Ontario Health Teams Central Evaluation

Formative Evaluation

Document Analysis of OHT Applications: A comparison across three cohorts

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HSPN Health System Performance Network

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Executive Summary

Background

This report explores the applications submitted to the Ontario Ministry of Health (MOH) by prospective Ontario Health Teams (OHTs) in Cohorts 2 and 3. This report is an addendum to the *Document Analysis of the First Cohort of OHT Applications*, published in February 2020. At the time of this report, there have been three rounds of application submissions: Cohort 1 submitting in 2019, Cohort 2 in 2020, and Cohort 3 in 2021. The application changed for Cohorts 2 and 3 to include fewer questions and a smaller maximum word count. This report summarizes information provided in applications from Cohorts 2 and 3, and also compares against the initial Cohort 1 application.

Key Findings

- All OHT applications (across all three cohorts) included questions about target population, team make-up, care transformation, and implementation plan.
- All three cohorts of applications focused on the role and integration of primary care in the development of OHTs. In Cohorts 2 and 3, applicants were more likely to have partnered with primary care through Family Health Teams (FHTs) rather than Family Health Organizations (FHOs) compared to Cohort 1.
- Questions about governance and organization structure were eliminated for Cohorts 2 and 3.
- In the applications of Cohorts 2 and 3, the focus of questions related to challenges shifted from managing familiar topics such as cross-provider funding and quality improvement to understanding capacity to deliver care during COVID-19.
- Across cohorts, frail older adults, individuals with mental health and addiction conditions were the dominant target/priority population to prioritize for integrating care service. Populations experiencing homelessness, food insecurity and lower income emerged as a new priority/target population in Cohorts 2 and 3.
- Cohorts 2 and 3 applicants showed a more detailed understanding of some of the barriers to OHT success compared to Cohort 1. For example, lack of or unreliable internet access for virtual care appointments was mentioned as a barrier to successful integrated care which became significant due to COVID-19.
- Cohorts 2 and 3 applicants further detailed the non-financial resources and supports that the MOH could provide (such as help with legislative barriers, past successes of other OHTs, and data sharing).

Summary

The application for the Cohort 1 had questions that required applicants to include more detail and description; whereas Cohorts 2 and 3 had more focused questions requiring applicants to respond more concisely. A definitive focus on integrating primary care was seen throughout all cohorts. An increased attention to goals, plans, and perceived barriers to reflect the new reality of COVID-19 on care delivery were expectedly more present in Cohorts 2 and 3. However, there was also an increased focus on the social determinants of health in Cohorts 2 and 3 when compared to Cohort 1.

Background

At the time of this report, there had been three intake rounds: the first in Spring 2019 (Report 1)[1], the second in Summer 2020, and a third round in Summer 2021 (this report). This report is an addendum to the *Document Analysis of the First Cohort of OHT Applications*[1] report. That report was created as a high-level summary of the first cohort of 30 initial OHT applicants (i.e., Cohort 1, in 2019) to develop a baseline understanding of OHTs' plans and goals for system transformation. This document provides a baseline understanding of the second and third cohorts of OHT applicants: N=15 in Cohort 2 (2020) and N=6 in Cohort 3 (2021), and compares the application process amongst all three cohorts.

The application form was changed after Cohort 1 in light of the COVID-19 pandemic and in response to feedback on the time required to complete the first application. Cohorts 2 and 3 were asked questions specific to the COVID-19 pandemic and how it has impacted integrated care planning and delivery.

Both the initial report and this addendum present findings according the the cohort of applications. In this report, we use the word 'cohort' to represent the group of applicants. Not all applicants from each cohort successfully became OHTs on their first application. One applicant team from Cohort 1, and two applicant teams from Cohort 2 were unsuccessful in becoming candidate OHTs (i.e., to move forward to officially begin their OHT work) on their first try. These teams were required to submit follow-up supplemental reports to the Ministry of Health (MOH) at regular intervals. For this report, we kept the teams in their respective original application cohort. However, in some cases applicants were counted twice (e.g., once for Cohort 1 and once in Cohort 3) when the information in the interim reports changed from the original application (e.g., performance metric or priority population).

The first part of this document compares the categories of questions asked of applicants by the MOH in each round. The second part of the report highlights key thematic differences in how OHT applicants answered questions, compares priorities across OHT cohorts and provides insight into the common goals across OHTs and how they can be supported for these goals.

The goals of this document are to:

- Compare and contrast OHT application *questions* amongst the three cohorts;
- Compare and contrast OHT application *answers* amongst the three cohorts where similar questions were asked;
- Build on an existing understanding of OHT goals and plans, as well as shed light on any changes as a result of the new context (i.e., in light of COVID-19 pandemic)

Methods

A document analysis extraction guide and protocol were developed for Cohort 1. For Cohorts 2 and 3, the extraction guide was amended in accordance with the new applications. All applications were reviewed, and information was extracted by trained research assistants. The data extracted from the full applications fell into three categories: (1) general characteristics, including, types of members, patient and community engagement, and prior partnerships; (2) target populations and plans for vulnerable populations; and (3) measuring system performance. Data validation was conducted: document analysis results were reviewed by the entire research team.

Key Findings

Part 1: Comparison of Application Questions

Application Structure and New Questions

All three cohorts were asked questions about target population, team make-up, care transformation, and implementation plan. In Cohort 1, 56 questions were asked across these categories along with four additional categories: teamwork (including proposed governance and leadership structures), team learning, home and community care (HCC), and digital health. The maximum allowable word count was 39,000 words (excluding tables).

Cohort 2 and 3 applications were identical. Eighteen questions (similar to Cohort 1) were asked across categories (long-term goals, accountability structures, support for specific populations, members of proposed OHT, previous experience with collaborative care, deliverables, plans to transform care, patient navigation, virtual care strategy). Half of the questions (n=9) related to COVID-19; these included responses to changes in services due to COVID-19, the ability to identify those most vulnerable to COVID-19, and whether they had any partnerships that could be leveraged to prepare for the next wave of the pandemic. The maximum allowable word count for Cohort 2 and 3 applications was 10,500 (excluding tables).

Cohort 2 and 3 applications had an additional category: learnings from COVID-19. For example, information was required about changes to services due to COVID-19 (including emergency department diversion services such as telemedicine or chronic disease management) and around the processes for population health on current care.

Questions about Population

All cohorts were asked for specific demographic information, including categorizing their geography as urban, suburban, rural, or remote; their attributed population and population of focus (i.e., “target population”); and their planning for Francophone and Indigenous populations.

Modified Questions

In Cohort 1, there were specific questions about the future structure of the OHTs, including proposed governance and leadership structure(s), goals, and vision that the OHT applicants would aim to achieve in Year 1. Applicants were asked to provide details about governing bodies, including the planned leadership approach and the roles and responsibilities of key team members. In Cohorts 2 and 3, these questions were mostly removed; questions about goals, vision, leadership, and governance were eliminated. The section about teamwork was included.

In Cohort 1, questions around team make-up and organizational capabilities were specific and detailed (e.g., How did you identify and decide the members of your team? How have the members of your team worked together previously?). Applicants were asked about: the number of primary care physicians and other physicians on the team; if any team members were formally a part of other OHT applications; and to list other organizations part of the OHT. In contrast, for Cohorts 2 and 3, questions which focused on team make-up and organizational capabilities were less specific; applicants were only asked to list all team members and other affiliated organizations, and whether teams had members experienced in collaborations similar to the new OHT model (such as integrated care, referral networks, shared accountability, value-based health care, or population health).

Cohort 1 was asked about patient involvement in OHT development and applicants were required to provide information on patient engagement in the development and maintenance of the future OHT. Cohorts 2 and 3 asked OHTs about how they will engage and involve patients, families and caregivers in care redesign. Questions about quality, performance improvement, and the relevant inputs were eliminated in Cohorts 2 and 3. Instead, Cohorts 2 and 3 were asked about their experience with populations vulnerable to COVID-19 and influenza.

Eliminated Sections in Cohort 2 and 3 Applications

Cohort 1 applications were between 100 and 125 pages; Cohort 2 and 3 applications were between 30 to 65 pages (>50% reduction). In Cohort 1, a specific appendix about virtual and digital care (labelled Appendix B in application packages) was created to answer supplemental questions. This was eliminated in Cohort 2 and 3 applications; however, one question in the 'Transforming Care' section was reworded to ask how digital healthcare would be used to transform care.

In Cohort 1, a second appendix was dedicated to gathering information about HCC. Questions about short term action plans for and identified barriers to improving HCC were asked. In Cohorts 2 and 3, HCC information was embedded in the application itself and focused more on the COVID-19 context.

In Cohort 1, teams were asked explicitly about financial and non-financial resources that could benefit the OHT (e.g., capacity to manage cross-provider funding). Cohorts 2 and 3 were not asked about financial resource management but were asked about non-financial resources (e.g., removing legislative barriers, reducing barriers to digital health tools, helping with facilitating teams).

Part 2: Thematic Comparison of Applicants' Answers

Demographics

In all cohorts, at least 60% of the teams were situated in urban and suburban areas and reported all of their members had worked together in the past (Table 1). The smallest attributable population in Cohort 1 (54,883) was twice as large as the smallest attributable population in Cohort 2 (21,170), and the smallest attributable population in Cohort 3 was similar to Cohort 1 (50,927).

Table 1: Characteristics of the three cohorts of applicant OHTs

CATEGORY	Cohort 1	Cohort 2	Cohort 3
Number of Applicants	N=30	N=15	N=6
Number of OHTs considered urban/suburban *	20 (66%)	9 (60%)	2 (33%)**
Mean size of population accountable for at maturity (range) **	332,663 (54,883 – 878,424)	292,619 (21,170 – 898,831)	166,790 (69,118 – 331,822)
Number of OHTs where members have worked together in past	30	15	6

* Urban/suburban was defined as ≥170,000 attributable population (Data Source: MOH Health Analytics Branch attributable populations sent to Applicant OHTs)

**Cohort 3 includes an OHT with a significant population of seasonal residents. The peak population was used in calculations (i.e., all-year residents plus seasonal residents) to reflect the maximum population the healthcare system may encounter.

Cohort 1 information sourced from http://hspn.ca/wp-content/uploads/2020/05/HSPN-Provincial-level-OHT-Document-Analysis-Extraction-Results.pdf

Governance

Only Cohort 1 was asked to explicitly describe their proposed governance and governance structures. They were asked to describe all members of their team, discuss common team goals and values. Specifically, teams were asked to discuss how they planned on making team decisions, how they would incorporate patients and families in their leadership and governance structures and how they would share information across team members.

Partnerships

Details regarding the composition of the team and the importance of collaboration with various stakeholder groups were shared in all rounds. Attributable to MOH guidance documents, all three cohorts of applicants had a heavy focus on primary care organizations as team members. In Cohort 1, 97% of teams partnered with Family Health Organizations, compared to 73% in Cohort 2 and 88% in Cohort 3. However, in Cohort 2, teams partnering with Family Health Teams and Community Health Centres increased by 33% and 10%, respectively. Partnering with solo practitioners remained low for all cohorts, 20% for Cohort 2 and 33% for Cohort 1 and Cohort 3. A greater proportion of Cohort 2 OHTs included mental health and addiction agencies, long-term care, and retirement homes compared to Cohort 1 and Cohort 3.

In terms of community partners, 50% of teams in Cohort 1 partnered with at least one municipality; in Cohort 2, this number dropped to 27% and to 22% in Cohort 3. Cohort 1 had one applicant that partnered with a laboratory and one with a pharmacy; there were none in Cohort 2. In Cohort 3, two OHT applicants partnered with a laboratory (and none partnered with a pharmacy). OHT partnerships with midwifery units and Indigenous care teams were similar for Cohort 2 (13%, 7%) and Cohort 3 (11%, 11%), and greater than Cohort 1 (10%, 3%).

Table 2: Types of organizations* in OHT partnerships by Cohort

Note: Percentages represent the proportion of OHTs in each cohort that had a partnership with each type of organization

TYPE OF ORGANIZATION	Cohort 1 (N = 30)	Cohort 2 (N = 15)	Cohort 3** (N = 6)
Hospital	100%	87%	100%
Primary Care	100%	100%	100%
Family Health Organization (FHO) ǂ	97%	73%	88%
Community Health Centre (CHC)	70%	80%	88%
Family Health Team (FHT) ǂ	60%	93%	100%
Family Health Group (FHG) ǂ	43%	40%	22%
Solo practice ǂ	33%	20%	33%
Nurse practitioner-led clinic	30%	33%	44%
Community support service	97%	87%	100%
Home care service provider organization	77%	87%	66%
Mental health and addiction organization	73%	93%	66%
Long-term care home	63%	73%	55%
Municipality	50%	27%	22%
Aboriginal health access centre	10%	20%	22%
Midwifery	10%	13%	11%
Retirement home	10%	27%	0%
Independent health facility	7%	20%	22%
Children's treatment centre	3%	13%	11%
Indigenous interprofessional primary care team	3%	7%	11%
Laboratory	3%	0%	22%
Pharmacy	3%	0%	0%
Public Health	13%	66%	44%
Other * **	90%	80%	55%

Source: Section 2.2.1, 2.1.2 of the full application.

ǂ Section 2.1.1, column C of the full application of Cohort 1

* OHT applicants were asked to identify partner organizations and categorize them based on the type of organization.

** Data includes one OHT applicant from Cohort 1 and one from Cohort 2 that were not approved to become a candidate OHT and begin their OHT work but were required to submit reports back to the MOH to respond to the ministry feedback and resulted in including additional partners to their OHTs. They were approved to become a candidate OHT and begin their work in the Cohort 3 application cycle and therefore their data are reflected in Cohort 3 and in their original cohort.

*** Other includes paramedic services, hospice, client & family advocacy groups, weight management clinics, community-based rehabilitation, dentists, schools, and housing services.

Cohort 1 Information sourced from http://hspn.ca/wp-content/uploads/2020/05/HSPN-Provincial-level-OHT-Document-Analysis-Extraction-Results.pdf

Implementation Goals and Targets

In Cohort 1, over 50% of OHT applicants identified both frail older adults and patients seeking care for mental health and addiction as the two main target populations. Thirty percent identified palliative care, chronic disease, COPD, and dementia as other targets. In Cohort 2, the frail older adults (N=9; 60%) and mental health and addiction (N=11; 73%) were listed as the target priority. Cohort 3 also prioritized frail older adults (N=4; 67%) and mental health and addiction (N=5; 83%).

Another high-priority demographic in Cohort 2 that was identified by around a quarter of applicants was people experiencing homelessness (N=4). In Cohort 3, one applicant explicitly included people experiencing homelessness as a prioritized population.

Table 3: Priority population for Cohort 1, Cohort 2 and Cohort 3

PRIORITY POPULATION	Cohort 1 (N = 30)	Cohort 2 (N = 15)	Cohort 3 (N = 6)
Frail/Complex Older Adults	16	9	4
MHA*	15	11	5
MHA and Youth	2	1	N/A
Palliative Care	10	1	N/A
COPD/CHF*	7	2	1
Dementia	5	2	N/A
Chronic Conditions**	5	4	1
Homeless	N/A	4	1
Unattached To Primary Care	N/A	2	N/A
Other***	7	3	2

* Mental health and addiction (MHA), Chronic obstructive pulmonary disease (COPD) and Congestive heart failure (CHF)

** Examples Include diabetes, heart disease, brain injuries, chronic pain, developmental disabilities and autism.

*** Other includes: Persons ≥65 years old who are receiving or require care from ≥2 provider partners; over 25 children currently waiting for services at The Hospital for Sick Children in Toronto; people living with complexities or at risk of developing complex conditions and caregivers; patients <75 with Ambulatory Care Sensitive Conditions; people presenting with episodic, minor acute issues that could be managed effectively in the community; high users (top 5%) of health care, community support, and social services; caregivers; Transitional Age Youth, lower income; refugees; COVID; entire population.

Performance Measurement

OHT applicants in Cohort 1 mostly focused on measuring avoidable emergency department (ED) visits, Quadruple Aim metrics (including Patient-reported experience measures (PREMs) and Patient-reported outcome measures (PROMs)), and 30-day readmission rates to evaluate performance; at least half of Cohort 1 OHT applicants mentioned those areas specifically. In Cohorts 2 and 3, the inclusion of Quadruple Aim metrics and avoidable ED visits remained high. Other metrics, such as measuring virtual care, increased among Cohort 2 and 3 applicants. In Cohorts 2 and 3, approximately 50% of teams included measuring virtual care encounters in the past 12 months; this compared to 20% of the teams in Cohort 1. A new performance metric, measuring attachment to primary care rosters, emerged in Cohort 2 (33% of applicants). Table 4 provides an overview of performance metrics; metrics listed are those that were explicitly provided by the MOH. Cohort 3 included approximately 50 different metrics across the applications (e.g., number of COVID outbreaks in a LTC setting, number of care partners who report improvement in stress levels due to interventions put in place for the client, number of gaps in care and regional variation identified, primary care council established). These metrics were mostly unique to one OHT applicant and were not repeated.

Table 4: Performance measurement metrics

METRIC (N, %)	Cohort 1 (N=30)		Cohort 2 (N=15)		Cohort 3 (N=6)	
Avoidable emergency department visit rate	23	77%	8	53%	2	33%
PREMs[1], Provider REMs[2], and PROMs[3]	19	63%	7	47%	0	0%
30-day inpatient readmission rate	15	50%	2	13%	0	0%
Community home care wait time for first home care visit	11	37%	3	20%	0	0%
Alternate level of care (ALC rate)	11	37%	3	20%	1	20%
7-day physician follow up after acute hospitalization	10	33%	3	20%	0	0%
Caregiver distress	8	27%	1	7%	0	0%
% of Frequent ED visits (≥4/y) for mental health and addictions	8	27%	6	40%	2	33%
Ambulatory care sensitive conditions hospitalization rate	8	27%	1	7%	2	33%
Timely access to primary care	7	23%	2	13%	0	0%
# of people in hallway health care beds	7	23%	0	0%	0	0%
% of Ontarians with virtual health care encounter in the last year	6	20%	7	47%	1	20%
Time to inpatient bed	5	17%	0	0%	0	0%
Hospital stays extended because right home care not ready	4	13%	1	7%	0	0%
Total health care expenditures	4	13%	1	7%	0	0%
% who digitally accessed their health information in the last year	4	13%	0	0%	0	0%
Median time to long-term care placement	3	10%	1	7%	0	0%
Time to ED[4] physician initial assessment	0	0%	0	0%	0	0%
Supporting LTC[5], especially in COVID outbreak	0	0%	2	13%	0	0%
Number of primary care providers from PCN part of OHT	0	0%	1	7%	0	0%
Number of PCN[6] Meetings	0	0%	1	7%	0	0%
Attachment to primary care	0	0%	5	33%	1	20%
Hospital days	0	0%	1	7%	0	0%
COVID-specific metrics	0	0%	1	7%	0	0%

[1] Patient-reported experience measures (PREMs)

[2] Provider reported experience measures (Provider REMs)

[3] Patient-reported outcome measures (PROMs)

[4] Emergency department (ED)

[5] Long-term care (LTC)

[6] Primary Care Network (PCN)

OHTs Who Reapplied and Were Not Accepted Until Cohort 3: What Changed Between Applications

For Barrie and Area OHT, it was found that their partners and caregiver support strategies changed from the first application to the second in Cohort 3. In regards to partner change: RVH Regional Cancer Centre, Hospice Simcoe, Palliative Care Physicians, Ontario Health and North Simcoe Muskoka Hospice Palliative Care Network, Ontario Health, NSMHPCN, HCC, Primary Care Service Providers were the new partners added. Regarding caregiver support change, a survey framed in the quadruple aim model will be distributed to caregivers to understand their experiences.
General changes observed: The overall change was that the report back template in Cohort 3 was more specific in terms of goal setting, and accomplishments. They incorporated MOH feedback into their application, and provided an update on year 1 progress of OHT. Success was measured using the Quadruple Aim model in terms of palliative care, palliative care competency, and health services delivery.

For North Simcoe OHT, there was no change in population of focus, caregiver support, or partners.
General changes observed: Goals and plans became more specific after incorporating MOH feedback into their report-back template*. Included mention of social determinants of health as it relates to their population of focus, and added more specific statistics related to the reason for their interventions. Incorporated MOH feedback into their application, and provided an update on year 1 progress of OHT.

For Windsor-Essex OHT, their population, partners, and caregiver support strategies changed. There was a shift of focus from complex adults with 4+ chronic conditions to adult patients living with COPD. There was also an evident focus on geography and the social determinants of health: mapping was done to relate geographical areas with disproportionately high rates of COVID-19 to social material deprivation %, in efforts to plan for the allocation of health resources. Congregate care settings were also considered as higher risk settings for COVID-19 contraction and COPD development. A solid plan for congregate care settings in healthcare facilities was proposed in the report back template. Co-morbidities are also considered as the OHT acknowledges that COPD in adults typically occurs in concurrence with other chronic diseases, such as mental health and addiction conditions. Population-based modelling revealed that COPD is now significantly affecting the population of Windsor-Essex OHT and has been exacerbated by the COVID-19 pandemic, revealing a need to focus on this population. In terms of partners, PFAC is now a formal part of the Steering Committee and Partnership Council, directly supporting the OHT initiatives now. Regarding caregiver support strategies, resources will be made available in multiple languages, locations, and formats to improve accessibility of information for caregivers and patients**.**
General changes observed: Greater specificity in population and implementation by Cohort 3. PFAC has provided the voice of lived and living experience that has helped the Steering Committee focus on the client experience. PFAC is a community voice for people with mental health and addictions challenges, people living with an HIV/AIDS diagnosis, physically and developmentally disabled people, members of local hospital PFACs, families of people with disabilities, newcomers and French speakers. Included the use of a quadruple aim model to measure success. Greater specificity in population and implementation by Cohort 3. Narrow population of focus based on relating geographic areas with social material deprivation and COVID-19 positivity percent, evident of the inclusion of social determinants of health.

*Note: The second “applications” of the OHTs were not necessarily applications. They were report-back templates for incorporating changes to their application based on MOH feedback, essentially a shortened and revised version of their application.

Key Barriers Identified

In Cohort 1, key barriers listed in applications included funding, clinical integration, and access to appropriate skills and expertise. Cohort 2 expanded on some of these barriers and what supports they felt were needed to overcome these challenges in the context of COVID-19. In Cohort 2, a common barrier to access was poor internet connectivity, as reported by 40% of applicants. One OHT applicant also mentioned that other priorities, such as long-term care, would be affected due to new spacing requirements for long-term care beds. Other barriers included a lack of transport to testing centres for COVID-19. Barriers identified in Cohort 3 included help with management and facilitation of collaborations within OHTs and legislative barriers to different types of integrated care. Additionally, Cohort 3 mentioned a lack of funding for physicians (who are expected to contribute to OHTs) as a barrier to OHT development. In Cohort 1, the specificity of barriers was less detailed, possibly due to the timing of the application being before the

pandemic. Cohorts 2 and 3 had more detailed outlines of their barriers, perhaps because the healthcare system was under stress and barriers were more evident.

All cohorts were specific in identifying populations that faced gaps in access to care. In all three cohorts, this list included marginalized and vulnerable communities, people experiencing homelessness, those unattached to primary care, those of lower socioeconomic status, who identify as LGBTQ, and refugees.

Summary

Overall, the Cohort 2 and Cohort 3 applications were shorter and questions were more focused questions and governance and OHT organizations questions excluded compared to Cohort 1 applications. The questions in Cohort 2 and 3 applications focused on the COVID-19 pandemic impact on care access and management. This resulted in applicants explicitly listing challenges such as access to information systems, poor internet connectivity and patient transportation services.

All cohorts identified populations with barriers to care, such as: marginalized and vulnerable communities (individuals who are unattached to primary care, people experiencing homelessness, of lower socioeconomic status, LGBTQ, and refugees). However, unlike Cohort 1, more teams in Cohort 2 and 3 identified these latter groups as priority populations. In terms of performance measurement, PROMs and PREMs remained one of the most common measures across all cohorts. However, contrary to Cohort 1, almost half of the teams in Cohort 2 and 3 identified virtual care visits and frequent MHA ED visits as a high priority.

The focus on new concerns amidst the COVID-19 pandemic was primarily seen in priority population selection (i.e., thinking more about the social determinants of health), performance measurement, and key barriers. This evolution in priority-setting, made apparent through the COVID-19 pandemic, is expected to impact the way healthcare is delivered to over 14 million people living in Ontario.

References

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Appendix A

List of Applicants in Each Cohort

Cohort 1 * N = 30	Cohort 2 ** N = 15	Cohort 3 N = 6
Algoma	Brantford Brant	Elgin
All Nations Health Partners	Connected Care for LLG	Four Rivers
Barrie and Area ¥	Downtown East Toronto	Great River
Burlington	Frontenac, Lennox & Addington	Grey Bruce
Cambridge North Dumfries	Kawartha Lakes	Hastings Prince Edward
Central West	Kitchener, Waterloo, Wellesley, Wilmot and Woolwich	Network 24
Chatham Kent	Mid-West Toronto	
Connected Care Halton	North Simcoe ¥	
Couchiching	Oxford and Area	
Durham	Rainy River District	
East Toronto Health Partners	Sarnia Lambton	
Eastern York and North Durham	Scarborough	
Guelph Wellington	South Georgian Bay	
Hamilton Health Team	West Toronto	
Hills of Headwaters Collaboration	Windsor Essex ¥	
Huron Perth and Area		
Middlesex London		
Mississauga		
Muskoka and Area		
Niagara		
Nipissing Wellness		
North Toronto Health Collaboration		
North Western Toronto		
North York Toronto		
Northumberland		
Ottawa East		
Ottawa Health Team		
Peterborough		
Southlake Community		
Western York Region		

*24 OHTs were approved Nov 2019 and 5 were approved in July 2020 (Algoma OHT; Niagara OHT; Ottawa East OHT; Eastern Ottawa OHT; Middlesex-London OHT; Western York Region OHT).

** 13 were approved in November 2020

¥ Barrie and Area OHT and North simcoe were approved in September 2021, Windsor-Essex OHT was approved in February 2022.