivery will be co-designed with providers to ensure positive impacts on provider experience. The KW4 OHT provides an opportunity for providers across multiple sectors to work together as one confident and trusting team, supported by community-based and hospital partners, in the delivery of care and wellness for our population across their lifespan.

Better Value and Efficiency

The data on potentially avoidable ED visits and inpatient hospital days for mental health (16%) and acute inpatient ALC days (14%) are an example of opportunities to optimize the use of healthcare resources. This can be achieved through further planning and system redesign that proactively meets patient needs and ensures optimal value for healthcare funds. Access to additional data on related costs would have provided a more comprehensive picture to further ascertain where the most economical value may be found. The KW4 Steering and Operations Committees will examine how the year one target population intersects throughout the healthcare system, what their social and medical profiles look like, and the associated costs of service(s) usage. An example of this is linking disease profiles

with acute care use data, including volumes and costs of quality-based procedures (QBPs). It is hypothesized that with better integration of care and services in the community, including the social determinants of health and services that are preventative in nature, system resources will be optimized, and care will become more proactive.

|  |  |
| --- | --- |
|  | **Proposed Priority Year 1 Population(s):** |
| *Please identify the priority Year 1 population(s) proposed in your Self-Assessment and note any changes that are based on a greater understanding of demographics, cost drivers, referral & utilization patterns, and barriers to equitable care. (1000 words maximum)* Overview and Approach  In the self-assessment, KW4 identified two first-year priorities: socially vulnerable residents and frail seniors who fall within the high risk and rising risk tiers of the Kaiser Permanente health pyramid (Appendix B). Since then we have further defined socially vulnerable residents to refugees and precariously housed and experiencing homelessness. These populations contribute to hallway medicine and we have opportunities to better serve them in the community by strengthening capacity and transitions between primary care, tertiary care, and community/social services, including mental health and addictions.   * Since May 2019, we have made significant progress in better understanding these populations and identifying integrated care opportunities that will be further developed at planning sessions in late January and February.   Refugees Demographics   * KW4 is home to more refugees than any other Ontario community outside the Greater Toronto and Hamilton areas, and receives the highest number of secondary migrants in all of Canada (iv). * The volume of refugees to Waterloo region has increased by 87% in the past ten years (v).   Cost Drivers   * KW4 refugees frequently arrive with acute and complex healthcare needs requiring immediate assistance and coordination across health and community services. * Refugees often present at hospital due to lack of long-term primary care and access to mental health services; and experience language and cultural barriers to care and follow up.   Referral and Utilization patterns | |

* + Four primary care signatories serve the majority of KW4 refugees (5,500), but are at and over capacity: Sanctuary Refugee Health Centre, The Centre for Family Medicine Refugee Health Clinic, Kitchener Downtown Health Centre, and Woolwich Community Health Centre.
  + Other primary care providers and community services in KW4 serve but are not tracking refugees.
  + Both hospital signatories serve refugees, often through emergency departments and visits that could be better addressed in primary care.

Year One Ideas and Opportunities

* + Addressing silos and capacity issues within primary care through integrating clinics and/or institutions.
  + Supporting transitions between primary care, tertiary care and community/social services to ensure better continuity of care.
  + Facilitating attachment to long-term and timely primary care.
  + Increasing access to mental health and addictions supports.

Precariously Housed and Experiencing Homelessness Demographics

* + Homelessness is difficult to gauge due to stigmatization and system barriers, however we estimate 450-500 people currently homeless in Waterloo Region (vi), 39% who are under age of 30, facing mental health and addiction issues (vii).
  + The regional shelter system is at or over capacity for most months of the year, with minimal health and social support within shelter facilities. In September 2019, one shelter had to turn away 193 different individuals who were seeking shelter due to capacity issues (viii).
  + 4,849 households are waitlisted for community housing, resulting in people staying longer in shelters (ix).

Cost Drivers

* + These individuals present frequently to hospital due to limited primary care attachment, and remain in hospital settings due to capacity constraints within the shelter system and an inability to discharge them into viable housing options
  + High prevalence of concurrent disorders creates complexities in care (e.g. 154 patients being treated for drug induced psychoses by one downtown clinic) and increased deaths due to overdoses, particularly in those who discharge themselves.

Referral and Utilization Patterns

* + Specialized primary care and acute care services outreach into the community, meeting residents where they’re at
  + Grand River Hospital and St. Mary’s General Hospital provide service and track clients through their emergency and specialized services.
  + Paramedic and Police Services have frequent contact with those who are homeless and make connections to community and health services where possible.

Year One Ideas and Opportunities

* + Diverting unnecessary ED visits by expanding 24/7 outreach efforts, the street, shelters, meal programs, motels, and consumption treatment service sites
  + Connecting providers through shared documentation and integrating services across health, justice, housing and social service sectors
  + Explore innovative affordable housing options (motels, shipping containers, etc.).

Frail Elderly Demographics

* + 15.8 % of the attributed population is over 65 years .
  + Waterloo region is projected to have over 100% growth in seniors over 2018-2046 (x).
  + Between 2008-2012, dementia and Alzheimers disease were the second leading cause of death in Waterloo region (xi).
  + COPD and CHF are the leading cause of hospital readmissions.
  + 2,929 patients in KW4 are 75+ and receiving home care supports through LHIN. Key Cost Drivers
  + Costs for patients with dementia estimated to be over five times more than for those without.
  + Behaviours and dementia are the top barrier to hospital discharges (xii).
  + Seniors with COPD and CHF are reasons #2 and #5 for hospitalizations.
  + COPD and CHF quality-based procedure volumes at GRH and SMGH cost approximately $1,000,000 annually.

Referral and Utilization Patterns

* + Seniors diagnosed with CHF, COPD or dementia draw on a multitude of healthcare and community services that would benefit from improved integration.
  + KW4 has provincially recognized programs for seniors demonstrated to reduce costs and unnecessary hospital admissions including:
  + C5-75 frailty measure.
  + Regional memory clinics that keep patients in their home reduce wait-times and lower costs.
  + Nurse-led outreach for long-term care.
  + Coordinated intake for Geriatric Services.
  + Home at Last programs facilitating transition from hospital to home.

Year One Ideas and Opportunities

* + Expanding primary care programs for frail elderly and their caregivers, including increasing regional memory clinics and linking them to 24-7 system navigation/care coordination supports.
  + Providing seniors presenting at hospital with CHF, COPD and dementia with alternative integrated community and primary care supports.

Other Year One Considerations Mental Health and Addictions

Pervasive across all three priority populations are challenges related to mental health and addictions. The KW4 OHT will coordinate with relevant integration work occurring in this sector. For example:

* + The Addictions and Mental Health Program Council comprised of 15 providers throughout Waterloo Wellington, which since time of self-assessment has transitioned into an advisory group for the newly formed Centre of Excellence for Mental Health and Addictions.
  + The Connectivity (situation) and Specialized Outreach Tables that work collectively to provide health and community interventions for vulnerable residents.
  + The Counselling Collaborative, a community-based partnership between six counselling providers within Waterloo-Wellington that is coordinating with primary care to ensure all residents attached to primary care have access to counselling services.
  + The Older Adult Strategy that includes mental health and addictions supports.

**Part II: In-Scope Services That Can be Provided by Team Members**

**Reflecting on your team’s self-assessment response for Model Component 4: In- Scope Services, please provide the following additional information.**

**Who are the members of your team and describe the breadth of services they can provide (e.g., in home and community care, primary care, and hospital care)?**

*Please note any changes from your self-assessment – if there are no changes to your team members, please indicate this here. (1500 words maximum)*

The vision for the KW4 OHT continues to be rooted in the community’s aspirations for health and wellness, and we continue to publicly frame this as an OHT for the entire KW4 community. Provider- partners in KW4 have a rich history of collaboration around initiatives that have been successful in improving the health and wellbeing of our community. Examples include but are not limited to:

* + Wellbeing Waterloo Region
  + Connectivity Tables for elevated risk case conferences
  + Older Adult Strategy
  + Region of Waterloo’s goal to end chronic homeless through a 10-year Housing Strategy
  + Implementation of the Care Community Model
  + Development of the Inner City Health Alliance and progress on ShelterCare

The continued maturation of the KW4 OHT promises to build and expand upon existing groundwork, using collaborative networks to realize improvements in both the health sector and our community more broadly.

KW4 OHT has attracted multi sectoral representation across the continuum of care. Our signatories and supporters represent hospitals, home care organizations, community based organizations, many offering services related to the social determinants of health, as well as primary care including community health centres, family health teams, family health organizations and collaborations offering interprofessional care.

Since the self-assessment was submitted, a number of important developments have occurred to deepen the relationship between some service providers, extend the breadth of services available for year one-target groups and integrate more deeply the connections to Primary Care. For example:

* + We look forward to collaborating with University of Waterloo’s recently created Health Initiatives Task Force whose aim is to promote innovation and collaboration across the University and partnerships with the community. Sponsored and lead by the President, the goal is to match the strengths and capabilities of the institution with the big questions surrounding health care in our community be it patient care, technology, public policy, education, and beyond.
  + The table around which the signatory organizations sit has been left open for other service providers to join our planning work. KW Habilitation, KW Counselling and KidsAbility are three that will join to help inform the thinking for the maturity care model and the strategy for scalability.
  + Among the strategies being developed to strengthen access to mental health resources, the KW Counselling Collaborative has developed and received funding for an initiative to integrate referrals for counselling from solo Primary Care physicians, into one intake. The model of centralized intake and referral management, including e-referral, achieves a common goal to reduce wait lists.
  + Inner City Health Alliance continues to deepen the relationship among members and to broaden services for homeless and at risk of becoming homeless populations. As examples:

-Shelter Care is a new initiative for House of Friendship which brings Primary Care to the shelters where residents are welcomed and have existing trusted relationships

-Water Street is a house renovation project in downtown Kitchener with a goal to

provide nine beds, supported by primary care physicians and nurses, to assist drug addicted residents to receive care for health issues while at the same time accepting their addiction as a given. This initiative alone will save lives lost due to over doses, create healthier members of the first year target groups (also providing a much improved care experience for them) and reduce repeated emergency room visits.

## How have primary-care providers been involved as members or leaders in your team?

*Please note any changes from your self-assessment. (750 words maximum)*

Primary care is integral to the launch and success of the KW4 OHT. Through leadership as signatory organizations, letters of support and participation on a new advisory Council, the majority of KW4 primary practitioners have been engaged in the OHT. Primary care organizations have led the OHT from initiation of the self-assessment in May 2019; and an advisory Primary Care Council has been established to expand and formalize primary care’s ongoing involvement in OHT design and implementation. In addition, primary care organizations will be key to tracking OHT patients in year one and beyond.

Primary care leadership and participation

Six primary care agencies showed leadership in initiating the KW4 OHT. The lead agency is the Centre for Family Medicine Family Health Team (CFFM FHT) with five additional primary care organizations amongst the signatory and supporting organizations. These 6 primary care practices collectively care for 70,000 + rostered patients:

* + CFFM FHT (24,805 rostered patients);
  + New Vision Family Health Team (25,403 rostered patients);
  + Waterloo Regional Nurse-Practitioner Led Clinic (2644 patients in KW);
  + Kitchener Downtown Community Health Centre (KDCHC) (3533 patients);
  + Woolwich Community Health Centre (6592 patients +1837 non-OHIP patients); and
  + Sanctuary Refugee Health Clinic (4,642 refugee patients).

Many CFFM FHT and KDCHC programs are also open to referrals from across the OHT - for example regional memory clinics, mobility clinics, an in-home team and a primary care outreach initiative, and thus support the entire KW4 OHT population.

In addition to the signatory organizations, two family health organizations representing 40 family physicians, and an additional five individual family physicians provided letters of support to the initial self-assessment.

Expanding primary care engagement

As further described in part three, we have been building on the engagement we began with the self-assessment. In June 2019, the 31 KW4 OHT signatory organizations established a Steering Committee. It is comprised of 10 elected members, and chaired by a primary care physician (Dr. Joseph Lee) to oversee development of the final proposal and OHT launch.

In October 2019, the KW4 OHT began consolidating its clinician engagement strategy with an initial focus on primary care; and in November 2019, a call went out to all KW4 primary care clinicians to nominate individuals for the KW4 Primary Care Council. The purpose of the Primary Care Council is to support development of an OHT by:

* + making recommendations related to the final KW4 OHT proposal, launch and implementation plan;
  + providing insight into how to continually engage and involve primary care and other clinicians in the KW4 OHT; and
  + supporting representatives in updating their respective primary care institutions.

All KW4 primary care institutions (e.g., family health teams, community health centres and family health organizations) were invited to identify representatives, and several spots were held for independent practitioners. Nineteen individuals representing the majority of primary care institutions in KW4 now comprise the Primary Care Council that met for the first time on January 15th. This group will continue to meet monthly during the OHT design phase.

In addition to actively engaging primary care in OHT co-design, the KW4 OHT is keeping the broader practitioner population informed through the KW4 Primary Care newsletter and associated website - a partner initiative in KW4 OHT development. These communication tools are currently being updated to include OHT content in the monthly newsletter that reaches over 300 KW4 primary care practitioners; along with a dedicated OHT page on the website that will include a mechanism for primary care users to communicate with OHT organizers.

Tracking KW4 OHT Patients

Primary care is also key to tracking KW4 OHT patients in year one and beyond. Members of the KW4 OHT Operations Team have met with the primary care signatories to identify opportunities for data capture and tracking year one targets; and where EMRs may need to be altered and/or aligned to better accomplish this work. Similarly, the Operations Team has been meeting with other relevant cross-institutional primary care programs, including:

* + KW4 Health Links to ensure we are building on gains already made to increase access to primary care for medically complex and vulnerable patients; and improve integrated care including coordinated care planning;
  + the Inner City Health Alliance that is implementing a shared EMR across a mobile bus and primary care clinics serving those who are homeless and precariously housed;
  + regional memory clinics for patients with dementia and other memory issues that receive referrals from all primary care providers across KW4; and
  + the Kitchener Downtown Community Health Centre’s primary care outreach program that provides primary care clinics to vulnerable patients in unique settings.

# Part III: Other OHT Building Blocks

## Reflecting on your team’s self-assessment responses for each of the Model Components, please provide the following additional information.

**Which of the following areas of the Ontario Health Team model have you focused your efforts on since receiving the results of your self-assessment? For each area you have chosen to focus on, please describe how these efforts have prepared you to complete the full application in the text field below:**

* **Patient partnership and community engagement (e.g., engagement of Francophone populations and Indigenous communities)** *(Self-Assessment Response to Model Component 1: Patient Partnership and Engagement)*
* **Patient care and experience (e.g., setting the stage to use population-health management to improve key metrics related to patient care and experience among groups of patients for whom quadruple-aim metrics are particularly poor)** *(Self- Assessment Response to Model Component 2: Patient Care and Experience)*
* **Digital health (e.g., steps that have been taken to support a current state assessment of each team member’s digital health capabilities and the identification of any gaps)** *(Self-Assessment Response to Model Component 8: Digital Health)*
* **Leadership, accountability and governance (e.g., shared decision-making approaches and steps towards building the trusted relationships needed for collaborative governance)** *(Self-Assessment Response to Model Component 5: Leadership, Accountability and Governance)*
* **Performance measurement, quality improvement, and continuous learning (***Self- Assessment Response to Model Component 6: Performance measurement, quality improvement, and continuous learning)*
* **Other components of the OHT model**

## In your response, please comment on how you have utilized resources and supports available through the OHT Central Program of Supports.

**Response** *(1500 words maximum)*

Patient partnership and community engagement

While patient and community engagement was an important part of our self-assessment, we have developed a more robust system for inclusion of patient and community experience since that time. Through the development of our interim governance structure, we have made it a priority to recruit both a patient and a caregiver to the Steering Committee that guides the work of KW4 OHT development moving forward. This Steering Committee meets monthly combined with the KW4 OHT operations group.

In addition, both a stakeholder engagement framework developed and a patient/caregiver engagement framework is in development. The stakeholder engagement framework focuses on the participation of community agencies, organizations, and businesses for the purposes of co-design. The patient/caregiver framework is being developed with a patient and caregiver, and will focus on the involvement of those groups in the co-design process. It will look towards current resources for patient/caregiver engagement such as the local Patient and Family Advisory Councils (PFAC), the previous LHIN PFAC, peer support networks, and the HQO Patient Engagement Framework. Both engagement frameworks are set to be launched in the new year.

Patient care and experience

One of the key design sessions since self-assessment submission was the engagement of individuals in designing the mission, vision, and values of the future state KW4 OHT. Through this process, patients/caregivers were engaged to share their experiences and help envision what they want their experience to include moving forward. In the new year specific working groups related to year one populations will be formed, and patients/caregivers will be invited to participate. They are currently involved at the signatory, and steering committee level.

Digital health

Since our original submission we have worked with our core partner, the eHealth Centre of Excellence (eCE), to conduct an inventory of tools being used by providers in our OHT. We know the following about the use of digital health tools and their realized benefits:

Virtual Visits: enhancing access to primary care, 8,321 patients and 88 primary care providers (PCPs) are enabled to do virtual visits through the Virtual Care platform. 6,949 visits have been completed with patients from KW4. Providers from KW4 have completed 17,715 visits. 4,841 patients have had at least one virtual visit. 88% of visits are responded within 24 hours, illustrating enhanced access to care and 4% of patients have indicated that if the virtual visit was not available, they would have visited the emergency department. Over 90% of patients believed that the visits provided convenient access to care and saved them time, and over 80% of providers indicated that virtual visits supported them in seeing patients in a timely manner. Levering change management support from the eCE, we plan to expand virtual visits to further enhance access to primary care and avoid visits to the ED.

eConsult: enabling timely access to specialist advice, 210 PCPs have signed up and 42% have sent at least three eConsult in the past 6 months. On November 12th, our region launched WW Regional BASE™ Managed Groups including 17 specialty offerings (Appendix C & D). Given the median Specialist response time on eConsult is 1.1 days facilitating timely care for patients (eConsult Centre of Excellence, Sept. 2019), we plan to expand the use of eConsult to enhance access to specialty care, particularly for Refugee Health and frail elderly patient populations.

eReferral: supporting transition in care and patient access to their information, eReferral has been used for over 30,000 patients in KW4, out of which 13,296 (44%) have received e-mail notification of their referral status, keeping them informed about their transitions. 95% of patients indicated that the eReferral notifications improved their experience and over 80% felt more informed about their care. Over 75% of providers believe that eReferral improves their communication with other providers. We currently have the most eReferral destinations live in the province. Continued expansion of eReferral is underway to provide patients with access to their health information and efficiently access specialty services.

Decision support tools: embedded into primary care EMRs translating quality standards at the point of care, related to year 1 patient populations, have been identified and plans to support further implementation are underway. Methods to track use of these tools have been established. 80% of providers have indicated that such tools impact the quality of care they provide to their patients.

Robotic process automation: work to code primary care data and share coordinated care plans across organizations is in progress. This will create efficiencies, improve information sharing, enhancing transitions in care and enabling integrated care for patients. Coding of

primary care data will improve data quality and allow for future population health assessments and management as our OHT matures.

Leadership, accountability and governance

Since submitting our Self Assessment, the KW4 OHT Signatory organizations have invested in the following aspects of leadership, accountability and governance:

* + Held four meetings to discuss leadership, accountability and governance for the OHT development process moving forward as well as to agree work plans and monitor progress.
  + Decision taken to establish a Steering Committee to oversee the continuing development work on behalf of the Signatory organizations.

- Agreement to establish a Nominations Committee and process to nominate 10 individuals to form the Steering Committee: five from among the Signatory organizations, three widely respected community leaders not directly associated with health and wellness organizations and two patient/family/caregiver representatives. Terms of Reference for Steering Committee established, monthly meetings held July through December and a bi- weekly meeting schedule planned for 2020.

* + Role for Advisory Group established to ensure Steering Committee access to specialized skills, expertise and experience on behalf of the Signatory organizations as the OHT development work continues.
  + Transformation Lead role description and recruitment process developed and implemented by Steering Committee. Candidate selected by September 1st.
  + Operations Committee in place to work with the Transformation lead to support work planning and implementation through a series of working groups including year one target groups and care transitions (three sub-groups), OHT end state maturity model, digital health and home and community care (Appendix E). Operations Committee members are five senior staff from signatory organizations.
  + Work plan for 2020 includes Steering Committee focus on development of ongoing governance model for the OHT Application phase. Research has been conducted as part of 2019 work plan.

Performance measurement

Since receiving the results of our self-assessment, work in this area has focused on: Enhancing the KW4 OHT Operations Committee understanding of best practice.

* + KW4 OHT Operations Committee members attended a two-day workshop on “Aligning Strategy and Measurement for an Integrated System of Care Workshop”, jointly hosted by the Ontario Health Association and the Institute of Health Policy, Management and Evaluation, University of Toronto. The first session focused on:
  + leveraging evaluation frameworks to shape measurement approaches,
  + operationalizing strategy through quality improvement,
  + performance reporting and information management,
  + maintaining good system hygiene, and
  + avoiding over-measurement and indicator fatigue.
  + The second session allowed our team to move through a systematic process to complete a driver diagram for a high-priority goal and take a deep dive into measurement and indicator selection.
  + We will begin to develop Driver Diagrams to articulate what parts of the system need to change for our year-one target populations, and in which ways.
  + Measurable aims will be identified along with a portfolio of actionable projects/opportunities that are needed to achieve these aim(s). Outcomes and process measures, which align to the Quadruple Aim, will also be identified so that teams can tell whether their efforts are leading to improvement.
  + Grand River Hospital has extended their relationship with Advisory Board International (ABI) to the KW4 OHT Steering Committee members to foster deeper knowledge. ABI is a thought partner and support for innovation, transformation and optimization and offers many resources such as research studies, toolkits, web conferences, expert consultation, news updates, etc.

Developing a quality improvement structure to support ongoing work

* + A Performance Measurement, Quality Improvement, and Continuous Learning Working Group will be established in early 2020. Early work will include reviewing detailed quality metrics; identifying opportunities for further reducing inappropriate variation across providers; and establishing a protocol for assessing, introducing and implementing clinical standards and best available evidence across all providers. HQO Quality Standards, which have been developed by expert advisory committees consisting of clinical experts and patients with in- depth knowledge and experience in particular topic areas will be a great source of reference for the KW4 OHT. We will also focus on strategies to better integrate and aggregate data to support meaningful reporting.

Conducting a current state analysis

* Understanding data sources for each of our proposed target population along with gaps in data and opportunities for addressing the gaps.
* Mapping signatory interactions with the proposed target population.
* Working with each primary care and hospital signatory to understand their respective EMRs and where they may be capturing information on the proposed year-one population. This will help us to determine what capabilities exist in the information systems to extract and analyze data on the target populations as part of measuring system performance.
* Understanding unique needs of our rural residents.

# Part IV: Preparing for and Completing the Full Application

## Reflecting on your team’s self-assessment response for Part III: Implementation Snapshot, please provide the following additional information.

**What challenges/barriers do you foresee in completing the full application and how do you propose to address these?**

**Response** *(750 words maximum)*

KW4 is committed to building on our commitment to the value of coordinated care plans (CCPs) as an integral tool to enable collaboration and integration among service providers for year one target groups. Our challenge will be to engage an increased number of primary care providers in the use of CCPs. We intend to build on our health links strategy and communicate the value of CCPs as demonstrated by the Centre of eHealth Excellence’s evaluation of our program, using our newly formed Primary Health Council as an advisory group to develop outreach tactics.

The regional planning of Home and Community Care (HCC) will be an essential part of our process given that we share services with two of our neighboring OHTs, and their planning is well underway. We have agreed to work together to ensure seamless services for our residents and to determine how to equitably share these resources. At the same time, we understand the Ministry is considering a variety of high-level strategies (Modernization of Home Care) for transitioning resources from the LHINs, and reviewing current HCC legislation that restricts these resources. We look forward to learning more about the Ministry’s plans and the implications for our OHT.

The engagement of clinical specialists in the co-design process will be critical for the development of our full proposal. At this stage, we have begun work with physicians through the establishment of the Primary Care Council. We anticipate creating a multi-pronged

**What supports from the OHT Central Program of Supports would you find particularly helpful in completing the full application?**

approach to engaging specialists; including working with our hospital partners to engage those with privileges. Gaining advice from our primary care participants about how best to identify and articulate the benefits for specialists to join us at this early stage will be beneficial, and essential to developing a year one service model.

Finally, multiple partners have identified challenges in planning for our shared service provisions within what was previously known as the Waterloo Wellington LHIN area (covering Guelph, Cambridge North Dumfries, and KW4). Early conversations with our neighboring OHTs have identified the need to approach equitable provision in a way that puts care for patients front and centre, and doesn’t burn out service providers. Additionally, we expect sharing of resources across the larger province, including communications and seamless coordination of services for KW4 patients, will become an issue requiring collaboration and conversations facilitated by Ontario Health West.

**Response** *(500 words maximum)*

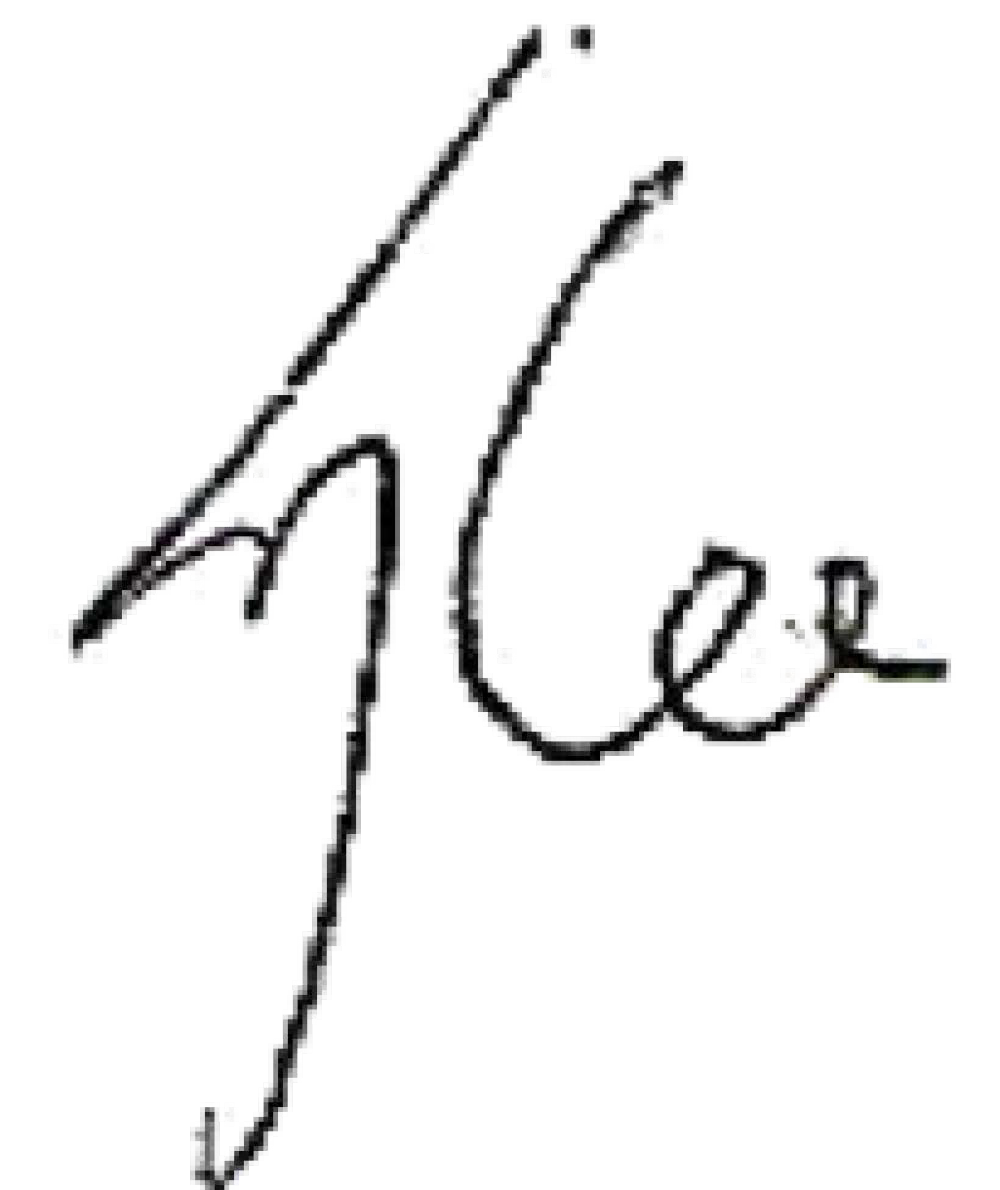
We have already appreciated the guidance and support provided through best practice research and documents, webinars, participatory “listening” sessions and two sets of attributed data provided by the Ministry.

Moving forward, it is clear to us that our success would be substantially enabled by the following:

* Provision of cost data for our attributed population. We understand this is available from the Ministry and look forward to an early opportunity to receive this information.
* Continued access to the plans of fellow OHTs. We conducted research into the plans of the 31 OHTs providing proposals to the Ministry including the 24 moving forward at this time. Learning what other communities are planning and how they propose to move those plans forward, provides new ideas as well as reassurance that our plans are in line with the provincial mandate, and provide equitable care for Ontarians

.

* Provision by the Ministry of dedicated resources (budget dollars or human resources) is critical. With only one contract full time paid resource (Transformation Lead) in the KW4 OHT, it is difficult to obtain the needed expertise to help process the full application, design, and implementation of this new model of care. Our partners are supporting with in kind resources, but only in addition to already full time roles. We are concerned that over extending these resources will lead to burn out long before the OHT plans are implemented.



**Part V: Sign Off**

|  |  |
| --- | --- |
| **Proposed name of the Ontario Health Team** | **KW4 OHT** |
| **Primary contact for this Progress Report** | **Name:** Joseph Lee MD, CCFP, FCFP,  MClSc(FM) |
| **Title: Chair & Lead Physician, The Centre for Family Medicine, Waterloo Region Clinical Lead, KW4 Subregion, Waterloo Wellington LHIN Chair, Kitchener-Waterloo-Wellesley- Wilmot-Woolwich (KW4) Leadership Table Clinical Associate Professor and Assessment Director, Dept. of Family Medicine, McMaster**  **University** |
| **Organization:** Centre For Family  Medicine |
| **Email:** [joe.lee@family-medicine.ca](mailto:joe.lee@family-medicine.ca) |
| **Phone:** 519 783 0021 |
| **Signature:** |

**Please describe how you have confirmed the contents of this Progress Report with the members of your team.**

**Response** *(250 words maximum)*

There are three groups in KW4 that have contributed to the OHT progress report:

1. The KW4 OHT Steering Committee - nominated by the signatory organizations in July 2019, that has been meeting monthly since August 2019 and bi-weekly since January 2020. The Steering Committee includes:
   * 2 individuals with lived experience as caregivers or patients;
   * 3 community members; and
   * 5 representatives from each of the following signatory organizations: Aids Committee of Cambridge, Kitchener and Waterloo Area; Centre for Family Medicine Family Health Team; Community Care Concepts; Grand River Hospital; and Schlegel Villages.
2. An Operations Team composed of the KW4 OHT Transformation Lead and representatives from the following:
   * Centre for Family Medicine Family Health Team;
   * Centre for eHealth Excellence;
   * Grand River Hospital;
   * Ontario Health West;
   * A system level support-person administered by the CMHA.

This Team has been meeting weekly since September 2019 to support the KW4 OHT Steering Committee in all aspects of project planning for the KW4 OHT.

1. The 31 signatory organizations that have been meeting bi-monthly since April 2019 and monthly as of January 2020.

The signatories group received notice of the Progress report at the meeting on November 20th 2019, and reviewed and provided input to the report at their meeting on January 8th 2020.

The Steering Committee reviewed the final draft on January 16th; the Operations Team finalized the report and submitted for January 20th.

Please have **only** those **new individuals or organizations (i.e., those who were not signatories to the initial Self-Assessment Form) sign below.** While Board approval is not required, participants are expected to confirm the highest level of commitment possible.

|  |  |
| --- | --- |
| **Endorsed by** | |
| **Name** |  |
| **Position** |  |
| **Organization** |  |
| **Signature** |  |
| **Date** |  |

**Endorsed by**

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| **Position** |  |
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*Please repeat signature lines as necessary*