Ontario Health Team in Mississauga

Stakeholder Engagement Session

September 23, 2019

Mississauga Ontario Health Team engagement

To date:

- As part of the self-assessment, engaged with over 200 people, including patients, families and local providers (including 95 primary care providers)
- Survey sent to 80 Patient and Family Advisors with targeted questions on tools and resources needed, supports for caregivers, and approaches to digital health and virtual care
- Primary Care engagement through sessions held by the Mississauga Halton LHIN, weekly primary care OHT meetings, and targeted engagement of through meetings
- Webinar on August 23rd to share evolving plans and hear community feedback (recording available online at www.moht.ca)
- Co-design session August 27th with diverse stakeholders, including patients and family, primary care, acute care, home care, and community partners

More to come:

- Presentation at the Health Leaders Quarterly Forum to share with local health service providers
- Meetings with primary care leaders and presentations to boards of local physician groups
- Engagement with the Mississauga Halton LHIN PFAC
- Presentation to the Region of Peel Health System Integration Committee

Objectives for this meeting

- Share an evolving vision, model and Year 1 plan for the Mississauga OHT, incorporating all feedback heard through engagement
- Provide more insight into the proposed approach to governance and membership, as evolving
- Give interested members and affiliates an opportunity to engage and ask questions

What are we trying to achieve?

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

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.

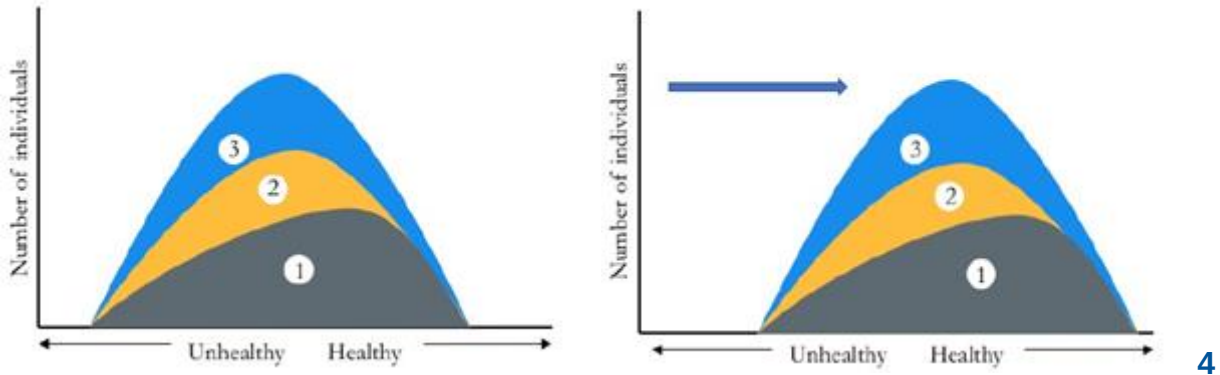
The Ministry's vision

- Full and coordinated continuum of care
- 24/7 access to coordination/navigation
- Improved performance on the Quadruple Aim*
- Single, clear accountability framework
- Integrated funding envelope
- Reinvest into front line care
- Improved access to digital tools

The strategy for our OHT

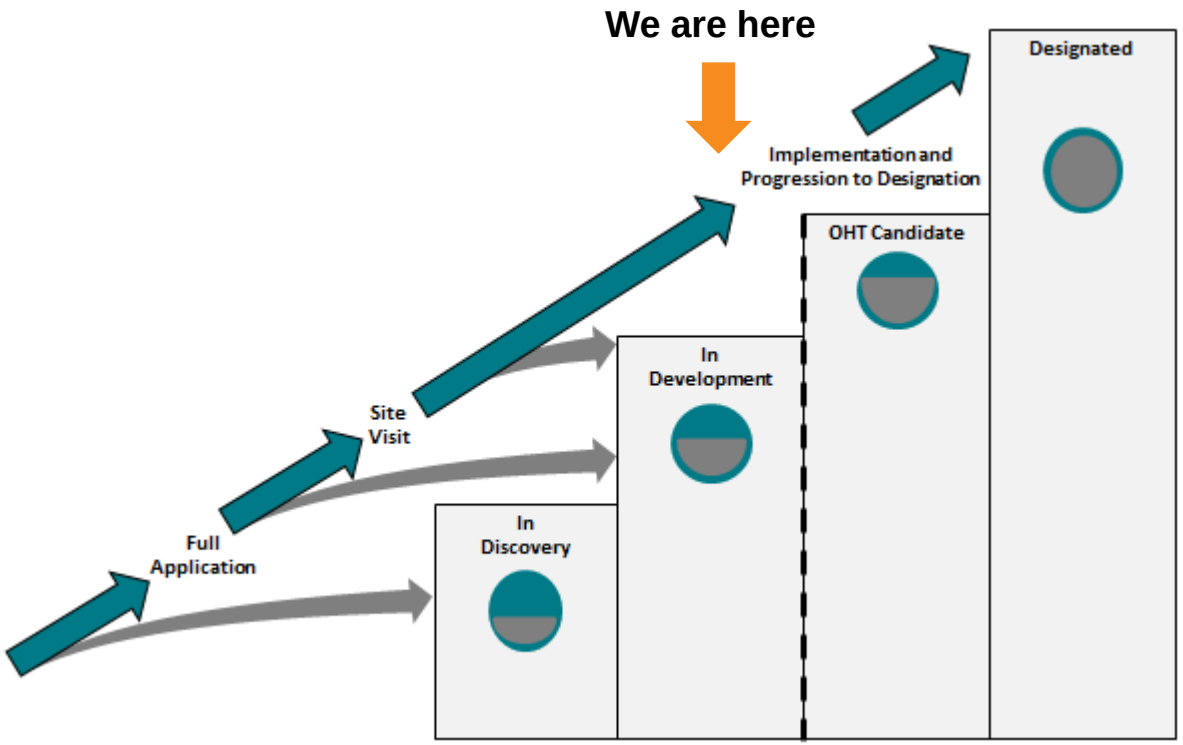
A population-based, evidence-driven approach to designing an integrated health system; strong foundations in primary, home and community care to shift the health of our population over time.

1. Patients seeking care from OHT partners
2. OHT population that is the focus of in-reach and out-reach approaches
3. Entire population of the community that would be affected by population-based approaches



*Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value

Where we are now



Assessment Process	Dates
✓ Open call for self-assessments	April 3, 2019
✓ Deadline to submit self-assessments	May 15, 2019
✓ Selected groups will be invited to submit a full application	July 18, 2019
Deadline to submit full applications	October 9, 2019
Announce OHT Candidates	Fall 2019
Deadline for Second Round of self-assessments	December 4, 2019

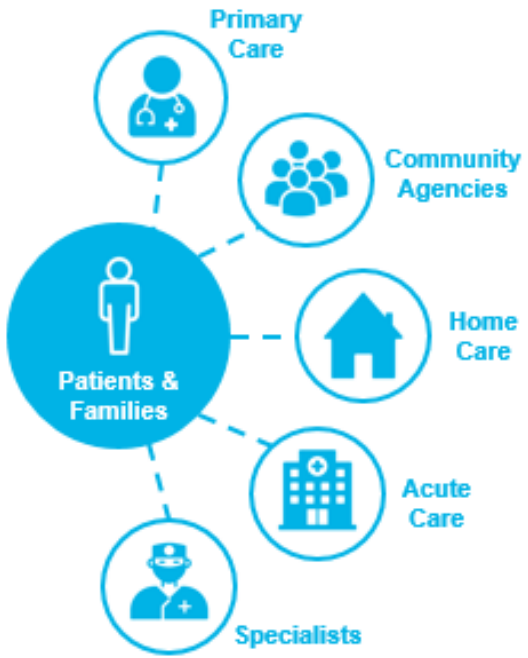
According to Ministry guidance, both “In Development” and “OHT Candidates” will:

- help demonstrate the impact of the model on quality of care, patient and provider experience, and cost, and will provide important lessons for implementing the model across the rest of the province
- set course for system-wide transformation
- prioritized for future investments and receive incentives based on performance
- have access to tailored supports

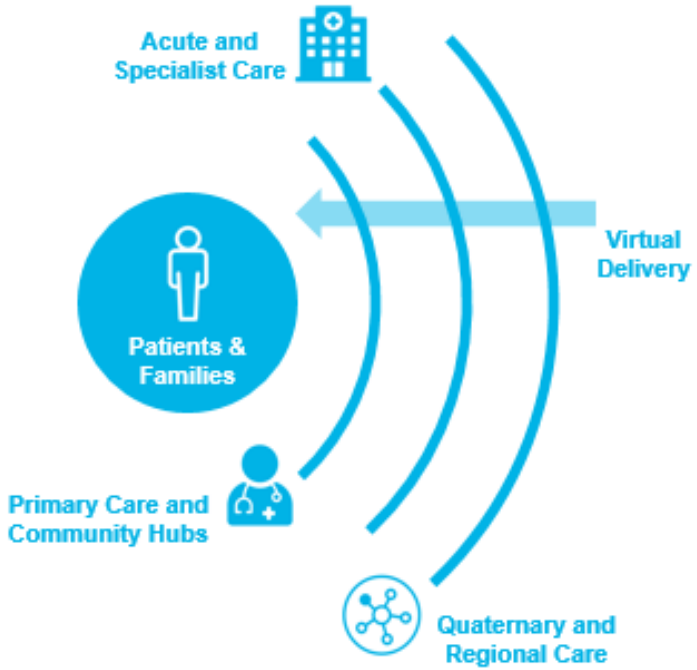
*Note: Ministry site visit has not yet taken place and will depend on Ministry timelines

Our model for the Ontario Health Team

Today



Tomorrow



878,000 people
at maturity

- Approximately 60% live in Mississauga
- Another 35% live in neighbouring communities (e.g. Toronto, Brampton, Oakville

Our vision

Together, improve the health of people in our community by creating an interconnected system of care across the continuum, from prenatal care to birth to end of life.

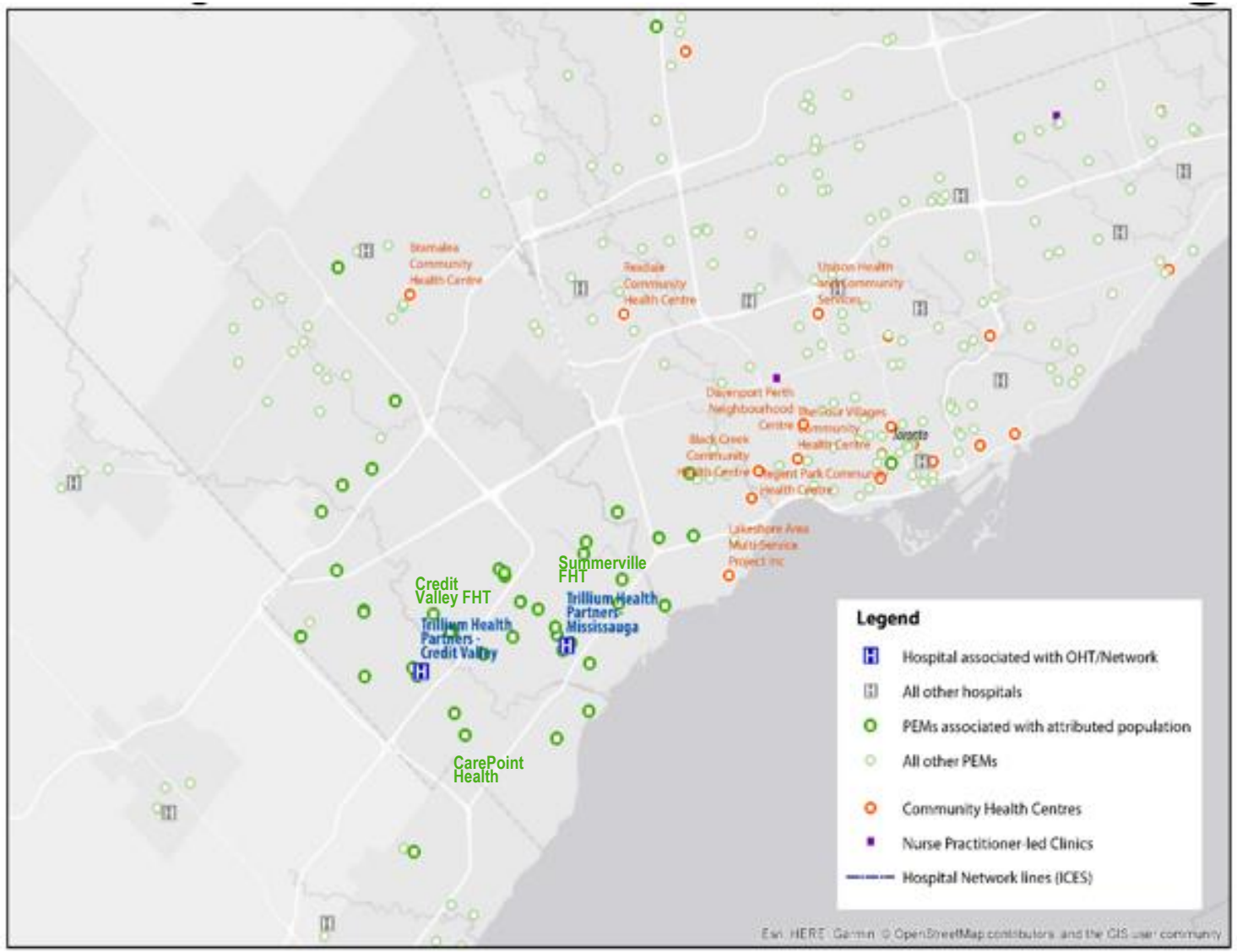
At maturity, our goals are to:

1. Support the health of our whole population
2. Create one seamless system
3. Provide access to holistic care that considers physical and social wellness
4. Empower patients and deliver a positive experience, with digital first

To be enabled by:

- Engagement and co-design with patients, providers and community members
- Rapid and continuous learning embedded within the system

Physician population



Identifying improvement opportunities

Healthy living and care across life-stages

Childhood → Adulthood → End of Life

	Criteria	People with minor acute gastrointestinal/ genitourinary (GI/GU)*	Seniors with Dementia	People who would benefit from a palliative care approach
Impact	Prevalence	High	Low	Low
	Cost drivers and utilization	Medium	High	High
	Addresses capacity constraints	Medium	Medium	High
	Timeliness to see change	High	Medium	Medium
	Patient/caregiver experience	High	High	High
Feasibility	Active clinical leadership	Medium	High	High
	Work underway	Low	High	High
	Degree of change required	Medium	High	Medium - High
	Hospital readiness (Y1 engagement)	Medium	Medium - High	Medium
	Primary care readiness	High	Low	Medium
	Home care readiness	High (N/A)	Low	Medium
	Evidence-based and proven pathways	Medium	High	High
Partnerships	Builds foundation (core partners)	Medium	High	High
	Partners already involved	High	Medium	Medium

Social determinants of health and co-morbidities considered throughout

*Intervention to focus on comorbid mood disorders in the short-term, but will need to build beyond to encompass other comorbidities being managed by this population

Populations of focus for Year 1 and beyond

While our goal over time is to integrate care for our whole population, it will be a journey to achieve this. We will begin by focusing on populations where we see the greatest opportunity for impact so we can build a foundation of trust over time.

Impact
Improves the efficiency and effectiveness of our system to free up capacity and resources; influences highly prevalent/resource-intensive conditions; considers the diverse needs across our community and opportunities to improve outcomes across the lifespan

Feasibility
Supported by best-practice, proven pathways; leverages work underway and considers readiness of our partners; considers complexity/size of populations

Partnerships
Builds a strong foundation with our core partners through early, quick wins; sets us the partnership up to tackle more challenging issues together in future; initiatives resonate with teams and address the pressures affecting patients and families, primary care, home care, community and hospitals

People who would benefit from a palliative approach (Phase 1)

People presenting with gastrointestinal and genitourinary conditions (Phase 1)

Seniors with dementia (Phase 2)

Playbook for the Mississauga OHT

Support the health of the **whole population**

Create one **seamless** system

Provide access to **holistic care** (physical and social wellness)

Empower patients; deliver **exceptional experience**

Built on a foundation of **engagement and co-design**

Supported by **rapid learning** and **continuous improvement**

Playbook for the Mississauga OHT

Support the health of the **whole population**

How will we get there?	Year 1 Actions: GI/GU and Palliative
• Use data-driven approaches to understand our population and deliver targeted services • Focus on upstream **prevention; health equity** lens	• Improve early identification • Enhance training and supports • Raise public awareness

Playbook for the Mississauga OHT

Create one **seamless** system

How will we get there?	Year 1 Actions: GI/GU and Palliative
• **Organize:** Clinical integration. One vision; one brand. Shared funding, incentives and accountabilities. Digitally enabled • **Implement Care Pathways:** Care crosses a network of core and extended providers; no referrals or transitions needed • **Integrate Specialists:** Primary care has rapid and urgent access to consults • **Partner Across Sectors:** Work towards links with other sectors • **Standardize/Automate:** Optimize processes across providers	• Improve access for primary care providers to timely testing • Link primary care to same-day advice from specialists • Design digital solutions to enable care plans to be shared across a team

Playbook for the Mississauga OHT

Provide access to **holistic care** (physical and social wellness)

How will we get there?	Year 1 Actions: GI/GU and Palliative
• **Modernized Primary Care:** Primary care is the foundation; a first stop linking patients to home, community and specialists. Establish interdisciplinary team-based primary care in practices; link patients to a core team • **Extended Teams:** Increase access in primary care to extended services needed, including rapid, urgent access to specialists • **Streamlining Care:** For patients with complex needs, a member of the core team serves as a point of contact. The whole team helps to “quarterback” care through the system • **Digitally Enabled:** Create a single digital care plan for each patient, accessible and shared across providers; include communication, virtual care options	• Provide access to a core team and a contact point on that team to help coordinate care • Integrate core teams with extended supports (e.g. palliative specialists) • Document care plans

Playbook for the Mississauga OHT

Empower patients; deliver **exceptional experience**

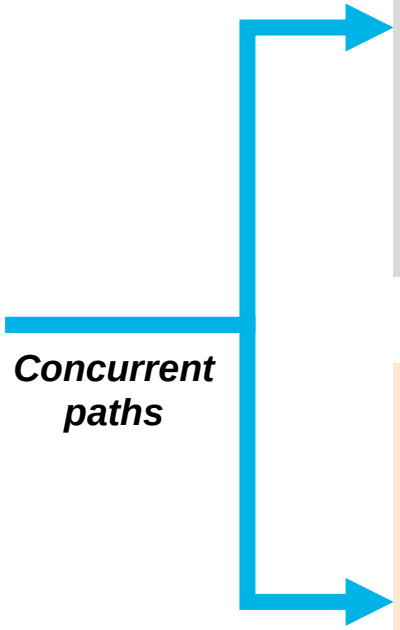
How will we get there?	Year 1 Actions: GI/GU and Palliative
• **Clear and Timely Access**: Patients know where to go for information and navigation; 24/7 • **Digital First:** Where preferred, patients will be offered virtual care options first • **Patient Portal:** Over time, patients access their medical record and care plan • **Service Excellence:** Design a standard experience that will be kept consistent; an “always” experience. Embed mechanisms to collect and respond to feedback	• Allow patients to schedule primary care visits for urgent issues via clear access points; provide virtual care options • Member of care team designated as point of contact for patients who need it (24/7) • Increased awareness of advance care planning

Digital health

Our Approach

- Build off existing digital tools in order to achieve Year 1 goals
- Emphasize programmatic and partnership development
- Begin long-term planning for modern, standard solutions across the OHT (beginning in Year 2)

We are in the early stages of planning for digital; proposed work could require additional investment



Year 1

For the initial Year 1 population rostered with primary care:

- Improve access to care through digital approaches (e.g. scheduling, virtual care)
- Improve patient access to select information to support self-management

For certain care pathways:

- Improved sharing of information across the care team to support care planning

Planning for Year 2 and Beyond

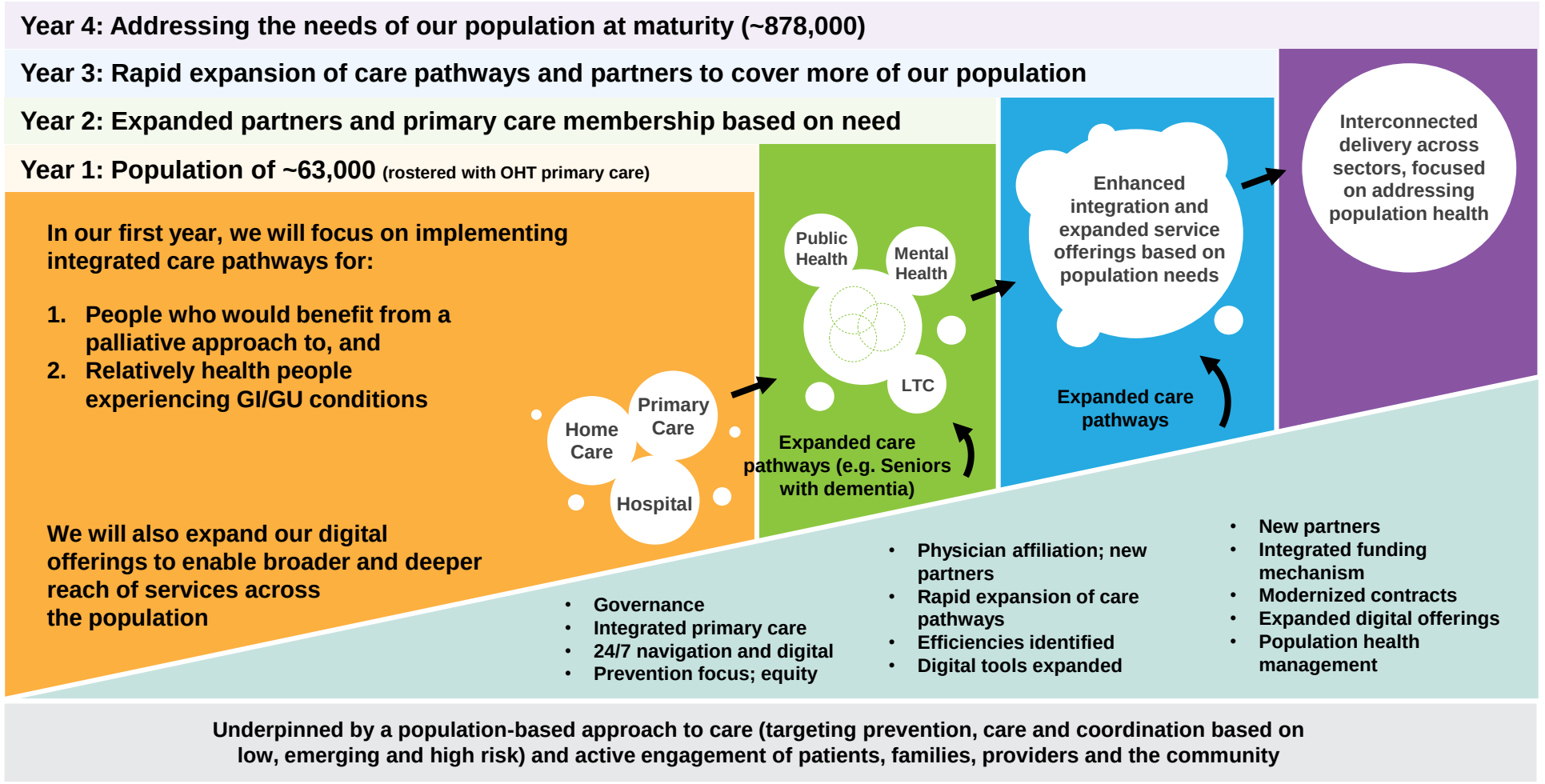
Considerations we are managing into the future:

- Establishing a common digital maturity framework across members
- Working towards more centralized planning for digital tools
- Seeking standard and integrated solutions, where feasible
- Collaborating and innovating to maximize our value through procurement

Our roadmap

We will implement the following strategies to address the health of our population and increase coverage over time:

1. Increase the number of primary care clinicians affiliated with the OHT, along with patients rostered here
2. Increase access to integrated care pathways and expand to new partners
3. Introduce population segmentation and risk stratification to manage the upstream health needs of our whole population



What will membership with the Mississauga OHT look like?

At maturity, the Mississauga OHT will be responsible for delivering a full and coordinated continuum of care to our attributed population. To get there, we will need to partner widely with organizations and care providers addressing a range of health needs for our community.

At this time, we envision two membership roles within the OHT.

Members

Involved in the day-to-day operations of the OHT; deliver services to the population of focus.

Willing to sign on as a party to an accountability agreement with the Ministry (pending further understanding of that agreement after October 9th).

Key members in Year 1: Home care (LHIN), primary care, acute care

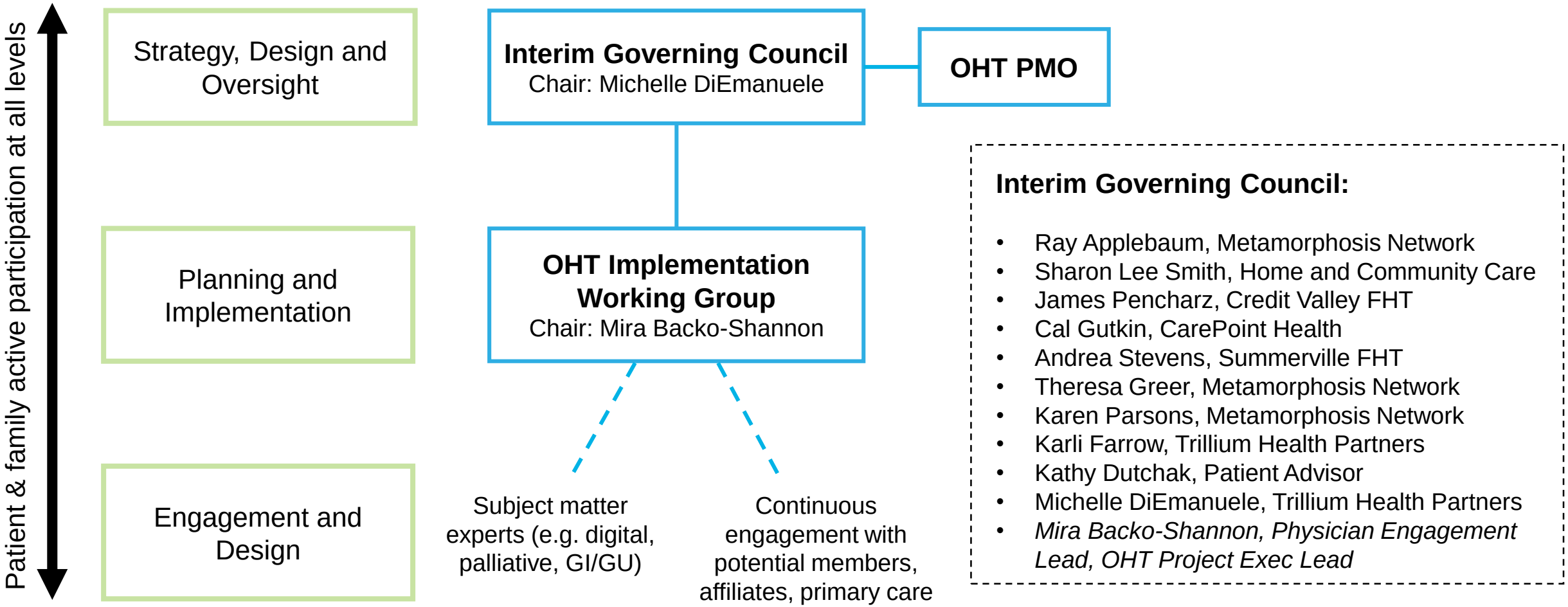
Affiliates

Have endorsed, supported or provided advice to the OHT but not central to day-to-day operations of the OHT.

May include contracted services.

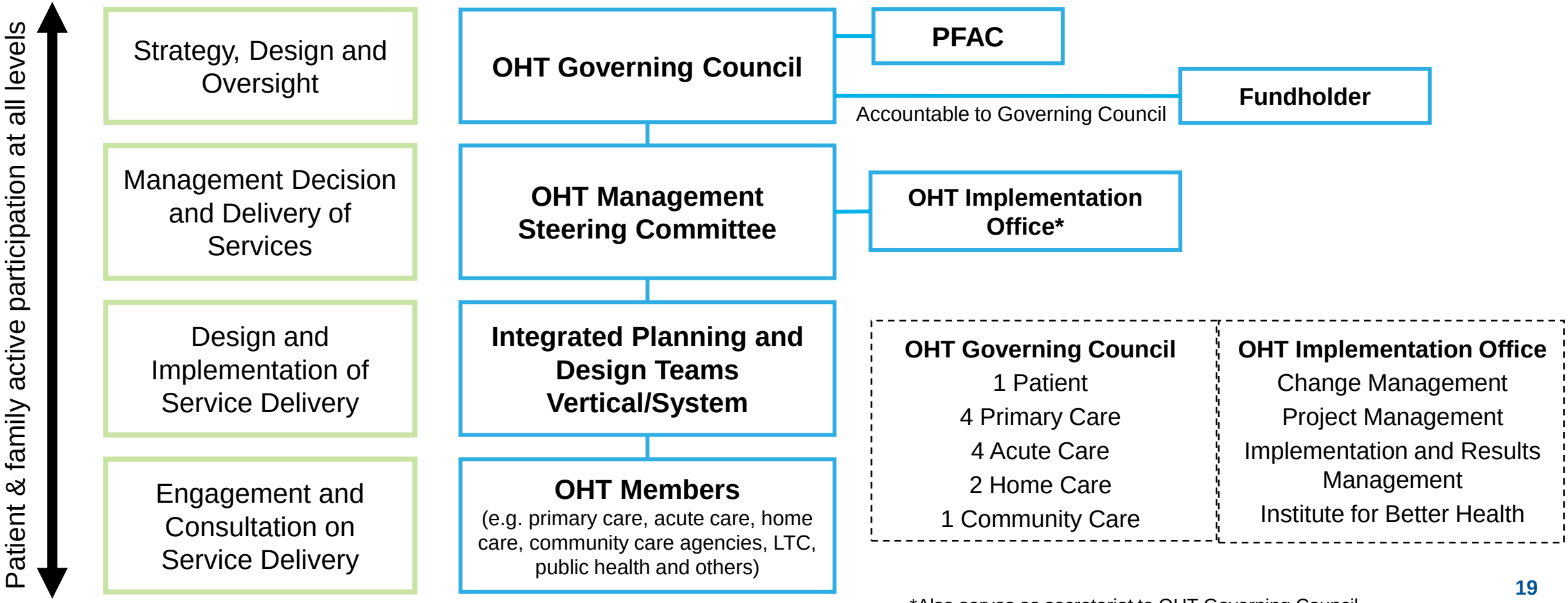
Anyone who interested in becoming a member is invited to sign on as part of our application at this time. This is a non-binding step, but indicates your interest and willingness to move forward in planning together for our future OHT.

Governance: Where we are



Governance: Where we are going

Governing Council membership will be determined using a skills-based approach that takes into account the membership of the OHT, services to be delivered in Year 1 and expertise needed to meet its deliverables. OHT members will retain their own governance structures; the OHT Governing Council and Implementation Office will support common work among the members towards building an integrated system



*Also serves as secretariat to OHT Governing Council

Home and community care

The application asks teams to outline a long-term vision for re-designing home and community care and a short-term action plan with immediate priorities.

The Mississauga OHT recognizes that this work will continue to require engagement with the Ministry and other stakeholders. We propose capitalizing on the strengths of our current home and community care model, while also working to address challenges. In partnership with the LHIN, we will look to how best to transfer home care responsibilities to the OHT, respecting legislative, human resource and procurement considerations.

Today

Three sectors of primary, home and acute care operate in siloes:

- Patients sometimes experience difficult transitions between primary care, home care and acute care
- Providers encounter barriers that prevent them from accessing information or working in coordination

Medium- to Long-Term

Moving to a system informed by the following principles:

- ‘One-team’ approach: patients experience their entire care journey through an OHT
- Care planning is prevention-focused
- Access to services is equitable and standardized across Ontario
- Patients and providers have a single point of contact available 24/7

Risks to achieving our vision

Issues and risks we are managing:

Labour Relations: Where and how people do their work may need to change to realize the vision of OHTs

Home Care Structure: System design still in flux; will depend on Ministry direction to determine future state

Level of Complexity: The change requires coordinated planning toward a single vision among diverse partners

Funding Drivers: Existing payment structures and incentives in the system could be a barrier to executing on vision

Will inform our decision-making on:

1 Governance

Across a spectrum of options related to integration and management, we will need to determine the approach that balances results with risks and best supports the goals.

2 Pace

Depending on the speed at which provincial decisions are resolved or structures are put in place, we will scope and pace our implementation accordingly.

3 Resourcing

As risks emerge through implementation, additional resources—both financial and human—may be required to ensure that execution continues to align with the vision for OHTs.

Your action required today on membership

The Mississauga OHT is now at a stage where we need to confirm who would like to be a member of the future team. Please complete the membership sign-on process—either via online survey or using the sheets provided in the room today.

We are asking that the survey be completed by September 30th to allow us to reflect the details you have shared in the application.

This is a non-binding decision and will not the only opportunity to sign on as a member. We recognize that membership will continue to evolve as we finalize year one plans with the Ministry and move through to maturity; membership will continue to grow and shift past the October 9th submission date.

If you feel your organization is aligned to the vision of the Mississauga OHT, and you provide services that that can support this work, please consider signing on.

To complete the survey, go to the following link: https://www.surveymonkey.com/r/5XHDL7F

Next steps

September 30th

- Submit your interest in membership or affiliation via the survey

October 9th

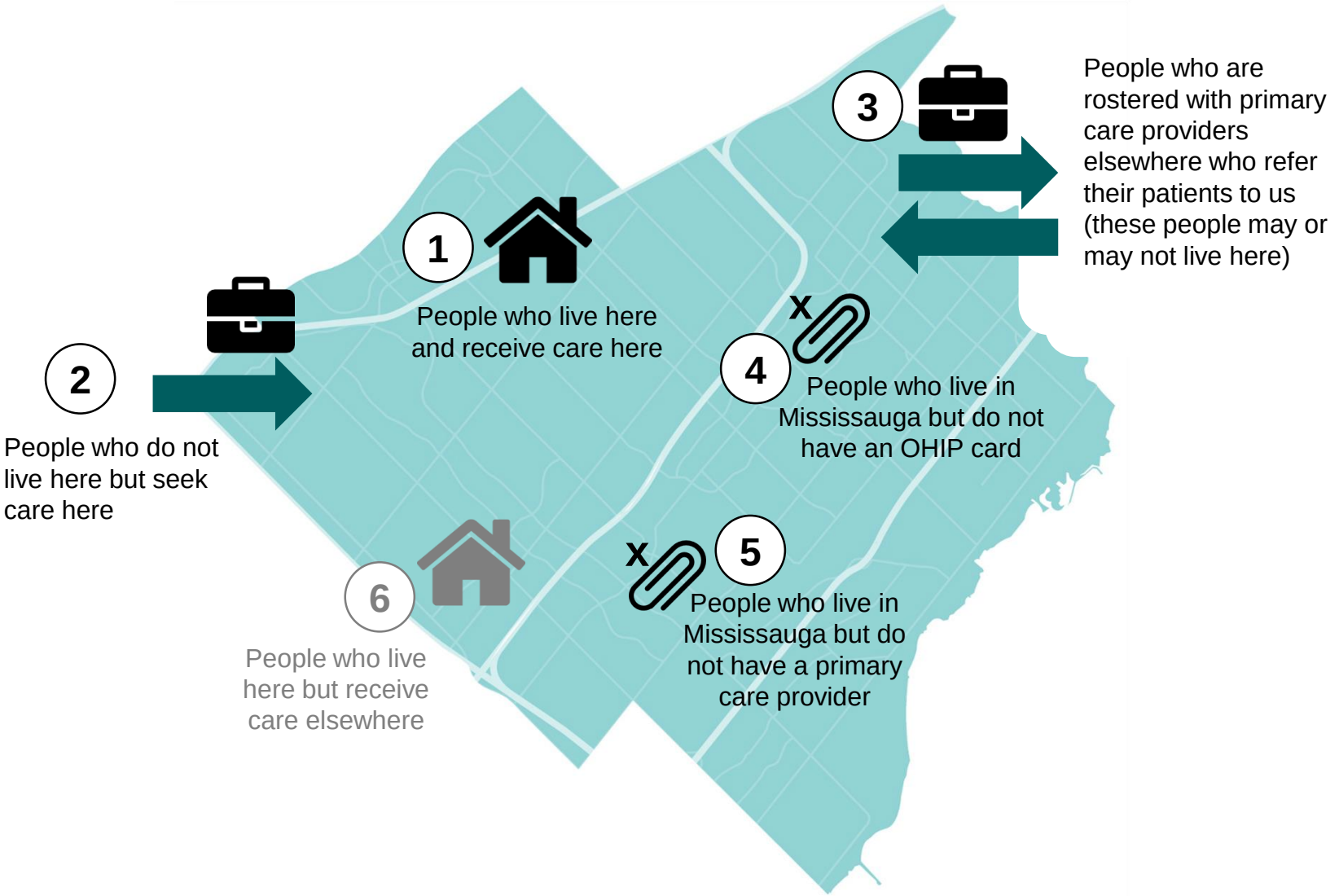
- Full Application due to the Ministry (draft to be made available for review at certain times/locations by request)

Fall, 2019

- Ministry plans to announce successful OHT candidates
- We will keep you updated as we know more!

Appendix

Who is our population?



Understanding our Population

The Ministry bases their estimates of our population on physician referrals.

Using the Ministry's methods, groups 1, 2 and 3 are considered part of the population this OHT will be accountable for at maturity.

In Year 1, we will begin by focusing on people rostered with one of our primary care partners; as we grow our primary care affiliation over time, we will continue to expand to cover the whole population.

We are also considering groups 4 and 5 as we plan—these are people living in our community who may need more support.

A few facts:

- Our total population will be about 878,000 people at maturity, making us one of the largest OHTs so far
- More than 60% of our population live here and seek primary care here