An Ontario Health Team for Mississauga

Summary of OHT Readiness Assessment Submitted May 15, 2019

May 23, 2019

Ontario Health Teams

The vision for Ontario Health Teams (OHTs) as set out by the Ministry of Health and Long-Term Care (MOHLTC) is to create integrated care systems in Ontario to improve health outcomes, patient and provider experience, and value.

The OHTs will consist of groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. OHTs will:

- Provide a full and coordinated continuum of care for an attributed population within a geographic region
- Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey
- Be measured, report on and improve performance across a standardized framework linked to the ‘Quadruple Aim’: better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value
- Operate within a single, clear accountability framework
- Be funded through an integrated funding envelope
- Reinvest into front line care
- Improve access to secure digital tools, including online health records and virtual care options for patients – a 21st century approach to health care

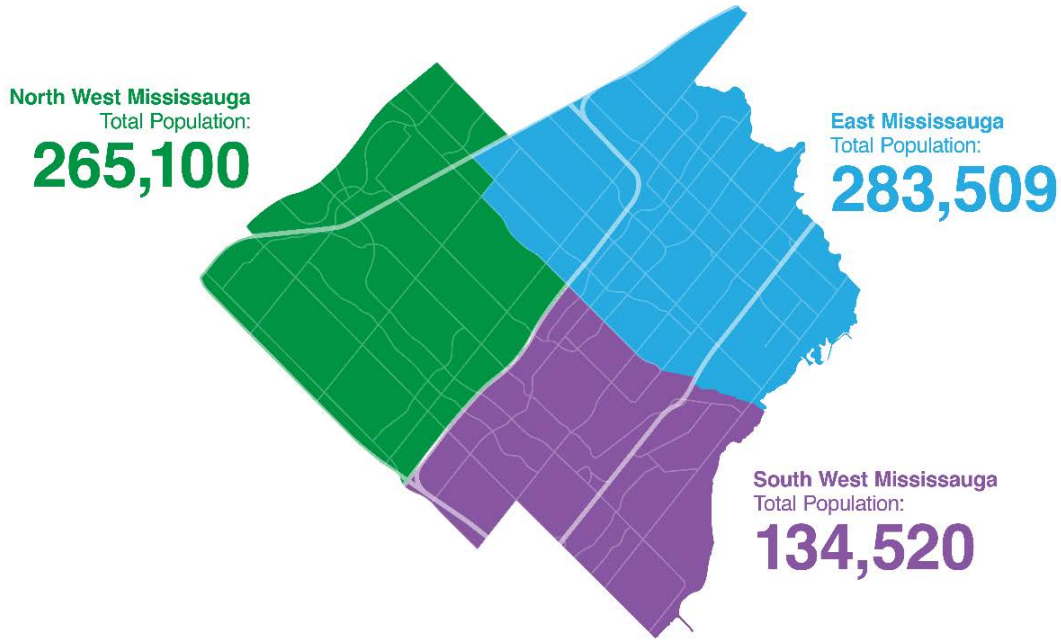
Caring for Mississauga

Mississauga is large, diverse community with many different cultural and ethnic backgrounds. This community is experiencing growth in populations across all ages, as well as increases in significant multimorbidity and social inequity.

On a per capita basis, we have the fewest interprofessional primary care teams in Ontario, no mental health youth beds and the fewest long-term care beds and hospice beds.

Of our population:

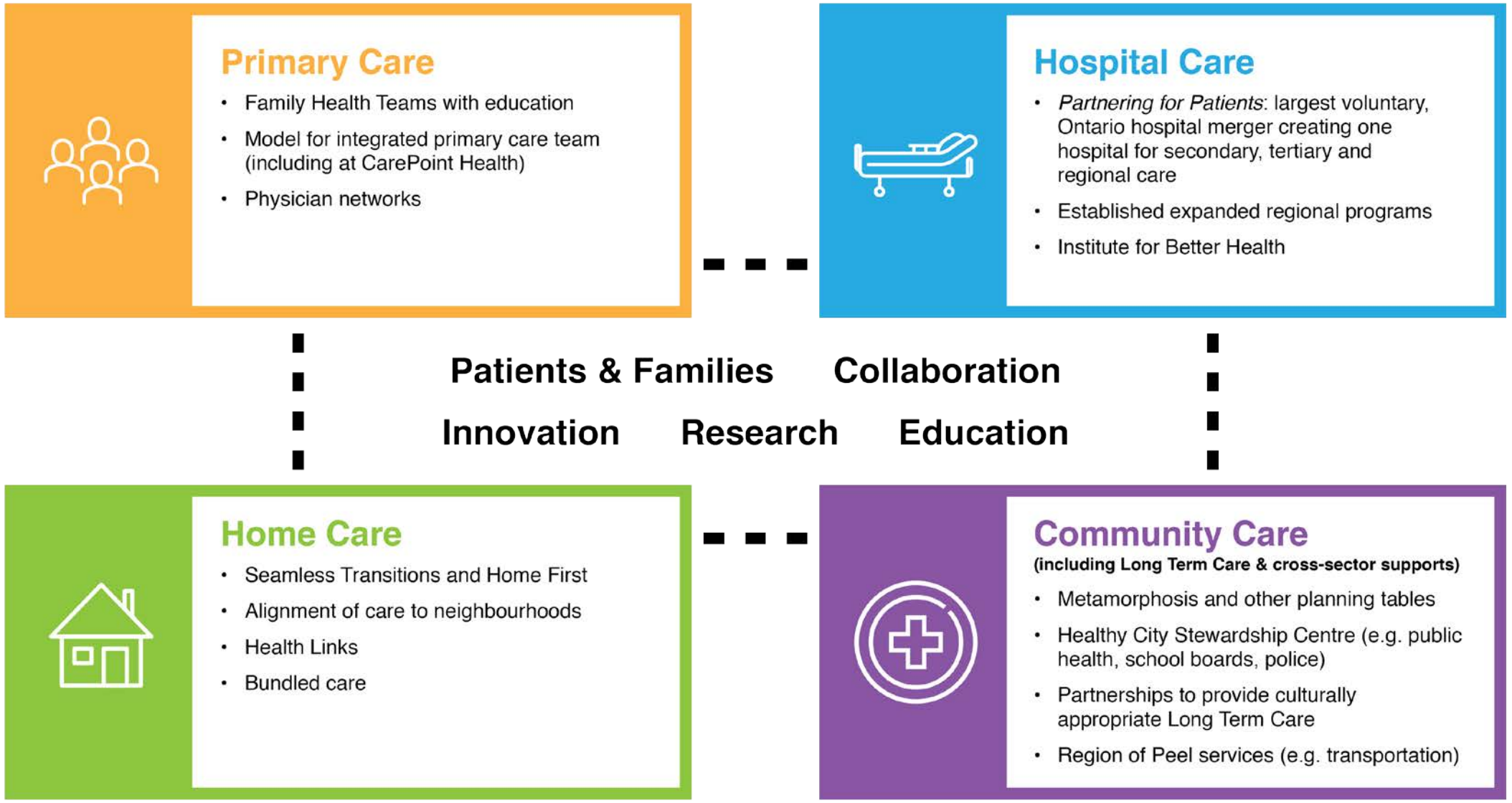
- 53% are born outside of Canada, making Mississauga one of the most diverse regions in the world
- 14.3% are seniors, with 6.3% over the age of 75
- 22.5% are children
- Over 28% are living with at least one chronic condition
- In 1980, only 2% of neighbourhoods were low income, while today, low- and very low-income neighbourhoods represent 51% of the community



The population of Mississauga is cared for by community partners who have a history of collaboration and working together.

Through an OHT, there is an opportunity for providers to improve the health of the approximately 680,000 people that live in Mississauga by providing high quality, integrated care across the continuum, from prenatal care to birth to end of life.

Our Collaborative Community: Strong Foundations for an OHT



Our Community Partners

Our Core Partners

Primary Care

- Credit Valley Family Health Team
- Summerville Family Health Team
- Care Point Health (formerly the Mississauga Integration Care Centre)

Home Care

- Home and Community Care

Hospital

- Trillium Health Partners

Community Care

- Metamorphosis Network
- Heart House Hospice Inc.
- Peel Senior Link
- Peel Addiction Assessment and Referral Centre

Our Community Partners

49 community partners have demonstrated support for this OHT including mental health and addictions, palliative and long-term care and social services:

- AbleLiving Services
- Alzheimer Society of Peel
- AstraZeneca Canada Inc
- Bayshore HealthCare
- Beacon
- Canes Community Care
- CBI Health Group
- City of Mississauga
- Closing the Gap Healthcare Group
- Dixie Bloor Neighbourhood Centre
- Dorothy Ley Hospice
- TEACH - Centre for Innovation in Peer Support
- United way of Peel Region
- Dufferin-Peel Catholic District School Board
- East Mississauga Midwives
- ErinoakKids
- Heart House Hospice
- Seniors Life Enhancement Centres
- Links2Care
- March of Dimes Canada
- Midwives of Mississauga
- Misissauga Board of Trade
- Mississauga Halton Palliative Care Network
- West Park Health Centre
- Yee Hong Centre
- Nucleus Independent Living
- Nurse Next Door
- Ontario Telemedicine Network
- Peel Addiction Assessment and Referral Centre
- Peel District School Board
- Peel Public Health
- Punjabi Community Health Services
- Peel Regional Police
- Peel Senior Link
- Univeristy of Toronto Mississauga
- The Victorian Order of Nurses
- ProResp
- Region of Peel
- Registered Nurses Association of Ontario
- S.R.T. Med Staff
- Saint Elizabeth Health Centre
- Schlegel Villages
- Sheridan College
- Sienna Senior Living
- Spectrum
- YMCA of Greater Toronto

*Home care will transition to the OHT in Year 1, in alignment with government direction to evolve and modernize these services. We see home care supporting more directly primary care and hospital operations as one opportunity

Our Plan for an OHT in Mississauga

Focus of the proposed OHT:

1. Population health approach

- Use data analytics and clinically significant risk stratification model to focus resources on emerging and high risk patients to improve health outcomes and better coordinate their care
- Simultaneously activating health prevention and promotion for all, including low risk populations
- Support holistic mental and physical health needs rather than solely disease-specific health needs

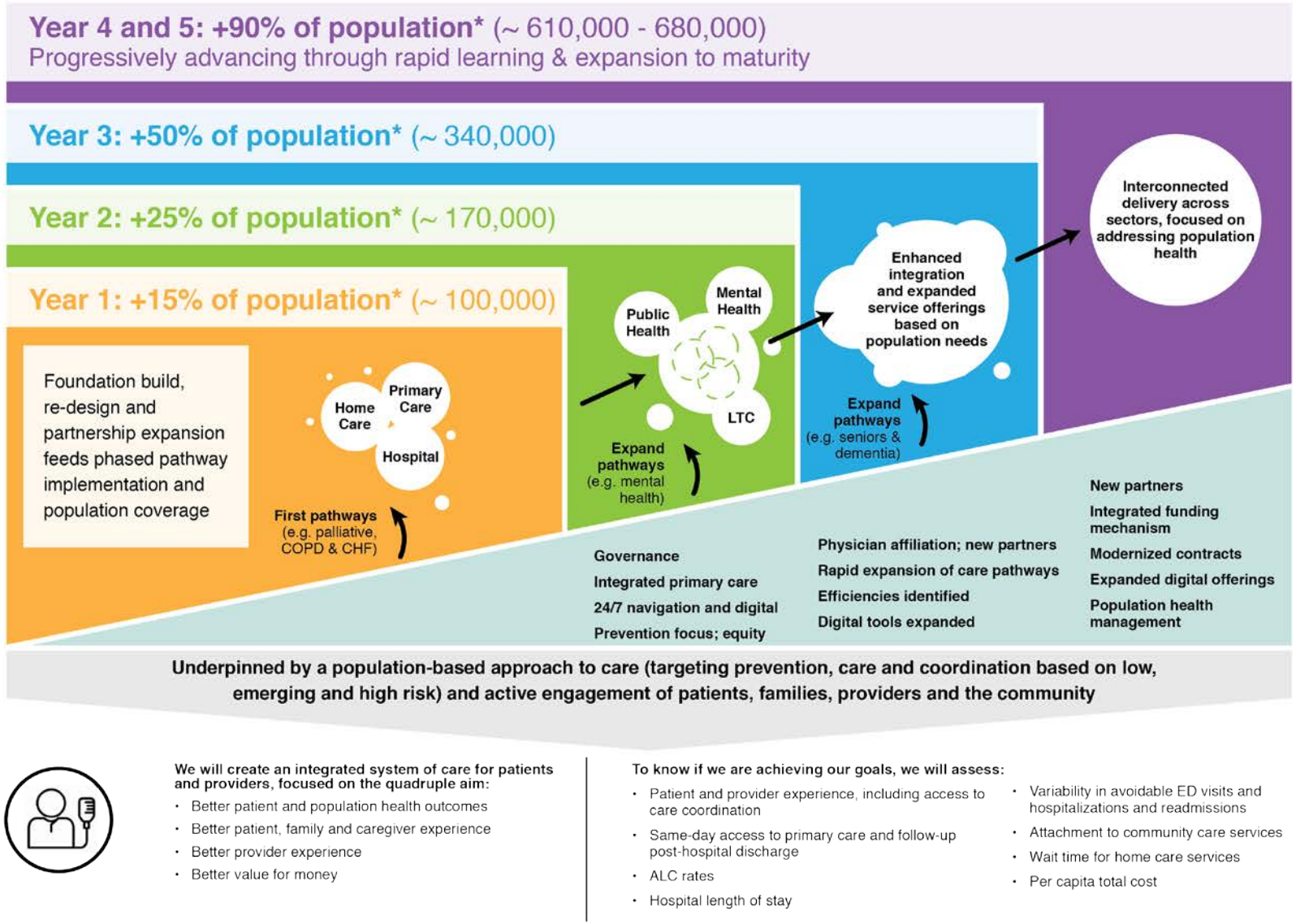
2. Implement integrated primary care model

- Standardized same-day access to primary care and access to 24/7 care coordination and navigation
- Expanded use of virtual care
- Increased access through interdisciplinary team-based care
- Prevention, health literacy and self-management support
- Enhanced integration across primary care, acute, home and community
- Digital portal to allow patients access to their health record across the continuum

3. Integrated continuous care pathways

- In Year 1, particular focus will be placed on implementing existing regional prototypes of continuous care pathways that consider the needs of the whole person in areas such as:
  - palliative care
  - congestive heart failure (CHF)
  - chronic obstructive pulmonary disease (COPD)
- Additional care pathways will be developed based on needs of the population, potentially including seniors' services, children's services and mental health

Roadmap: How we will get there



We will create an integrated system of care for patients and providers, focused on the quadruple aim:

- Better patient and population health outcomes
- Better patient, family and caregiver experience
- Better provider experience
- Better value for money

To know if we are achieving our goals, we will assess:

- Patient and provider experience, including access to care coordination
- Same-day access to primary care and follow-up post-hospital discharge
- ALC rates
- Hospital length of stay
- Variability in avoidable ED visits and hospitalizations and readmissions
- Attachment to community care services
- Wait time for home care services
- Per capita total cost

*Dependent on pace of related government changes (e.g. labour relations and funding) and based on current population

Our Self-Assessment Summary

In completing the OHT Readiness Assessment, we feel we are well positioned to advance the OHT model and vision. We are committed to addressing any challenges that arise through partnership and investment in order to build this model for an improved system of care for Mississauga.

Final submission scales for OHT in Mississauga application:

Model Component 1: Patient Care and Experience

Model Component 2: Patient Partnership and Community Engagement

Model Component 3: Defined Patient Population

Model Component 4: In Scope Services

Model Component 5: Leadership, Accountability and Governance

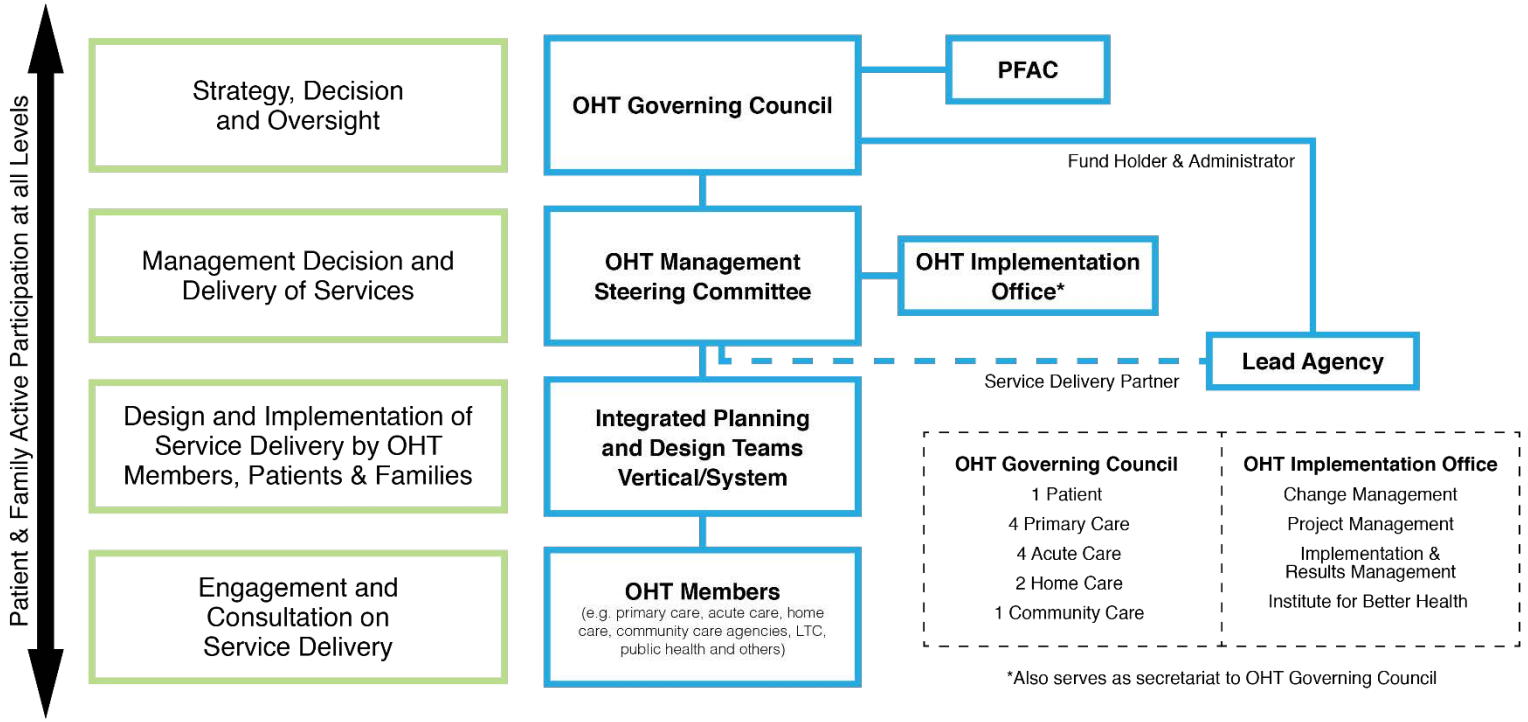
Model Component 6: Performance Measurement, Quality Improvement and Continuous Learning

Model Component 7: Funding and Incentive Structure

Model Component 8: Digital Health

Proposed Governance

- An OHT Planning Steering Committee, representing organizations across sectors, came together to complete the Readiness Assessment submission on behalf of the community
- The proposed governance structure below will evolve as the OHT matures
- Patient and family participation will exist at all levels of governance and be representative of our diverse community
- Trillium Health Partners has been proposed as the “Lead Agency” and fund holder accountable to the governance structure



Next Steps as Outlined by the MOHLTC

1 READINESS ASSESSMENT

- On May 15, 2019 the core partners submitted a “Readiness Assessment” on behalf of the community.
- The MOHLTC has received over 150 applications.

2 BUSINESS CASE

- Following review of the Readiness Assessments, a select few will be chosen to complete a business cases
- If invited to proceed with a Business Case, this will be completed in partnership and due in July, 2019.

3 ANNOUNCEMENT OF OHT CANDIDATES

- Fall 2019

Appendix

Integrated and Accountable Care Systems

Essential Features of an Integrated and Accountable Care System:

1. Shared vision and goals for a common destiny – co-design and co-lead
   Clinical leadership to enable all steps and distribute ownership
2. Trusting relationships – between providers, hospitals and other care settings
3. Primary Care involvement and focus
4. Defined population with adequate risk pooling
5. Patient engagement and self-management support
6. Effective care coordination and coordinators
7. Rapid-cycle and reliable audit and feedback – including feedback to physicians
8. eHealth supported care – technology to support integrated care

Fisher ES et al. Health affairs (Project Hope). 2012;31(11):2368-78
Gittell JH et al. Journal of interprofessional care. 2013;27(3):210-3.

OHT Planning Steering Committee

Organization	Sector	Representative
Metamorphosis Network	Community Network	Ray Applebaum
Heart House Hospice Inc.	Hospice and Palliative Care	Theresa Greer
Peel Senior Link	Seniors Services	Ray Applebaum
Peel Addiction Assessment and Referral Centre	Addictions	Karen Parsons
Trillium Health Partners	Hospital	Michelle DiEmanuele
Credit Valley Family Health Team	Primary Care	James Pencharz
CarePoint Health (formerly the Mississauga Integration Care Centre)	Primary Care	Cal Gutkin
Summerville Family Health Team	Primary Care	Andrea Stevens
Primary Care Leader/ Physician Engagement Lead	Primary Care	Mira Backo-Shannon
Home and Community Care (proxy)	Home Care	Sharon Lee Smith

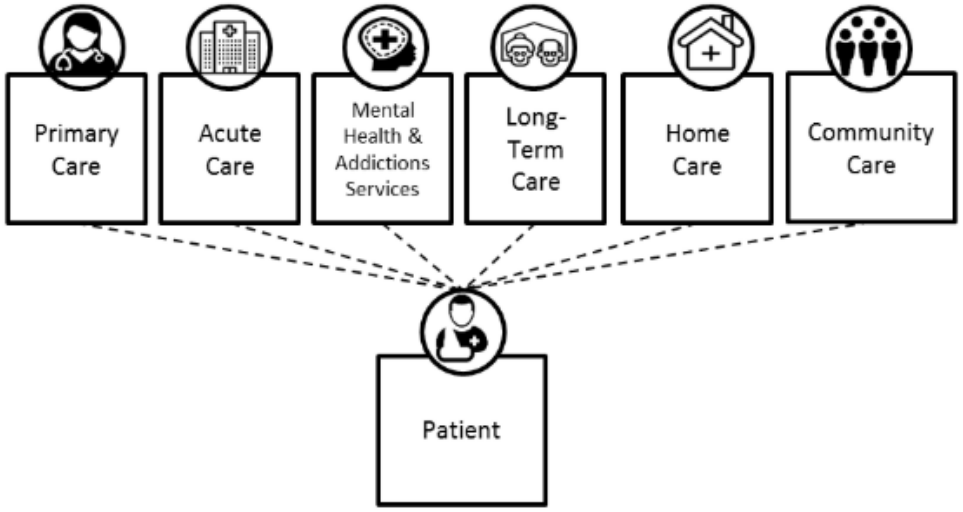
Ontario Health Team
Proposal Summary

Brampton, Bramalea, North Etobicoke,
Malton, West Woodbridge

June 2019

The Vision for Ontario Health Teams At Maturity

Current State



- Transitions in care across the continuum are not reliable – patients 'fall through the cracks'
- Navigating the healthcare system can be confusing for patients and providers
- Services are not organized to more easily address social determinants of health
- Digital connectivity between providers is not consistent, and no one provider has the 'entire story'

Ontario Health Team at Maturity

- Seamless care for all patients within a defined geography
- Offer 24/7 access to care coordination & system navigation
- Improve quality, cost, patient experience, provider experience
- Measured against standard performance indicators
- Operate within a single accountability framework
- Funded through an integrated funding envelope
- Reinvest into frontline care
- Take a 'digital first' approach
- Address hallway medicine

OHT Proposal: The Integrated Care Hub

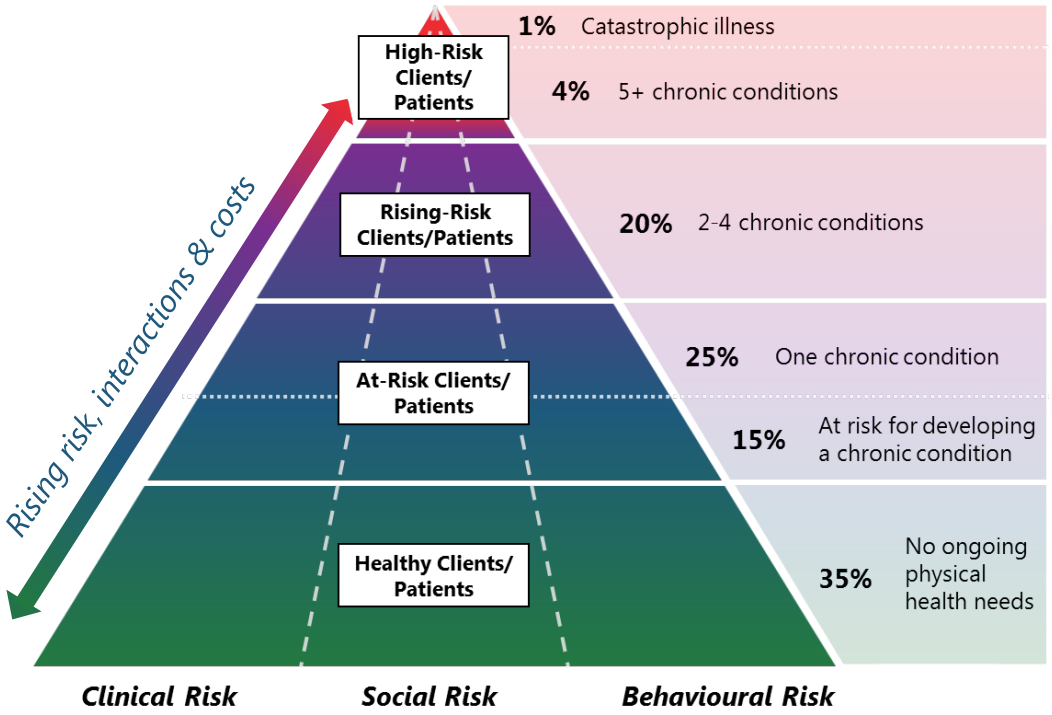
- The OHT will create an **Integrated Care Hub (ICH)** whose primary goal is to support people to live independently and safely in the community
- Facilitate tele-triage, system navigation and care coordination, and provide primary care with supports they need to keep people healthy in the community

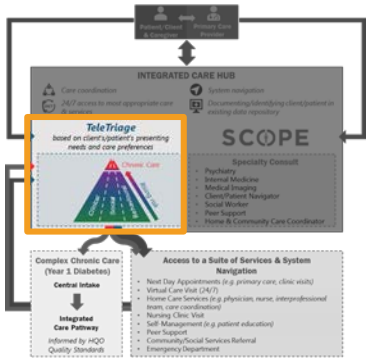
✓ Care coordination through **24/7 "one-door" access** for patients / clients and providers
✓ Improved identification and care pathways for patients / clients with complex needs

Patient/Client & Caregiver Benefits:	Provider Benefits:
• 24/7 connections to appropriate health and related services based on individual needs *e.g. next-day appointments, virtual care, emergency services, etc.* • Access to health data through digital tools	• Connect primary care to interprofessional advice/ resources on demand (SCOPE model) • Evidence-based care pathways for complex care patients and specialty consults • Digital tools (mobile apps / monitoring)

More equitable, effective and efficient services region-wide

The Integrated Care Hub: Patient Stratification

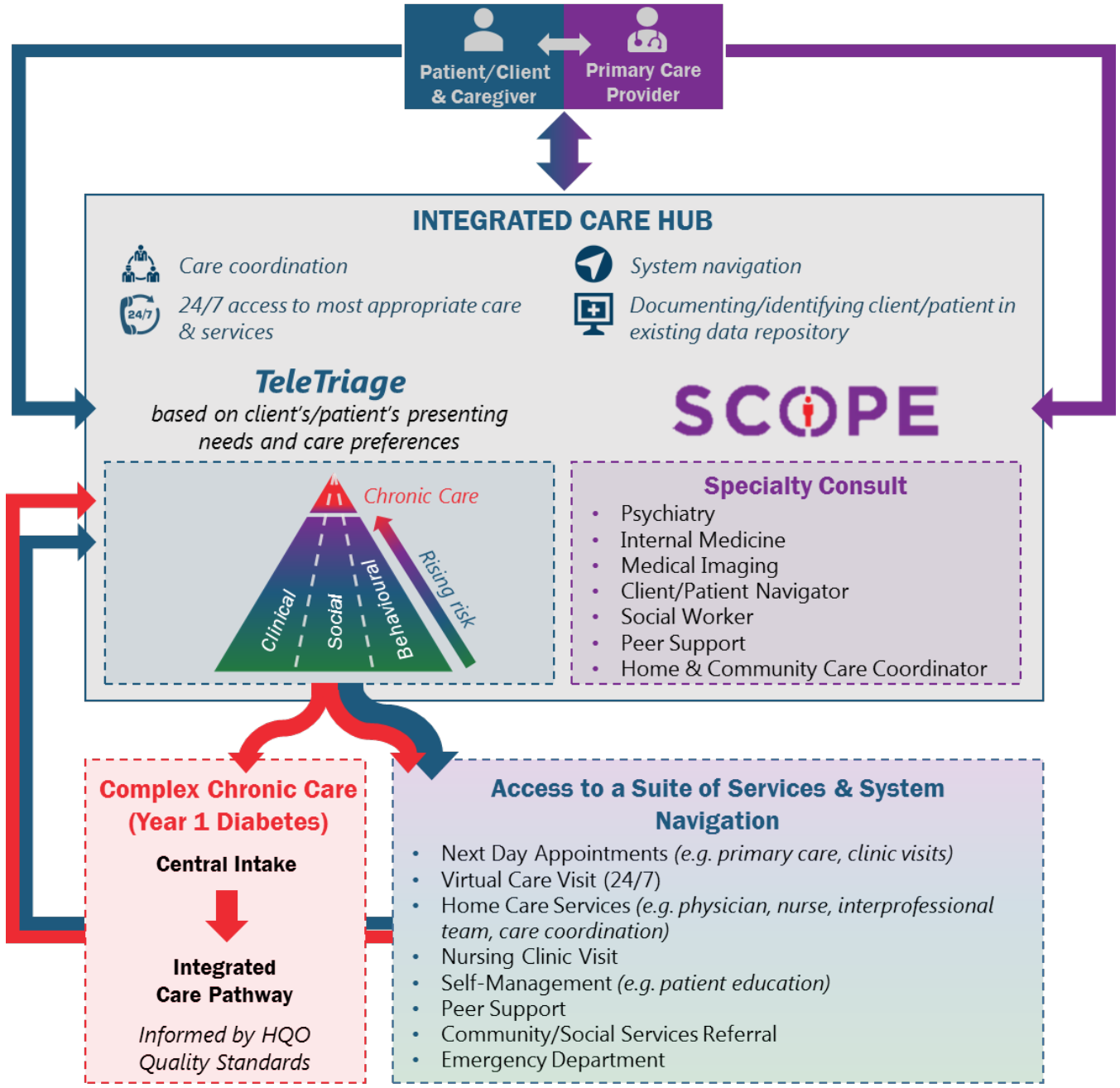




THE POPULATION HEALTH PYRAMID

A key component of the Integrated Care Hub is the identification and stratification of patients according to *The Population Health Pyramid*

- Demonstrates that high-risk clients/patients are lower in volume, but higher in costs due to complex care needs
- The ICH will enable the OHT to identify people at each point of the pyramid, design appropriate interventions to manage and reduce risk, and positively impact the Quadruple Aim over time
- Targeted interventions can range from prevention and wellness services to more complex health and social services
- Identifying and stratifying the population by complexity will be critical to deliver efficient services



OHT Integrated Care Hub Model

At a Glance

- **24/7 comprehensive care coordination** within OHT Geography
- **Specialist access pathways** for Primary care (e.g. the SCOPE model)

  …in a primary care system that largely does not have access to these services

- **More comprehensive primary care** across the region by encouraging participation from primary care practices without interprofessional resources

Accessing the ICH: Healthy Person/Person without Complex Health/Social Needs

1

Patient / Client calls ICH with health need

24/7 access through one phone number

2

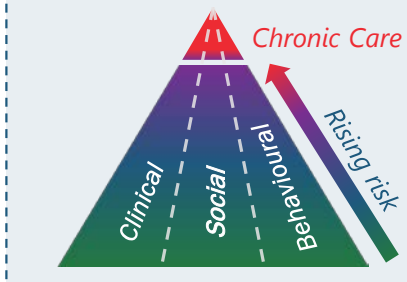
ICH Provider accesses patient chart from clinical data repository

Integrated view of complete patient history

3

ICH Provider identifies their risk level

Including clinical, social and behavioural risk



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ICH Provider connects patient to services

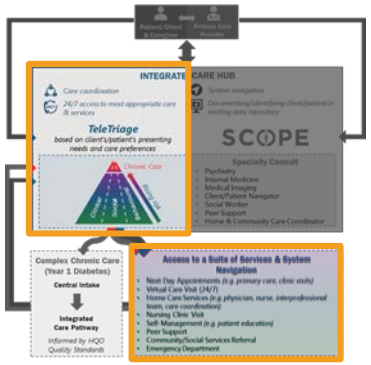
*To address **both** their immediate need & additional needs based on risk assessment*

- Next Day Appointments *(e.g. primary care, clinic visits)*
- Virtual Care Visit (24/7)
- Home Care Services
- Nursing Clinic Visit
- Self-Management *(e.g. patient education)*
- Peer Support
- Prevention & Wellness services
- Community/Social Services Referral
- Emergency Department

5

Patient receives care and services

Interaction information is shared back to their primary care provider and the ICH



Accessing the ICH: Person with Complex Health/Social Needs

1

Patient / Client calls ICH with health need

24/7 access through one phone number

2

ICH Provider accesses patient chart from clinical data repository

Integrated view of complete patient history

3

Patients with complex care needs are partner-identified

Through a locally-designed, first-of-its-kind identification tool

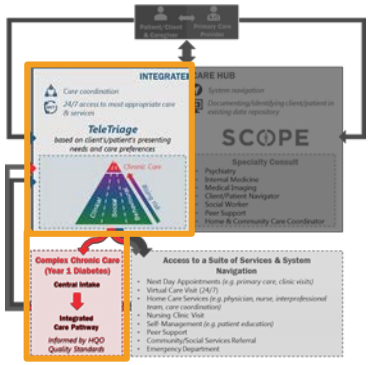
4

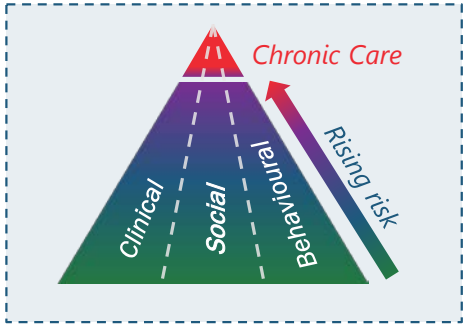
ICH Provider connects patient to Central Intake process & additional services

5

Patient placed on Integrated Care Pathway

Informed by HQO Quality Standards





Suite of Services

Central Intake

Integrated Care Pathway

Accessing the ICH: Primary Care Providers

1

Primary care physician requires specialist or inter-professional team

Consultation, patient navigation, coordination services, advice

2

Primary care physician calls ICH

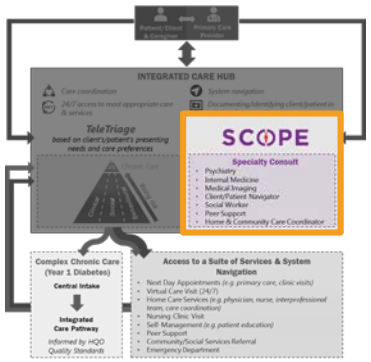
24/7 access through one phone number

3

ICH connects primary care physician virtually to specialist services through SCOPE

Example Services:

- *Psychiatry*
- *Internal Medicine*
- *Medical Imaging*
- *Client/Patient Navigator*
- *Social Worker*
- *Peer Support*
- *Home & Community Care Coordinator*



Target Populations & Geography

Initial Client/Patient Population to be served:

Individuals attached with an OHT primary care and/or community provider

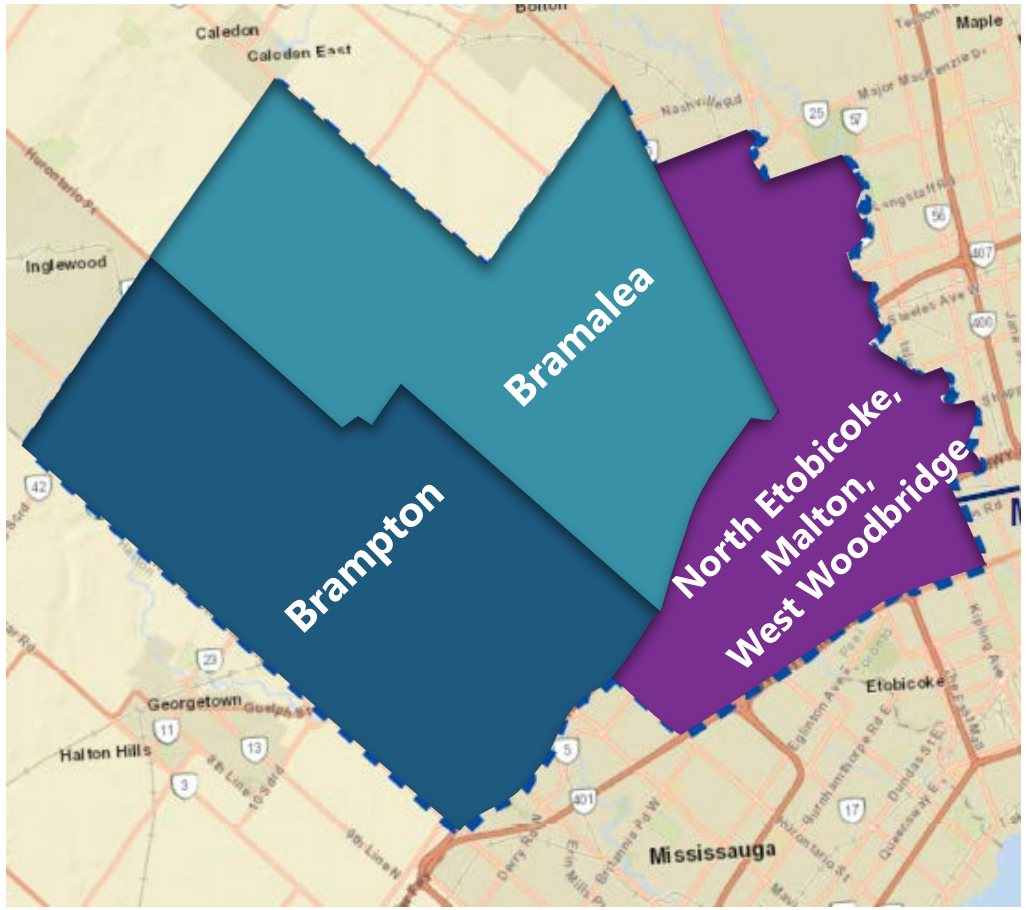
(80,000+ people)

+

Individuals with *complex care needs* – to be further supported through an integrated care pathway

Year 1: Diabetes

Target Geography:



* Patients accessing acute care will not be excluded; they will simply need to demonstrate attachment to an OHT primary or community care partner to be included in the Year 1 population.

At Maturity

Model will be flexible to adapt to geographic boundaries, population needs, and realignment as needed based on ministry directions

The OHT will provide **system navigation** and **care coordination** for **800,000+** people

Building on client/patient access patterns, the OHT will better **connect health** and related **social service supports** across the continuum to:

- **Increase timely (24/7) access** to system navigation and care coordination through the ICH for **all people**
- **Enhance care coordination** for patients with **complex needs** through **integrated care pathways** (sub-population of 40,000+)

Digital Enablers

Current partner assets will be leveraged, including:

Common Electronic Medical Record

Virtual Care

Regional and Provincial Portals

Client/Patient-Facing Technologies

Populate and access data and information

Regional Clinical Data Repository

Scaled to enable partners to contribute and view patient & administrative data

Back office business intelligence, decision support, communications, and analytics tools may also be scaled across partner organizations

Quadruple Aim Benefits of the Integrated Care Hub (ICH)

QUADRUPLE AIMS	BENEFITS				
	Client/Patient Stratification	**Seamless Transitions**	**System Equity**	**Technological Interoperability**	**Client/Patient Empowerment**
Better Patient and Caregiver Experience	• Individualized care plans	• Greater "warm" handoffs	• Access to interprofessional care regardless of location, provider, socio-demographic status	• "One truth" record negates duplication of story	• More in control of own health outcomes
Better Patient/ Population Health Outcomes	• Match care to level of need	• Greater adherence to appropriate care pathways/protocols	• Increased comprehensive interprofessional care across the entire geography (at maturity)	• Aggregated data, AI to predict rising risk and initiate/promote early intervention	• Increased awareness and adoption of behaviours that promote health
Better Value and Efficiency	• Appropriate allocation of resources	• Reduction in service fragmentation and duplication	• Redistribution of resources to increase value to the system	• Reduced duplication/ overutilization of services *(e.g. diagnostic tests)* • Streamlined care pathways	• Improved determinants of health
Better Provider Experience	• Better understanding of roster/enrolment list and care needs	• Greater confidence in care pathways for clients/patients	• Access to comprehensive interprofessional services regardless of practice model	• Timely access to "one truth" record	• Ability to see more motivated clients/patients

Categories of OHT partners and definitions

Anchor	Community	Innovation
• Organizations that are also in a position to commit resources to planning and implementation of an early OHT • Support onboarding additional same sector partners • Primary Care Teams / Groups / Organizations • Representative group for all Primary Care models • Acute Care • Home and Community Care	• Organizations that have a desire to participate and contribute to the development of an OHT in the future • Organizations that have a desire to participate and contribute to the operation of an OHT on a limited basis and/or through the provision of a specific service to the OHT • Solo Primary Care Providers • Specialist Providers	• Organizations that offer unique solutions and technologies to enhance and streamline health care delivery in an OHT

Next Steps & Year 1 Goals

- Operationalize Integrated Care Hub
- Promote self-management and health literacy

- Identify clients/patients with complex needs and diabetes
- Develop clinical pathway for diabetes

- Enhance health information access
- Conduct technology audit, gap analysis, and plan

- Develop digital strategy to create integrated client/patient record

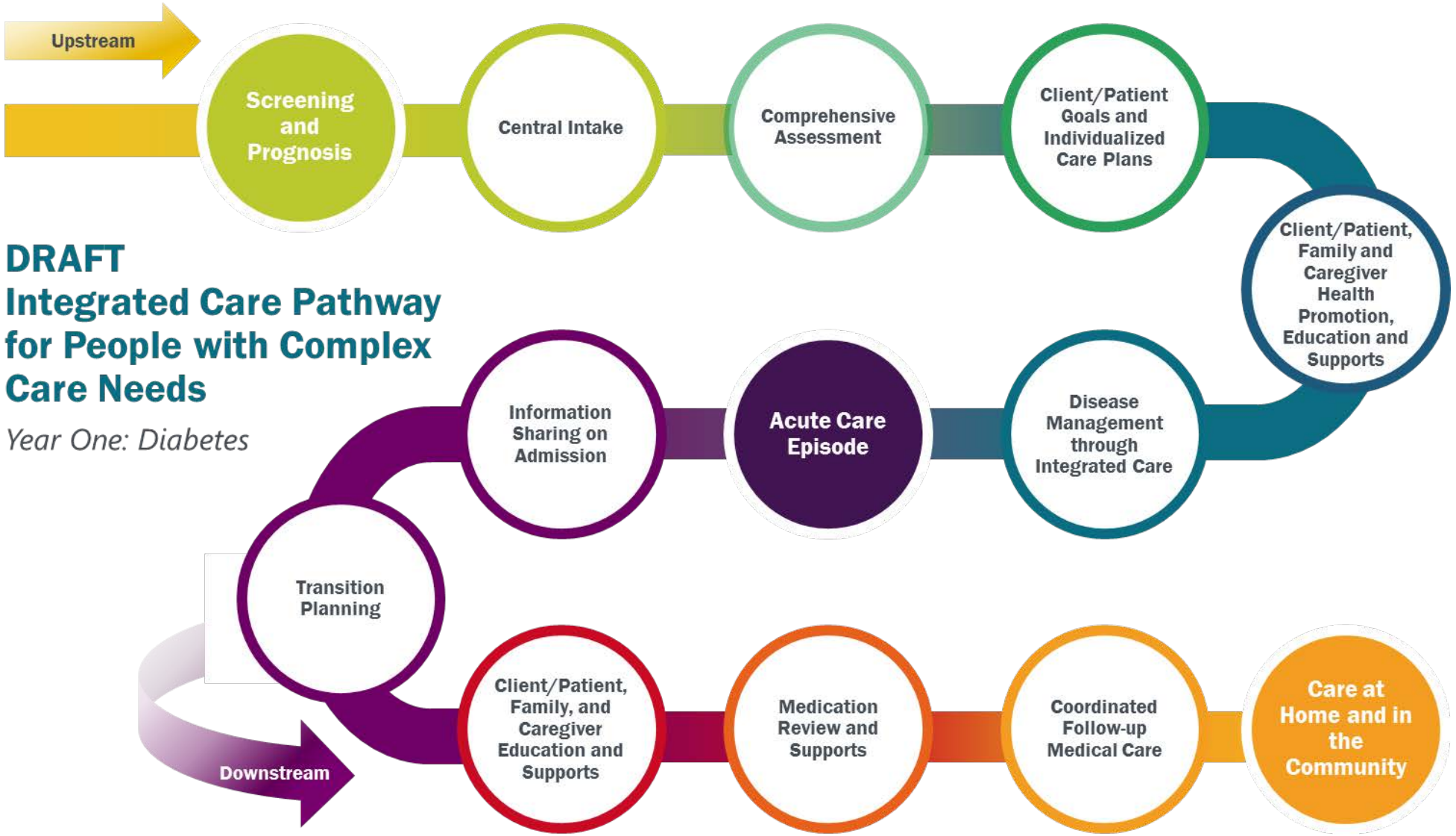
- Identify Quadruple Aim metrics and processes to measure them

- Co-design with clients/patients, community, and partners

- Diverse co-designed governance structure
- Fit-for-purpose governance and adding partners over time

Appendix Slides

Integrated Care Pathway for People with Complex Care Needs (Year 1: Diabetes)



Model is adapted from Health Quality Ontario quality standards for Draft Transitions from Hospital to Home, COPD, and Diabetic Foot Ulcers

Can be scaled and adapted for future care pathways for patients with other complex conditions

OHT Partners: Anchor Category (as of June 17th)

Anchor Partner Category					
Primary Care	Community Services	Home Care	Acute Care	Public Health/Other	Innovation
• Central Brampton FHT • Queen Square Doctors • Queen Square FHT • Rexdale CHC • Rexdale Family Practice • Woodbine FHT • Wise Elephant FHT • Urgent care Centres • Representative group for all Primary Care models (to be determined)	• ESS Support services • Metamorphosis Network • Peel Addiction Assessment and Referral Centre • Peel Senior Link • Punjabi Community Health Services • Richview Community Care • Sienna Senior Living • Services and Housing in the Province • Wellfort Community Health Services • CANES	• LHIN Home and Community Care	• William Osler Health System	• Region of Peel (for the corporation)	• Humber College • Innoneo Health Systems Inc. • TELUS Health

OHT Partners: Community Category (as of June 17th)

Community Partner Category				
• 6 FHOs (5th Floor, Brameast, West Vaughan, Wise Elephant, Rexdale Medical, Central Brampton) • 7 FHGs (Castlemore, Chenab, NW Brampton, Kipling Heights, Westbram, AAA3, Claireville) • Airport Health Centre • Bramalea & Bovaird Clinic • Comprehensive Care Group • Malton Medical Group • MacKenzie West All in One Medical Clinic • North Bramalea Family Physicians • Queen's Urgent Care • 15 solo practitioners (Dr's Cheskes, Kachron, Gupta, Nixon, Saihi, Usman, Preet, Grewal, Price, Choudhry, Chaudhry, Cheema, Saini, Breen, Sachdeva) • Albion Finch Medical Clinic • Clinic Ontario • Sunnyvale Medical Centre • Family Health Medical	• CMHA Peel Dufferin • Healthy Communities Initiative • ProResp	• 1to1 Rehab • Bayshore • Calea • CANES • Care Partners • CBI Home Health • Circle of Care • Closing the Gap • Extendicare • March of Dimes • Medigas, Praxair • Nurse Next Door • Right at Home Canada • RNS Health Care Services • SE Health • Spectrum Health Care • S.R.T Medstaff • VHA Home Health Care • Victorian Order of Nurses	• CanMed Multispecialty Clinics (Endocrinology and Nephrology) • Nephrology Group • Palliative Care physician group • WestPark Health Care Centre • Endocrinologist physician group	• Heart House Hospice • Dorothy Ley Hospice • Potential to add: Bethell Hospice (need to confirm with new Executive Director)