# Ontario Health Team in Mississauga

Peel Senior Link – Board Teleconference

October 3rd, 2019

Working Document

# Objectives for this meeting

- Share the vision and goals behind the Mississauga Ontario Health Team (M-OHT)

- Review key content of the Full Application, including:
  - M-OHT Population
  - Proposed areas of focus and strategy
  - Top risks and issues
  - Governance considerations

- Next steps

- Board resolution

# Ontario Health Teams

**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.**

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

# Our community and the case for change

**Ours is a large, diverse community with many different cultural and ethnic backgrounds.**

**We are experiencing population growth across all ages, and increases in significant multimorbidity and social inequity. In many cases, our health care infrastructure is stretched beyond capacity.**

65% of our population are immigrants; 50% are visible minorities and 50% report a first language other than English or French*

15% of our population are seniors and more than 6.4% are over 75 years of age; 22% are children

Over 22% are living with at least one chronic condition, but this community currently has the fewest interprofessional primary care teams in Ontario, no youth mental health beds, and the fewest long-term care beds; its acute care services are stretched to capacity, with gaps in beds to care for the community

In 1980, only 2% of neighbourhoods were low income, while today, low- and very low-income neighbourhoods represent 51% of the community



* Population demographics to be updated as understanding of our attributed population evolves

# What are we trying to achieve?

## Our goal

To improve the health of our population by providing high quality, integrated care across the continuum, from prenatal care to birth to end of life.

## Our strategy

We will take a population-based, evidence-driven approach to design an integrated health system with strong foundations in primary, home and community care to change the health trajectory for individuals.

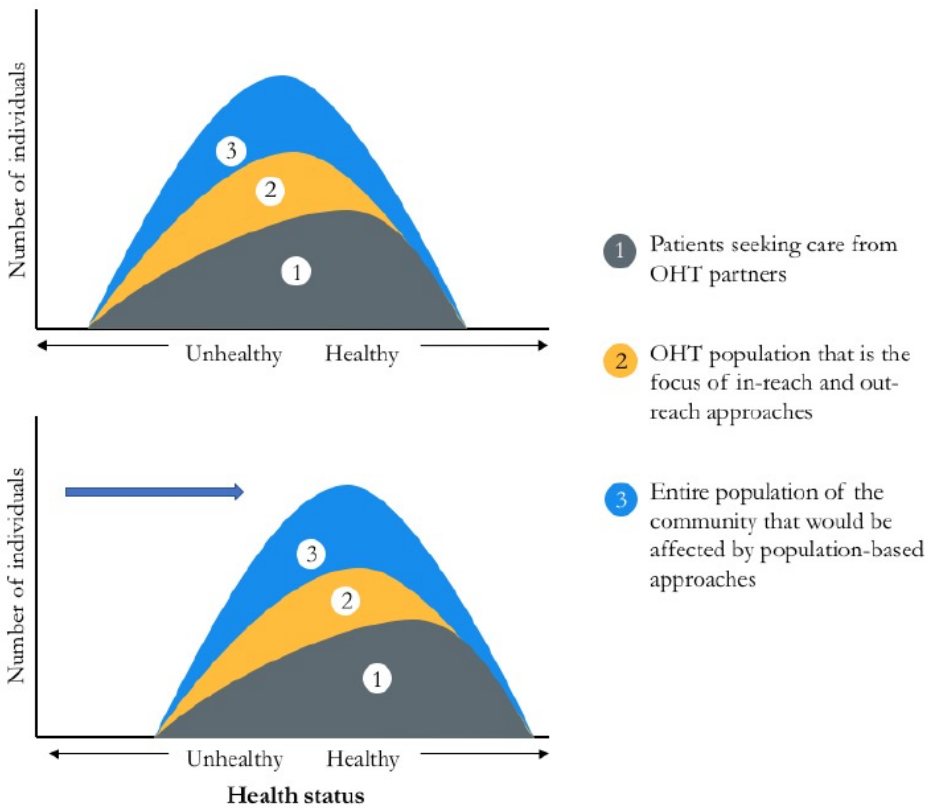
## Our outcomes

Over the longer-term, we will aim to improve the health of our population and address capacity pressures on our system, with a focus on enhancing quadruple aim indicators.*

In the medium-term, a key indicator of improvement will be improving system capacity, measured through avoidable ED visits and hospitalizations and improving total health system utilization costs.

More immediately, key lead indicators will include patient and provider experience and process metrics on integration and access.

*Shifting the health of our population over time*




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

# The future OHT care model: How are we different?

## We took a user-centred design approach to develop our OHT care model

1. Developed patient personas based on our two Year 1 priority populations:
    - People who would benefit from a palliative approach to care
    - People with minor acute gastrointestinal (GI) / genitourinary (GU) issues
2. Created maps of the patient journey to identify pain points / challenges to improve upon in the future patient experience
3. Mapped the patient journeys onto a service blueprint to identify the various health care service touchpoints that needed improvement
4. Held a co-design session with diverse stakeholders, including patients and family / caregivers, primary care, acute care, home care, and community partners, to:
    - Validate our understanding of the current-state patient experience and service challenges
    - Generate “Big Ideas” for improvement in the future OHT care model
    - Discuss how these ideas could be implemented and measured in the new OHT model by describing a “Road to Success”

# How could the future be different for patients?

## Examples for people who would benefit from a palliative approach to care

### Patient Persona: Sita

72-year-old South Asian woman living with her daughter in Mississauga. She has a previous diagnosis of Type 2 Diabetes and sees her primary care physician regularly.

Sita has recently been diagnosed with a life-limiting illness, COPD.

### Today:

- Sita is diagnosed with congestive heart failure (CHF), but is not identified as someone who would benefit from palliative care. She visits the emergency department three times in one month before she is referred to a palliative physician.
- Sita's primary care physician is not made aware that she has been referred for palliative care; when he discovers she has ongoing palliative needs, he is not sure he would be able to provide the supports she needs and refers her to a palliative specialist.
- As Sita's symptoms become more severe, she and her daughter are not always sure how to manage them; they often end up at the emergency department in these moments.
- Sita is admitted to hospital during a severe symptom crisis. Though both she and her daughter would like to have her at home, she is not linked to hospice services in time to be able to return there before she dies.

### In future:

- Even before Sita is diagnosed, she and her provider have already **documented an advance care plan**.
- As soon as Sita receives her diagnosis, she is **flagged as someone who would benefit from palliative care** in her primary care doctor's EMR. Her clinicians have access to her **shared record** so her care team is aware of her status.
- Sita's primary care physician feels confident and supported as part of **an interprofessional team** to manage her palliative needs; a conversation about her **goals of care and an end of life plan** begins.
- Sita has access to a key contact in her care team who will **provide support and answer questions 24/7** (on call). She and her daughter also have a plan in place on how to manage her symptoms and have home care supports.
- Sita's family is **connected** to hospice care; her care team understands her wishes for end of life and can support her to achieve them.

In five to ten years, what else could our vision include?

**Change in the culture around palliative care, including a more compassionate care in the community**

# How could the future be different for patients?

## Examples for people with minor acute gastrointestinal (GI) and/or genitourinary (GU) issues

### Patient Persona: Ana

26-year-old Colombian woman who moved here with her boyfriend at 22. Spanish is her first language and her English is limited. She has limited emotional and financial support and is not employed. Ana has a primary care physician and is generally healthy.

She is experience vague lower right abdominal pain, but it is a weekend.

### Today:

- Ana looks up her primary care provider online to see if the office is open. She calls, but cannot get an appointment until Monday. She goes to a walk-in clinic instead.
- Ana waits a long time at the walk-in clinic. She takes a pregnancy test there and discovers she is pregnant; however, the physician is unable to determine the cause of her pain and refers her to the ER for an ultrasound.
- Ana receives an ultrasound that confirms she is pregnant; she is sent home. However, she continues to have pain and follows up with her primary care provider, who does not have a record of any of her visits at the ER or walk-in clinic and has to request them.
- Ana has continued pain and is once again required to visit the ED for a follow-up ultrasound. Her primary care provider determines the pain is due to constipation and refers her for pre-natal care.

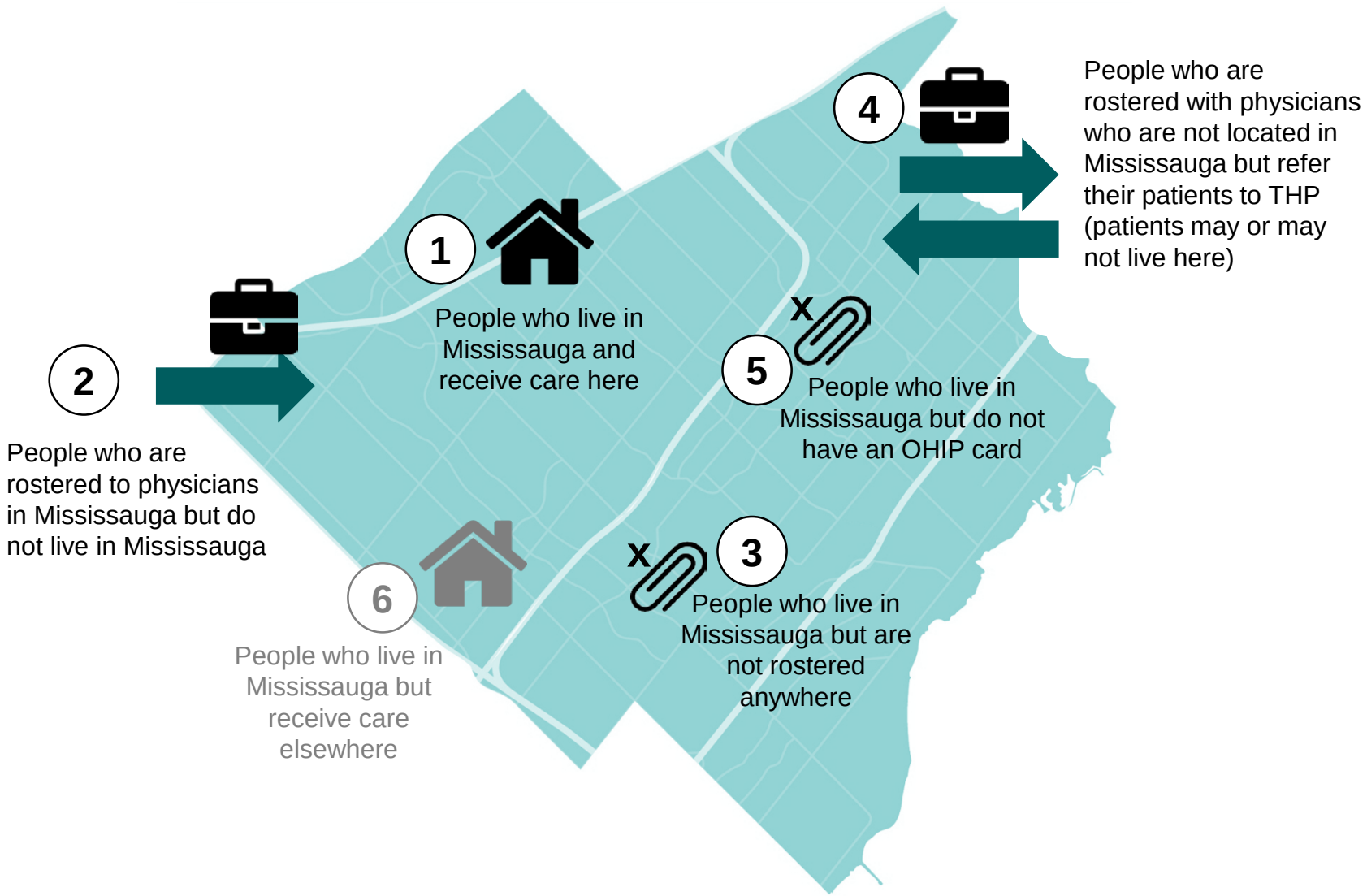
### In future:

- Ana reaches out to her OHT central access number and understands her **options for seeking care**, including a virtual visit or after hours care.
- Ana's primary care provider has urgent **access to the diagnostic and lab supports** needed to diagnose Ana's condition. She is able to get the tests she needs right away from a high-quality and reliable location.
- Through access to a **shared record**, Ana's ultrasound data can easily be called up and reviewed by her primary care provider as needed.
- Ana's primary care provider has virtual **access to the advice of a specialist** and can interpret the results of her ultrasound quickly.

In five to ten years, what else could our vision include?

**An integrated digital record, a patient portal, opportunities to use AI for triage, point of care diagnostics**

# Who is our population?




## Understanding our Population

The Ministry uses an attribution methodology that is based on physician referral networks. Using the Ministry's methods, groups 1, 2 and 4 are considered part of the population this OHT will be accountable for at maturity.

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

We are also considering groups 3, 5 and 6 as we plan to ensure that we are taking a holistic view of the people who live in the region.

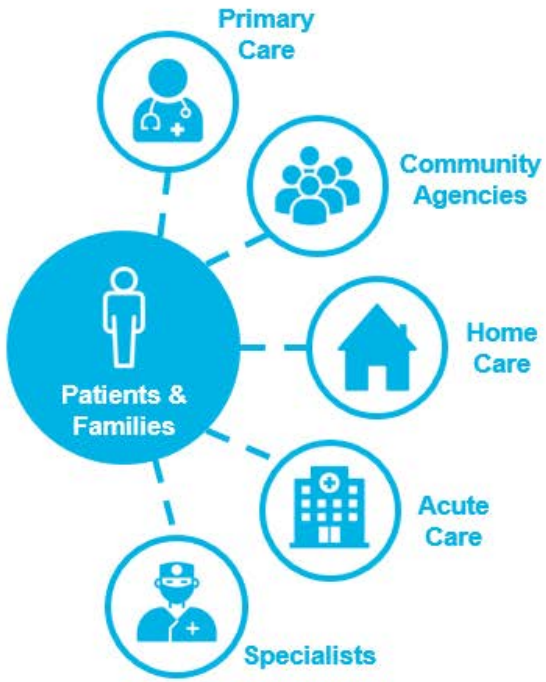
**A few facts about our population:**

- According to the Ministry's methodology, we will be accountable for approximately 878,000 people at maturity
- About 50% of those people live in Mississauga and are rostered with primary care physicians located here

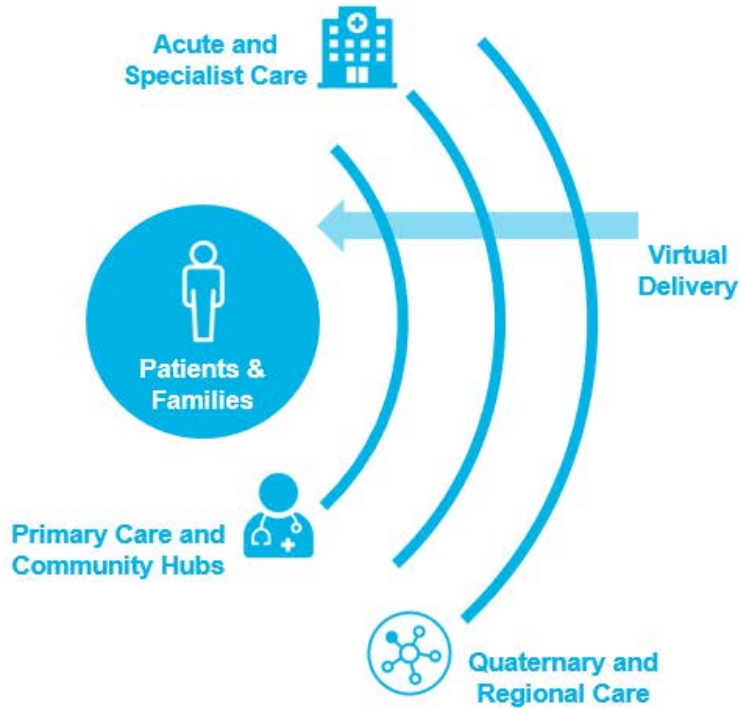
* As we work with the Ministry to further understand our population, this will continue to evolve; we will keep you informed as this develops

# Our model for the system

## Today




## Tomorrow




## At maturity, our OHT vision is to achieve:

1. A healthier population that has improved wellness and disease prevention
2. Primary care is a person's medical home and first point of access; it exists as a hub that should also serve as the first point of access to home, community, social and specialist services
3. The approach is local and population based; it is designed around ongoing relationships and is not transactional
4. Integrated care pathways are built into the system using evidence-based and proven approaches
5. Digital options should be made available first as a general principle, based on patient preference
6. Embedded rapid and continuous learning into the system

# Potential populations of focus and our principles for decision-making

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 and/or people at end of life (Phase 1)

- 46% of people who die in our community do so without receiving palliative care
- An average of 54 patients per day receive palliative care in the hospital. Many of these patients could receive care in the community
- The MH LHIN has one of the longest palliative home care wait times in Ontario

## People presenting with gastrointestinal and genitourinary conditions (Phase 1)

- Minor acute utilization of the emergency department, including for GI/GU, is the top category of utilization across all sectors
- Visits for these conditions account for 8.3% of all emergency department visits in a year

## Seniors with dementia (Phase 2)

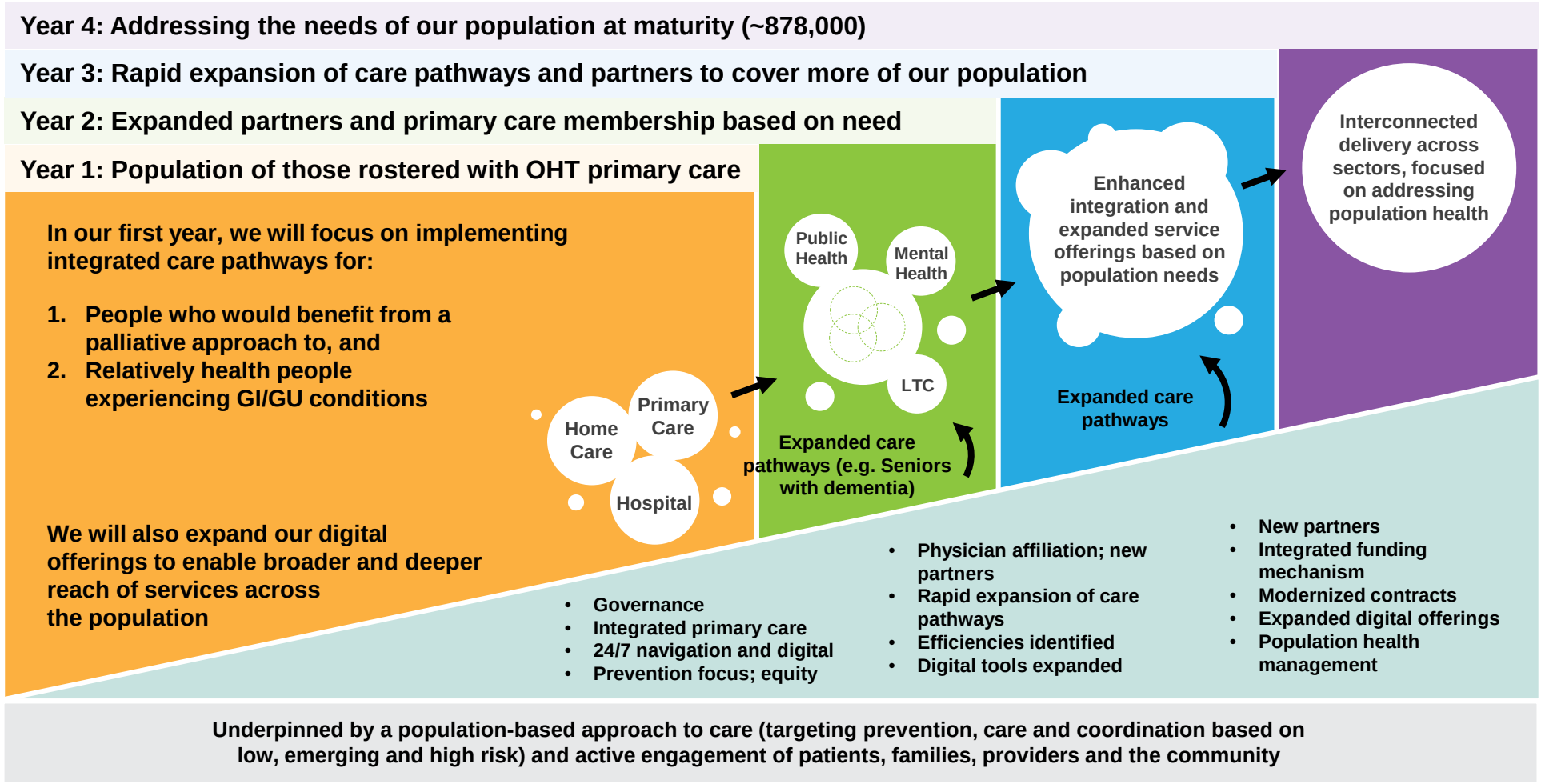
- Dementia is one of the leading causes of death among residents in our community
- Of people living with dementia in our community, only 54% received home care in 2015/16

Sources include: Mississauga Halton LHIN IHSP, 2016-2019; Health Quality Ontario Dementia Quality Standard; ICES population data; Seow et al. BMC Palliative Care (2018) 17:70; Trillium Health Partners data

# 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 members
3. Introduce population segmentation and risk stratification to manage the upstream health needs of our whole population



# How will we measure success?

The Ministry has identified a number of health system measures that they envision OHTs helping to improve, and has provided us with some data on our current performance.

Over the coming weeks we will be working through specific performance measures and evaluation opportunities; however, early thinking suggests driving improvements on metrics listed below.

**Our goal:** Create an integrated system of care that improves patient and population health outcomes; patient, family, and caregiver experience; provider experience; and value

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**Early opportunities identified through Ministry/our own data:**

- Reduce additional growth in the number of individuals in hallway health care beds;
- Decreasing the number of avoidable ED visits;
- Improving patient and provider reported experience measures and patient reported outcome measures; and,
- Decreasing caregiver distress

# 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

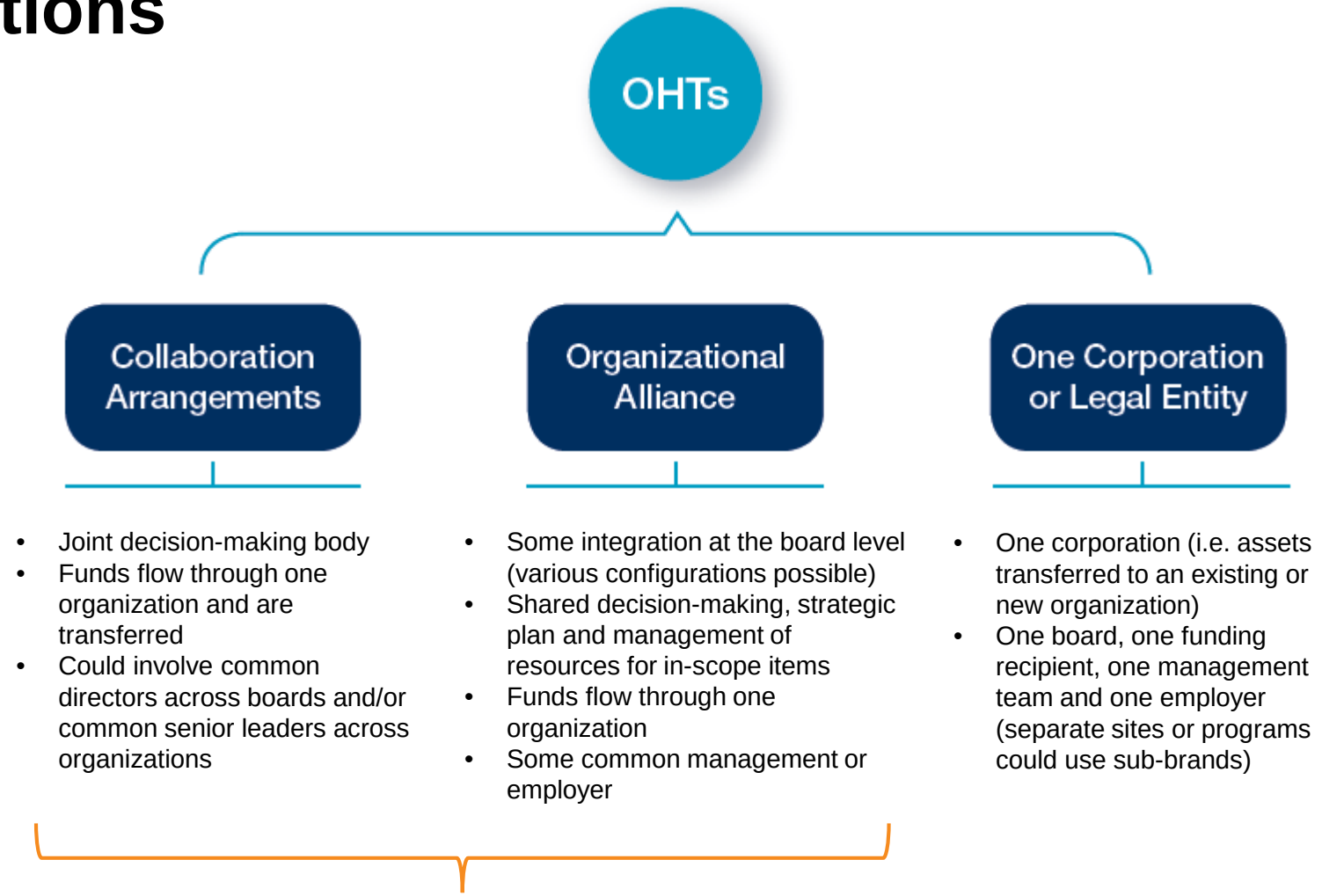
As risks emerge through implementation, additional resources—both financial and human—may be required to ensure that execution continues to align with the vision for OHTs.

# Governance considerations

The Ministry has left decisions on governance up to local communities to determine. Groups like BLG and others offer guidance to OHTs on setting up governance structures.

Signing on as part of the submission of the OHT application indicates an intention to proceed, but does not commit organizations to being part of the ultimate OHT structure. No decisions at this time are binding.

Once OHT candidates are announced, each team will negotiate an agreement with the Ministry.




**As part of our discussions, we are focusing on Collaboration/Alliance models and are not considering incorporation at this time**



Adapted from resources available through the RISE collaborative and BLG

# What will membership with the 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).

## 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.

# Next steps

## Work to date

- In August, the project team held a co-design session to understand our opportunities to change care for our population
- Several workstreams have been active in helping to articulate a future approach to digital health, leadership and governance and quality and performance improvement

## Next Steps

- On September 23rd, the project will be holding another information session with stakeholders to share the outputs of the co-design session, and discuss membership options for stakeholders at this time
- The application is due to the Ministry on October 9th, 2019; once the application has been submitted, the Ministry will be reviewing and responding back to teams.
- Teams invited to become an OHT will then work with the Ministry to define an accountability agreement that includes all OHT members. This agreement will be in addition to existing accountability agreements, which will continue to be in effect
- The project team is encouraging interested stakeholders to reach out and connect with us through our website (www.moht.ca) or the M-OHT inbox (info@moht.ca)

# Board resolution

The decision to participate as a member as part of the application is non-binding; until an agreement is negotiated and signed with the Ministry, we have an opportunity to consider how we would like to be involved moving forward. Today, we are asking for a resolution from the Board to proceed with planning.

If the Ministry selects this OHT to move forward, we will report back to you and will continue to seek your approval on next steps.

Should any further information become available related to governance in advance of the October 9th submission, the Board will receive this information for endorsement. This may include the need to call an ad hoc meeting.

## Resolution

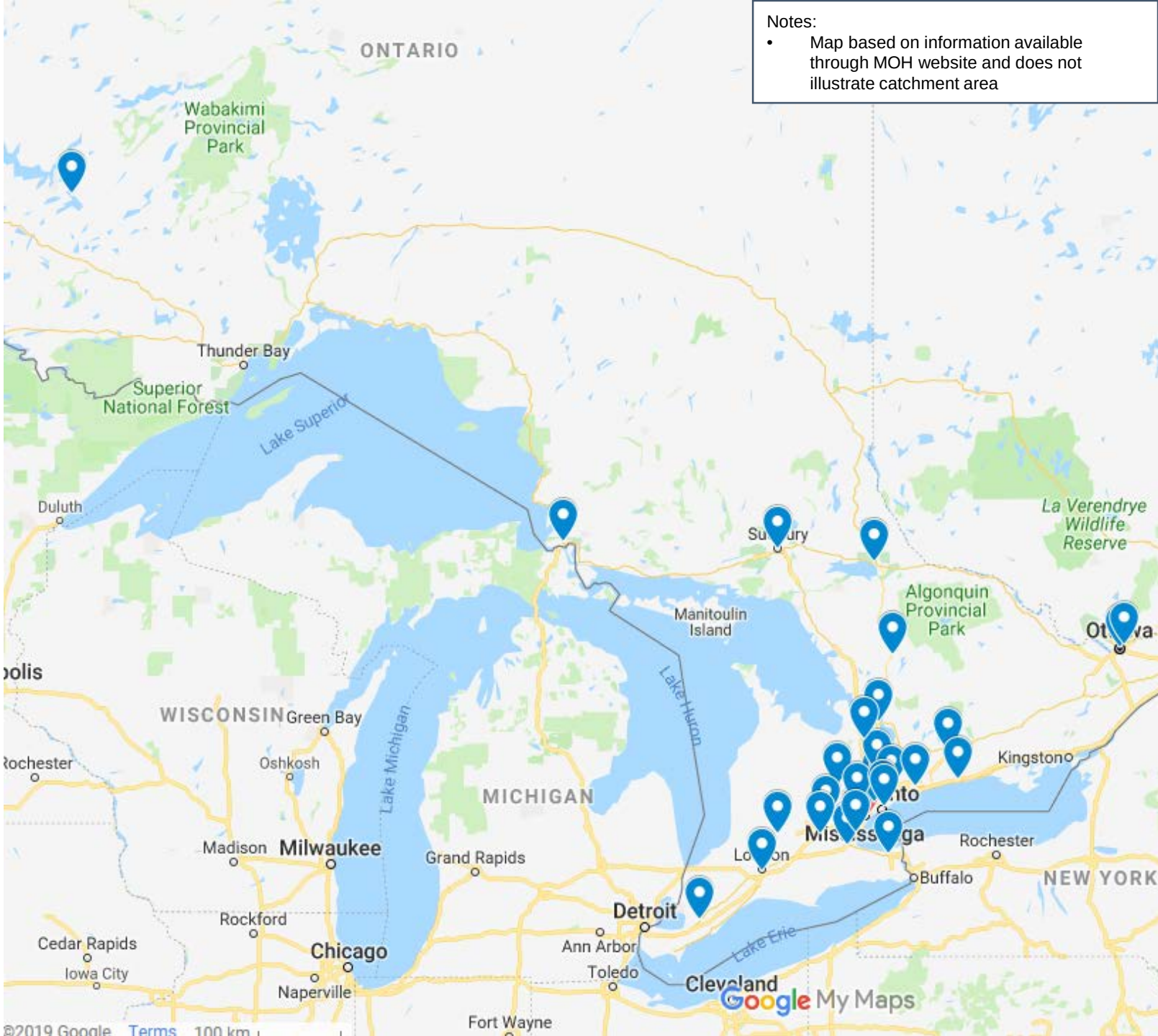
- WHEREAS, our organization would like to continue to plan to become a member in the future Mississauga Ontario Health Team

- BE IT RESOLVED, that the Board provides its in-principle approval to proceed with planning for membership in a manner that is consistent with our strategic plan, risk profile and financial obligations

# Appendix

# OHTs in Full Application

| Location | Team Name (Provisional) |
|---|---|
| Hunstville | Muskoka and Area OHT |
| Oakville | Connected Care Halton OHT |
| Orangeville | Hills of Headwater |
| Toronto - North West | North Toronto OHT |
| Richmond Hill | West York OHT |
| Toronto/North York | North York Central Health System OHT |
| Newmarket | Southlake Community OHT |
| Orillia | Couchiching OHT |
| Markham | Eastern York Region and North Durham OHT |
| Barrie | Great Barrie Area OHT |
| Guelph | Guelph and Area OHT |
| Mississauga | Mississauga OHT |
| Brampton | Brampton, Bramalea, North Etobicoke, Malton and West Woodbridge OHT |
| Peterborough | Peterborough OHT |
| Ottawa | Ottawa Health Team/Équipe Santé Ottawa |
| Cobourg | Northumberland OHT |
| Ottawa - East | ÉSO Ottawa-Est/Ottawa East OHT |
| Oshawa | Durham OHT |
| Kenora | All Nations Health Partners OHT (Kenora) |
| North Bay | Near North Health and Wellness OHT |
| Sault Ste. Marie | Algoma OHT |
| Sudbury | Équipe Santé Sudbury and Districts OHT |
| Toronto - North East | North Toronto OHT |
| Toronto/East York | East Toronto Health Partners |
| Hamilton | Hamilton OHT |
| Burlington | Burlington OHT |
| Stratford | Huron Perth and Area OHT |
| London | Western OHT (London) |
| Chatham-Kent | Chatham Kent OHT |
| Cambridge | Cambridge OHT |
| Niagara Falls | Niagara OHT |



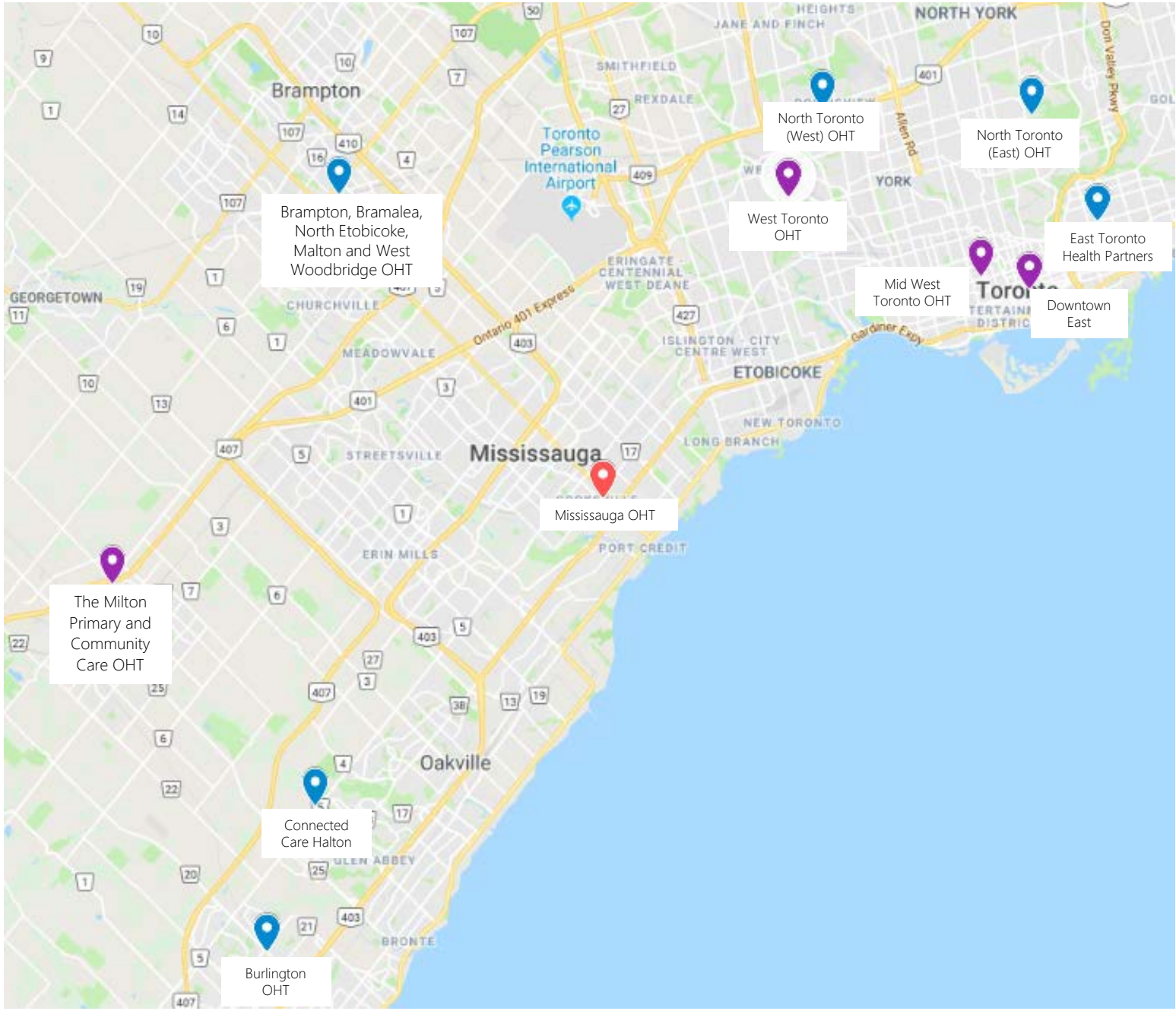
# OHTs Bordering M-OHT

OHTs in **Full Application** that are in the same vicinity as the M-OHT include:

- Brampton, Bramalea, North Etobicoke, Malton and West Woodbridge OHT
- Connected Care Halton
- Burlington OHT
- North Toronto (East) OHT
- North Toronto (West) OHT
- East Toronto Health Partners

OHTs **In Development** include:

- The Milton Primary and Community Care OHT
- West Toronto OHT
- Mid West Toronto OHT
- Downtown East

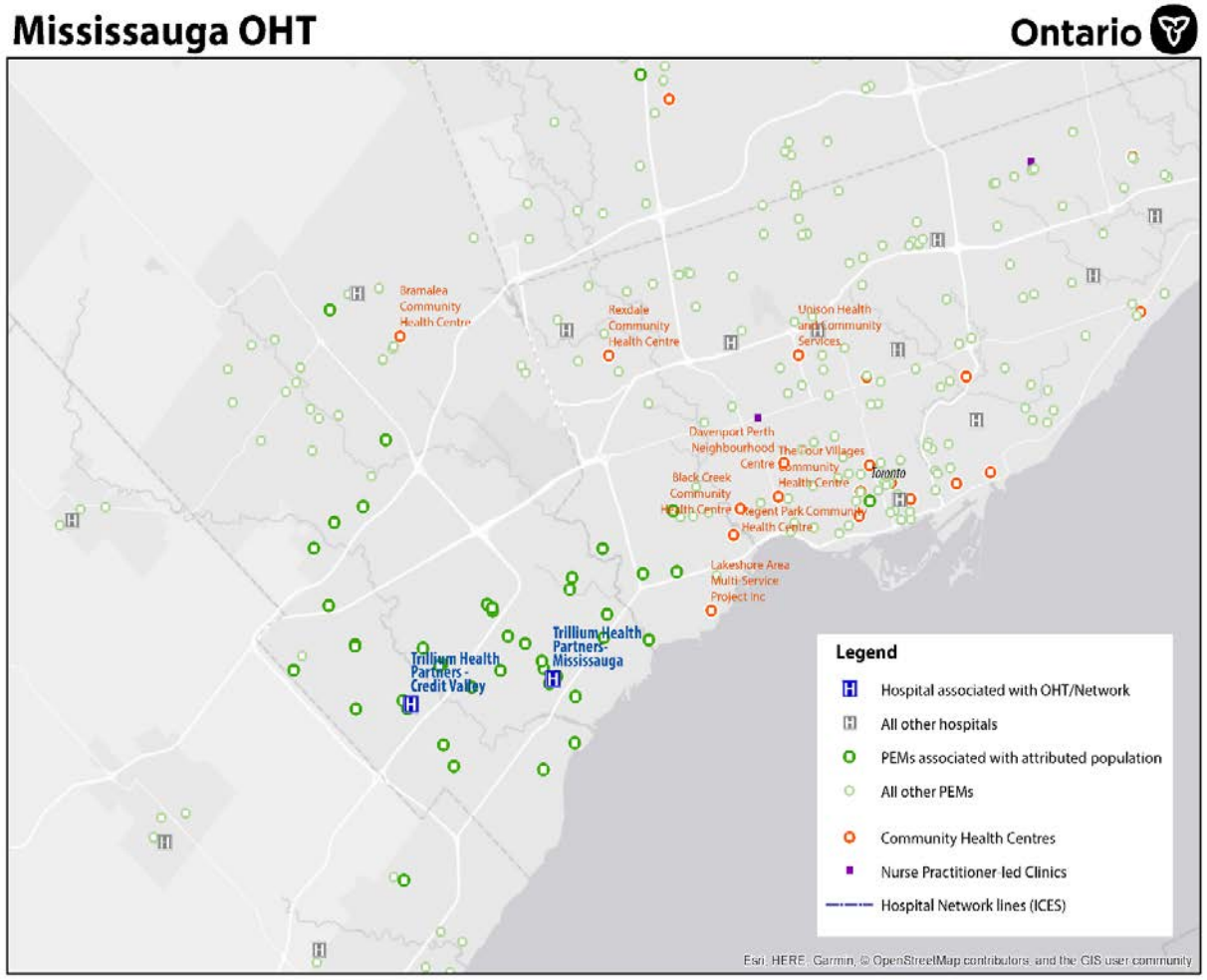


# Our commitments in Year 1

The Ministry has articulated a number of requirements for OHTs in Year 1. We have an opportunity to consider how this would unfold for us.

| | |
|---|---|
| **Defined patient population** | ✓ Access and service delivery targets met<br>✓ Plan in place to expand target population |
| **In-scope services** | ✓ Additional partners identified and engaged for Year 2<br>✓ Plan in place for expanding range and volume of services<br>✓ Primary care coverage for a significant proportion of the OHT population |
| **Patient partnership and community engagement** | ✓ Patient and community engagement strategy and patient relations processes in place |
| **Patient care and experience** | ✓ Redesign care for Year 1 patients and show improved performance against targets<br>✓ Every Year 1 patient has experienced coordinated care; zero cold handoffs<br>✓ Any Year 1 patient can access 24/7 coordination and system navigation services; public website in place |
| **Digital health** | ✓ Harmonized information management plan in place<br>✓ Expanded digital access for patients to their health information; expanded virtual care offerings<br>✓ Plan in place to streamline/integrate systems and to use data for population health management |
| **Leadership, accountability and governance** | ✓ Agreement with Ministry on service delivery and performance obligations<br>✓ Formal agreements in place between OHT partners<br>✓ Strategic plan and central brand in place for the OHT<br>✓ Physician and clinical engagement plan implemented |
| **Funding and incentive structure** | ✓ A single identified fund holder (for future integrated funding envelope)<br>✓ Refined understanding of population health care costs |
| **Performance measurement, QI, continuous learning** | ✓ Integrated QIP in place for the following fiscal year<br>✓ Progress made to reduce variation/implement standards or best evidence<br>✓ Complete and accurate reporting on required indicators<br>✓ Participation in central learning collaborative |

# Physician population




- 31 Primary Care Enrollment Models (PEMs) have been identified by the Ministry as within a physician referral network that is highly aligned to our OHT
- This includes both the Summerville and Credit Valley FHTs
- The majority of these PEMs are located in Mississauga or Etobicoke
- An additional 14 PEMs have been identified as partially within our referral network, but they also align to other OHT networks
- These are located in places like Brampton, Etobicoke, Toronto and Oakville, as well as in Mississauga

*The map shows all hospitals that are associated with the OHT/Networks, in addition to Primary Care Enrollment Models (PEMs), Community Health Centres and Nurse Practitioner-led Clinics.*

*'Hospital associated with OHT/Network' includes all hospitals that are partners in the OHT application as well as additional hospitals that are part of any of the Network(s) these hospitals belong to (based on analysis provided by IC/ES).*

# Identifying improvement opportunities

Healthy living and care across life-stages

Childhood → Adulthood → End of Life

| | Criteria | Minor Acute | | Adults with Chronic Disease (COPD or CHF**; to include a stream for comorbid mood disorder) | Seniors with Dementia | People at End of Life |
|---|---|---|---|---|---|---|
| | | Children's Mental Health | People with gastrointestinal/ genitourinary (GI/GU)* | | | |
| Impact | Prevalence | Medium | High | High | Low | Low |
| | Cost drivers and utilization | Low – Medium | Medium | High | High | High |
| | Addresses capacity constraints | Low | Medium | Low – Medium | Medium | High |
| | Timeliness to see change | Medium | High | Low – Medium | Medium | Medium |
| | Patient/caregiver experience | High | High | Low - Medium | High | High |
| Feasibility | Active clinical leadership | High | Medium | Medium | High | High |
| | Work underway | Low – Medium | Low | Medium | High | High |
| | Degree of change required | Medium | Medium | High | High | Medium - High |
| | Hospital readiness (Y1 engagement) | Medium | Medium | Low | Medium - High | Medium |
| | Primary care readiness | Medium | High | Low | Low | Medium |
| | Home care readiness | Medium | High (N/A) | High | Low | Medium |
| | Evidence-based and proven pathways | Medium | Medium | High | High | High |
| Partnerships | Builds foundation (core partners) | Medium - High | Medium | High | High | High |
| | Partners already involved | Low | High | Medium | 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

# Our co-design process