CREDIT VALLEY
Équipe de Santé Familiale • Family Health Team

CarePoint Health

SUMMERVILLE
Family Health Team

Mississauga Health
Partnering for your health

Ontario Health Team Readiness Assessment: In-Person Visit

November 7, 2019

Attendees: Mississauga Ontario Health Team Interim Governing Council and guests

Metamorphosis
Building your Community Health Network, Neighbourhood by Neighbourhood

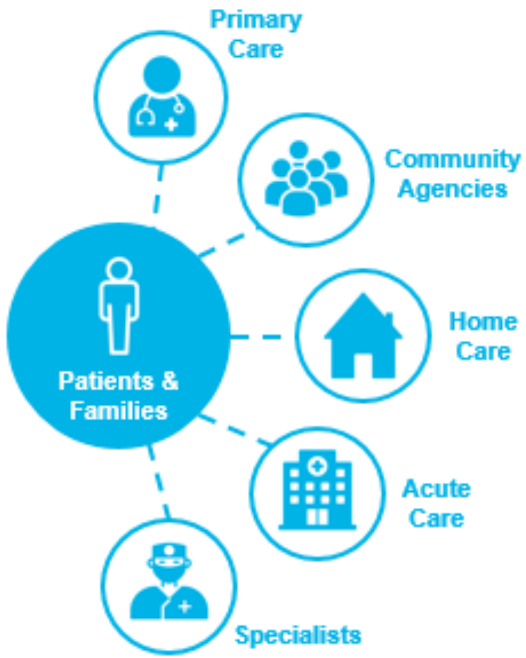
Trillium Health Partners
Better Together

Presentation outline

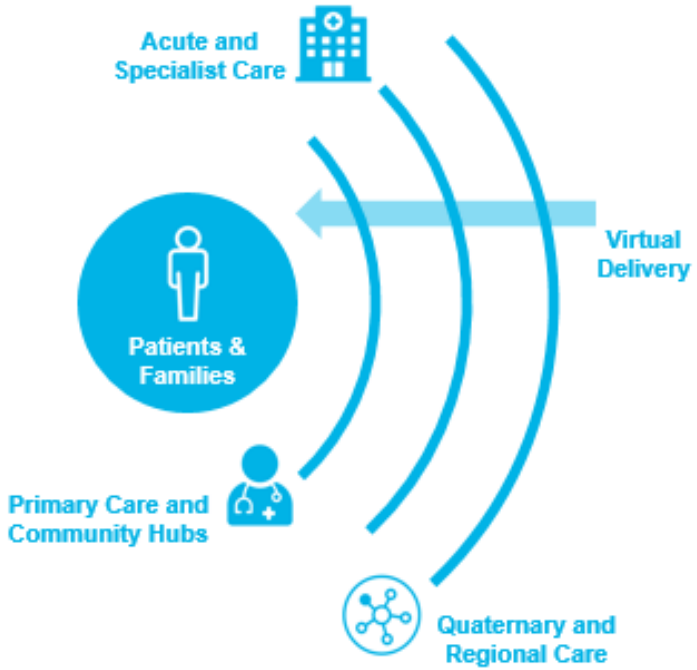
1. Overall vision and design principles for the Mississauga Ontario Health Team
2. Engagement strategies and approaches to date and moving forward
3. Implementation plan, including:
    - Our roadmap to maturity
    - Approach to service coordination and navigation
    - Approach to virtual care and digital health information
    - Shared decision-making frameworks and structures
    - Readiness to implement the plan
4. Anticipated successes in Year 1
5. Supports and enablers needed from the Ministry

Overall vision for our Ontario Health Team

Today



Tomorrow



Our vision

Together, our vision is to 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.

Care we provide will address physical, mental, social and emotional well-being, and will be reliable, high quality and grounded in exceptional experiences and sustainability, delivering on the Quadruple Aim.

Our population: **878,000 people** at maturity →

- Approximately 60% live in Mississauga and roughly 75% see primary care providers in Mississauga
- Another 35% live in neighbouring communities (e.g. Toronto, Brampton, Oakville) with 5% from other regions

Ontario Health Team design principles

1. Support the health of the **whole population**

- Work towards a full and coordinated continuum of services for our population at all stages of life, building over time across subpopulations
- Use a population health approach with data and evidence to focus on upstream prevention, predict trends and emerging issues, and apply a health equity lens

2. Create one **seamless** system

- One vision and brand and a culture of shared continuous improvement
- Structures to support shared accountability, including data sharing
- Implement evidence-based integrated care pathways for subpopulations across partners and standardize and digitally automate processes

3. Provide access to **holistic care**, with a foundation in Primary Care

- Establish interdisciplinary team-based care, with a point of contact for patients as needed through a core team
- Link patients to all services needed in the extended team, including home, community, specialists and social supports
- Create a seamless experience by embedding care coordination and 24/7 navigation as functions within primary care
- Create a single digital care plan for each patient, accessible and shared across providers, including communication and virtual care options

4. **Empower** patients and caregivers; deliver **exceptional experience**

- Patients know where to go for information and navigation on 24/7 basis
- Patients have access to digital options, including video visits and secure messaging; over time, access to patient portal
- Design a standard experience that will be kept consistent across members of the OHT
- Embed mechanisms to collect and respond to feedback

Built on a foundation of **engagement and co-design**, supported by **rapid learning** and **continuous improvement**

The Mississauga OHT engagement strategy

The Mississauga OHT members are committed to engagement and recognize that the community we serve is highly diverse. Our goal is to integrate care in a way that improves the health and well-being of all people in the population.

Engagement will be guided by a best practice framework that ensures we are intentional in design of initiatives and explicit about the goal of each as we build trust relationships with the full diversity of our community.

INFORM	CONSULT	COLLABORATE	CO-DESIGN
Share information to stakeholders in an accessible way; provide frequent and transparent updates, and centralize resources through the M-OHT website	Consult with the community so they have the opportunity to share feedback, for example through Tele-Townhalls; ensure mutual understanding of the M-OHT's objectives	Problem solve and validate new ideas to continually improve the care and services provided; work with stakeholder groups to identify issues/strategies for the OHT to focus on going forward	Co-design care to meet the needs of the community, including through opportunities to share in decision-making and implementation of proposed solutions

COMMUNICATION — **ENGAGEMENT**

Inform to Understand **Partnership, rapid learning, continuous improvement** *Partnering to Create*

All engagement will ensure an ongoing culture of continuous improvement to meet the needs of our community, and will adhere to our commitment to transparency, an openness to sharing and a willingness to adjust our approach throughout implementation based on feedback.

Engagement strategies: Patients, families and caregivers

To date

- Patients, families and caregivers have been embedded in M-OHT planning and decision making from the outset this spring and throughout Full Application development. Patients were represented at all levels of the interim governing structure
- Over 40 patient and family advisors were engaged in the application, including attending co-design sessions, providing feedback at meetings and completing a targeted survey. The MH LHIN PFAC signed on as affiliates, as did 7 patients

Going forward

Building upon our members' successful track record of engagement, the M-OHT is committed to recognizing patients, families and caregivers as partners in health care to ensure lived experience drives priorities for improvement and design.

INFORM

Share existing resources and supports through central M-OHT website, provide early and ongoing education opportunities for patients and caregivers, and proactively communicate to ensure awareness of any changes to care.

CONSULT

Establish a centralized, transparent and accessible patient relations process for all in-scope services that is informed by patients, families, and caregivers, including a process for timely response to patient complaints.

COLLABORATE

Leverage existing Patient and Family Advisory Councils (PFACs) across the partners to establish an M-OHT PFAC to streamline engagement processes for ongoing feedback.

CO-DESIGN

Embed and engage people with lived experience as equal members of the M-OHT's governance, including in care co-design working groups and the Governing Council, and design resources to meet user needs.

Engagement strategies: Primary care

To date

- As part of the self-assessment, the M-OHT engaged 95 primary care providers, many of whom are connected to the Integrated Primary Care Centre (IPCC) at CarePoint Health and the two FHTs
- Primary care was engaged for the Full Application through weekly targeted OHT meetings and engagement sessions held by the MH LHIN
- 80 people reviewed and provided feedback to the application in full, including more than 20 physicians in our community
- Our Interim Governing Council includes 4 members from the primary care sector (2 of which are current primary care providers); 7 physician groups/FHTs signed on as members to our OHT and 16 as collaborating physicians/groups

Going forward

Engaging clinicians early and often will continue to be central to the M-OHT's strategy. Through our members there is a foundation of evidence-based IPCC, and a focus of engagement going forward will be for the M-OHT to serve as a catalyst for modernization and organization of primary care in Mississauga, including through formation of a primary care network.

INFORM	CONSULT	COLLABORATE	CO-DESIGN
Work with the Primary Care Network in Mississauga as it is launched to keep providers informed and engaged. Spread the IPCC model through primary care advisors and their communication channels.	Consult on the change and stay abreast of the work of clinical associations to ensure messaging and approaches are aligned; work with neighbouring OHTs to discuss partnership opportunities and understand referral patterns.	Engage with PEMs and fee-for-service practices not yet connected to an IPCC to encourage involvement as a means of community-building, diversity, supportive networks, learning, practise facilitation, and back office consolidation.	Engage with Primary Care Network to ensure clinicians are engaged through all phases. Use a physician-champion model to help engage peers in change and ensure the voice and influence of primary care in the region is fully represented in the OHT.

Engagement strategies: Communities

To date:

- Over 200 individuals and community organization and associations attended stakeholder information sessions to hear updates, provide feedback and discuss membership; 75 individuals attended co-design sessions
- Engaged with community leaders and organizations that represent Indigenous, Francophone, newcomers (immigrant, refugee, ethnocultural and racialized) and 2SLGBTQ+, and met with representatives from eight organizations and associations to discuss the vision of the OHT
- Members of the Healthy City Stewardship Centre, including the City of Mississauga, signed on as affiliates. Other affiliates include groups representing Indigenous populations, Francophones and newcomers.

Going forward:

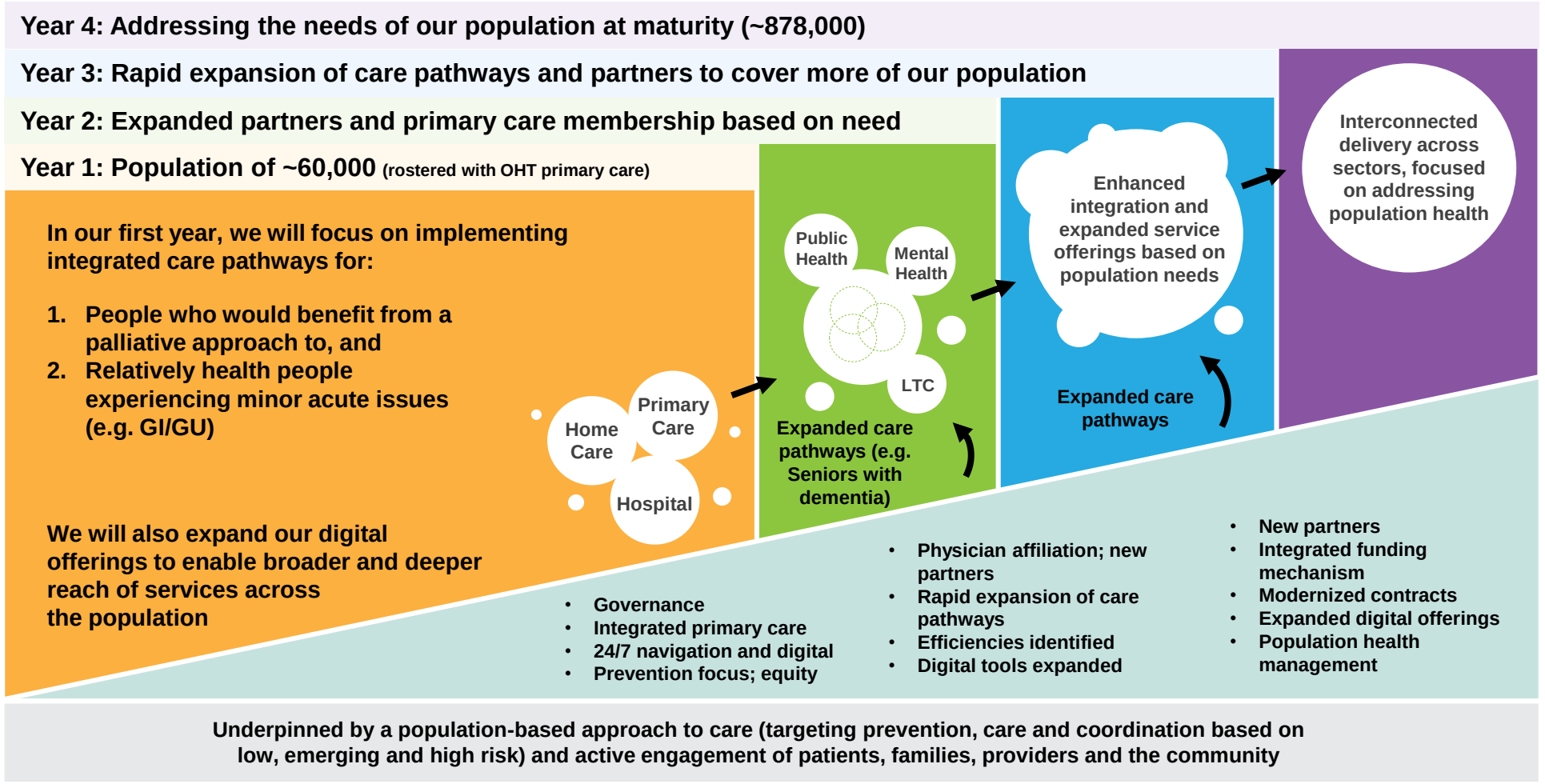
We will continue to engage with diverse stakeholders to challenge inequities and improve overall health and well-being of the community, including pursuing learning and training together on issues like cultural safety.

INFORM	CONSULT	COLLABORATE	CO-DESIGN
Scale and spread existing public awareness initiatives around clinical areas of focus through members' current marketing channels/resources; leverage these channels to share new initiatives as they are developed.	Consult with diverse community groups through townhalls to ensure service delivery, including system navigation, is culturally and linguistically appropriate and meets their unique health and social needs.	Build relationships with representatives across vulnerable population subgroups; develop health equity plan through engagement of multi-disciplinary, cross-sectoral partners and diverse and underserved communities.	Invite community groups to participate in co-design of the integrated care pathways and future training and education for leaders and providers; use the Health Equity Impact Assessment (HEIA) tool to continually inform our approach.

Implementation plan: Our roadmap to maturity

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



Note: Our roadmap is dependent on pace of related government changes (e.g., labour relations and funding)

Identifying improvement opportunities

We considered several opportunities to improve health outcomes and the quadruple aim, based on the health status of our population and patterns of health service usage. Opportunities were evaluated based on the following criteria, assessed through data and engagement with subject matter experts.

1. 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

2. Feasibility

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

3. Partnerships

Builds a strong foundation with our core partners through early, quick wins; sets up 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

Healthy living and care across life-stages

Childhood → Adulthood → End of Life

	Criteria	Children's mental health	People with minor acute issues (gastrointestinal/ genitourinary)	Adults with Chronic Disease (COPD or CHF; to include a stream for comorbid mood disorder)	Seniors with dementia	People who would benefit from a palliative care approach
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

Note: The five sub-populations considered are shown in the columns above

Implementation plan: Year 1 subpopulations of focus

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 subpopulations within our Year 1 population (60,000) where we see the greatest, feasible opportunity for impact so we can build a foundation of trust over time.

Subpopulation	Rationale for Focus	Year 1 Change Ideas
 **People who would benefit from a palliative approach**	• Estimates suggest that approximately 75% of people approaching the end-of-life may benefit from palliative care. [1] • **46% of people who die in our region do so without receiving any palliative care**.[2] Only a third of people received a physician home visit(s) in the last 30 days of life.[3] • **About two-thirds of Ontarians would prefer to die at home**, yet over 55% of people in our region had one or more ED visits in the last 30 days of life and 65% died in hospital.[2,3] • Costs reach nearly $1B per year for those that would benefit from a palliative approach to care, with a high proportion at end-of-life.[2] • Establishes a strong foundation for integrated care for future design.	1. Access for patients to interdisciplinary team-based care, including a core team and extended services 2. Standardized trigger for early identification of palliative care needs 3. Documented and regularly reassessed Goals Of Care and an End Of Life plans, sharable across the care team 4. A designated key contact (within the core team) 5. Palliative awareness and education for broader population (including Advance care planning)
 **People presenting with minor acute issues (e.g. gastrointestinal and genitourinary conditions)**	• **Over 60% of our population has at least one minor acute health care-related visit in a given year**.[2] • These highly prevalent issues can often be effectively managed in the community, but without access to supports/diagnostics, people are often required to visit the ED and/or incur duplicate visits and tests. • Minor acute GI/GU issues (such as UTI, constipation, gastritis) are among the top reasons for an ED visit. In the Year 1 population, **we anticipate up to nearly 1,300 ED visits for minor GI/GU issues.[2]** • In addition to fragmented care, this results in millions in ED costs. [2] • Builds the resources and links in the community for primary care to support primary care; enhances trust between sectors.	1. People have appropriate access to health care services for urgent needs (including in person/virtual primary care) 2. Primary care providers have access to urgent diagnostics to support patient care management 3. Primary care can access same-day advice or timely follow-up from specialists (e-consult, phone or ambulatory care clinics)

[1]Etkind et al. 2017. BMC Medical
[2]ICES Administrative Data Holdings, 2019.
[3]Health Quality Ontario. Palliative Care at End of Life, 2016.

Implementation plan: 24-7 care coordination

Our Vision: Through an integrated primary care team that knows each patient best, people with complex medical or social needs have access to 24/7 care coordination services.

Year 1 Implementation: Focusing in particular on patients with complex palliative care needs, we will implement the following care coordination approaches, functions and digital supports in M-OHT integrated primary care teams

A member of the core team (registered health professional) will be designated as the most responsible person for care coordination; to serve as a point of contact for patients and families and stay connected to them throughout their journey.

All team members will play a role in coordination, but the contact will be expected to:

- Support care planning and provision
- Arrange and track internal and external services
- Communicate and coordinate across the core and extended teams
- Assist patients in accessing services (e.g. LTC, ODSP applications)

Implementation plan: 24-7 navigation services

Our Vision: People will have access to both 24-7 navigation through their integrated primary care teams, as well as centralized (more general) navigation services through the broader OHT. Over the long-term, this will include a centralized scheduling and referral database across the OHT.

Year 1 Implementation*: We will implement the following care navigation services; these may be particularly relevant for the minor acute subpopulation (e.g. GI/GU) as they access specialists, lab services, and other clinical care. Those with more complex needs may find they require care coordination support.

Care Navigation

24-7 on-call group for support (8 pm to 8 am)

Embedded in the integrated primary care team, care navigation services are provided by non-clinical team members with training and appropriate access to patients' electronic medical record.

Services will include:

- Connecting patients to health/social services and service providers
- Supporting centralized referrals and referral tracking
- Addressing inquiries
- In future, supporting referrals using appropriate decision tools

Centralized Navigation (Year 1)

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Pamphlet **Website**

To include information on:

- Providers in the M-OHT network
- Services available
- Other general information

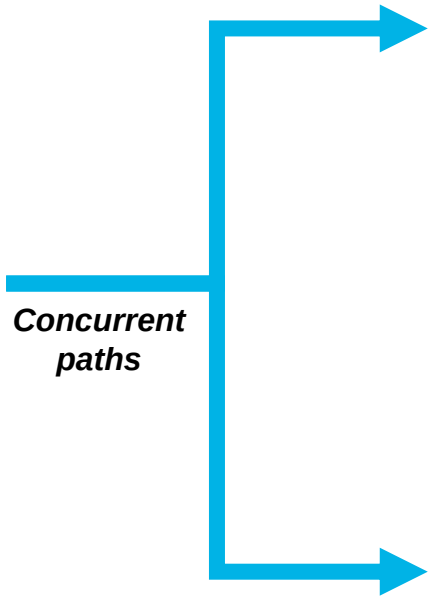
**Expansion of care navigation services in primary care beyond Year 1 would require additional investment*

Implementation plan: Expanded virtual and digital offerings

Digital tools are key to enabling the M-OHT to create a seamless system for patients and providers that is reliable and supports both active care management and population health management.

Our Approach

- Build off existing digital tools and provincial assets in order to achieve year 1 goals
- Develop a longer term digital strategy for modern, standard solutions across the OHT



Year 1

For the initial Year 1 population rostered with primary care, we will:

- Leverage existing digital tools to improve access to care through digital approaches (e.g. virtual care and a patient portal to schedule visits)
- Establish processes and procedures to ensure patient consent and privacy when sharing information across providers

For palliative approach to care pathway:

- Implement solution to support sharing of care plans for palliative patients between M-OHT team members, levering existing assets

Planning for Year 2 and Beyond

To plan for Year 2 and beyond, we will develop a digital strategy that will include:

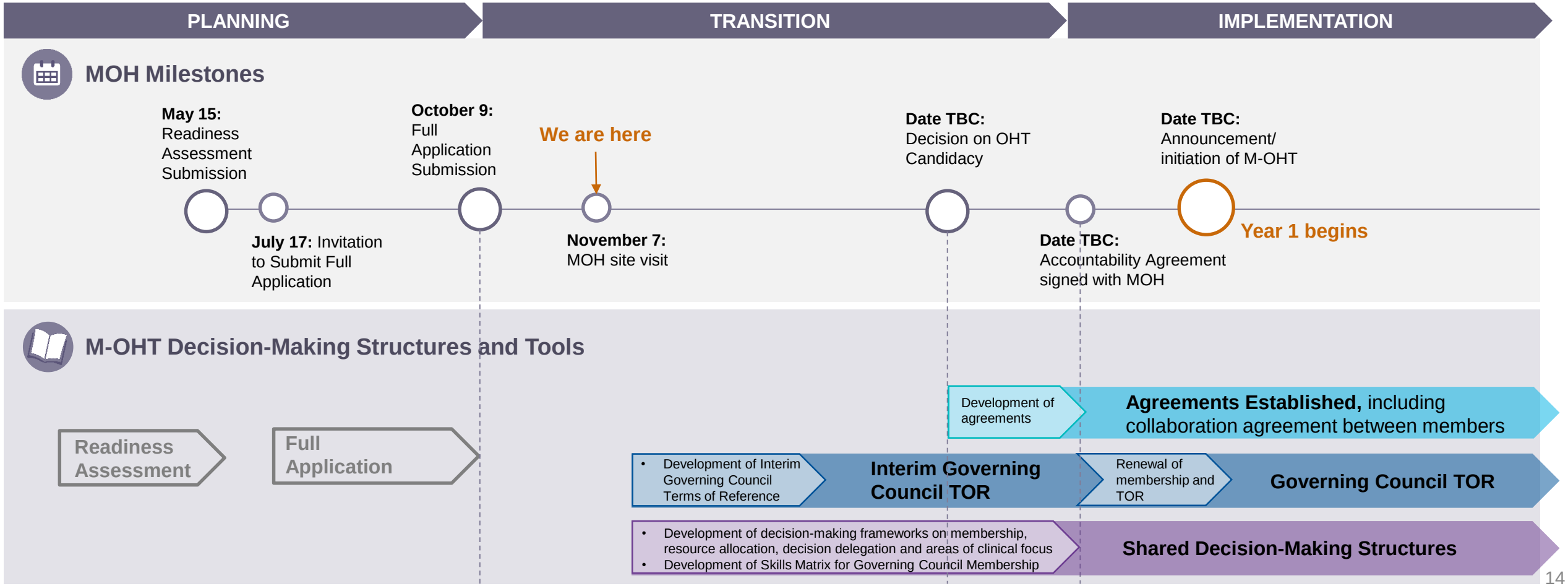
- Establishing a set of principles that would guide digital investment across the M-OHT
- Establishing a common digital maturity framework across members
- Seeking standard and integrated solutions, where feasible, including a common EMR or the fewest number of EMRs with integrating functions between them
- Collaborating and innovating to maximize our value through procurement

Proposed work would require additional investment

Implementation plan: Shared decision-making frameworks

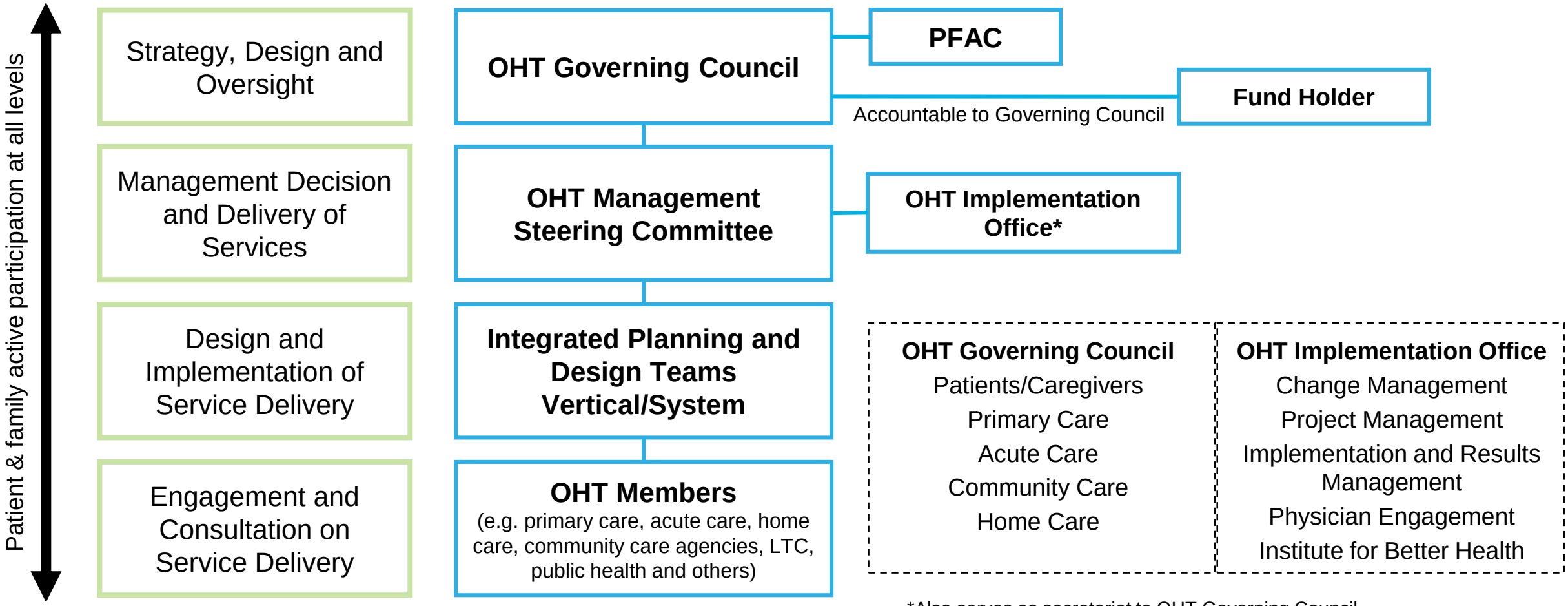
To date, the Interim Governing Council has engaged widely and used a consensus-based approach to inform decision-making. Boards of respective Signatory Members have demonstrated their commitment by signing onto the Full Application. The Interim Governing Council will now work to establish Terms of Reference, as well as decision-making frameworks to guide future resource allocation, OHT membership and clinical areas of focus.

It will also develop collaboration agreements for Year 1 members involved in implementation and a skills matrix for the future Governing Council, to be established following the transition phase.



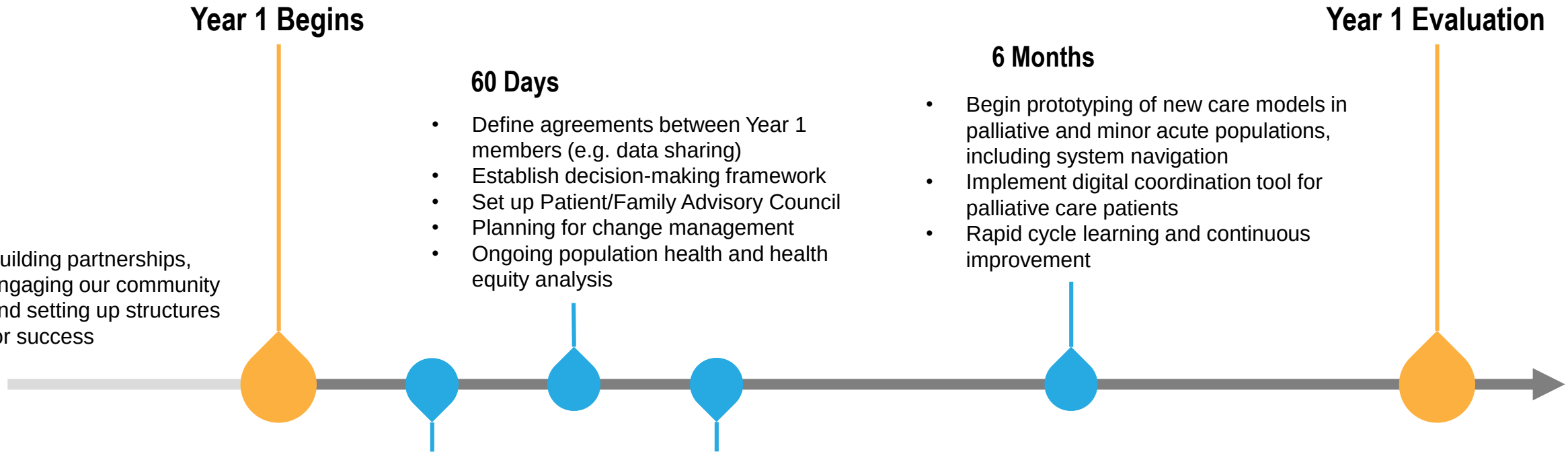
Implementation plan: Governing Council structure

Through engagement and consultation, the M-OHT has designed the following governance structure to be initiated at the start of Year 1. Until transition to this structure, the Interim Governing Council will support decision-making and establishing frameworks for future decisions.



*Also serves as secretariat to OHT Governing Council

Implementation plan: Proposed Year 1 outlook



Note: Proposed year 1 outlook is dependent on pace of related government changes (e.g., labour relations and funding)

Implementation plan: Readiness to implement against Year 1 milestones

Category	Progress to date	Milestones for Year 1
Defined patient population/services	✓ Target population for Year 1 identified ✓ Analytics completed on maturity and Year 1 populations ✓ Early targets (e.g. for volumes) defined ✓ Year 1 services identified; expansion roadmap created	• Detailed targets developed related to service delivery and access • Detailed plan for service expansion defined • Service inclusion/exclusion criteria developed in detail for care pathways • Partnership strategy for future years developed • Data and information-sharing in place to monitor Year 1 population • Ongoing population health management and data strategy developed
Patient partnership and community engagement	✓ Patient/family advisors on interim governance structures ✓ Patients and families engaged as part of all planning ✓ Engagement begun with key groups (Indigenous, FLS)	• Patient declaration of values embedded • Patient relations process in place • Engagement plan developed and executed for key community groups
Patient care and experience	✓ Subpopulations of focus determined ✓ High-level change ideas designed through engagement	• Changes implemented in primary care to establish interdisciplinary team-based care, navigation and coordination services • Care pathways (palliative, minor acute) designed and implemented • Detailed population health management approach developed • Pamphlet distributed to Year 1 population; website established • Outcome and experience measures in place (PREMs and PROMs)
Digital health	✓ High-level approach, targets and metrics established ✓ Initial costing completed	• Digital solutions in place for online scheduling of in-person primary care visits, secure messaging, and video visits for Year 1 population • Data sharing agreements established; digital strategy developed to guide our Year 2 and beyond (e.g., standardized, integrated digital solutions)
Leadership, accountability and governance	✓ Interim Governing Council in place ✓ Clinicians engaged in all governance and planning ✓ Future governance structure developed ✓ Central brand designed ✓ Single fund holder identified	• Agreements developed and signed; Implementation Office formed • Governing Council in place, including representation from patients and clinicians • Central brand and strategic plan developed • Patient and Family Advisory Committee struck; engagement framework complete • Detailed clinician engagement plan developed and executed
Performance measurement, QI, and continuous learning	✓ Early goals/targets determined ✓ Lessons learned from Regional Integrated QIP	• Integrated planning and design teams in place to measure performance of Year 1 and plan for Year 2 and beyond; • Ongoing monitoring of Year 1 improvement metrics (via PROMs and PREMs); • Reporting processes established; integrated QIP developed

Note: Proposed year 1 milestones are dependent on pace of related government changes (e.g., labour relations and funding)

Anticipated successes in Year 1

In the long-term, we hope to see improvement across Quadruple Aim indicators and a reduction in hallway medicine. In Year 1, we hope to achieve the following:

Support the health of the whole population

- ✓ All 60,000 individuals in our Year 1 population have the opportunity to benefit from integrated care

Create one seamless system

- ✓ Partnerships are strengthened across members involved in Year 1 through successful implementation of proof-of-concept integrated care pathways
- ✓ Additional partnerships are enhanced and new ones built with key groups in the community, including Indigenous, Francophone and newcomer

Access to holistic care, with a foundation in Primary Care

- ✓ Care pathways implemented have the opportunity to impact as many as 18,500 people or 30% of our Year 1 population (2% of our population at maturity)
- ✓ More patients who would benefit from a palliative approach to care are assessed for their palliative needs, have a care plan in place and are using digital coordination tools
- ✓ More patients with minor acute needs are receiving virtual consults with their primary care providers and have fewer repeated tests

Empower patients and caregivers; deliver exceptional experience

- ✓ Patients in our Year 1 subpopulations of focus have improved experiences and outcomes (as measured through PREMs and PROMs)
- ✓ Virtual care services reach at least 5% of people in our Year 1 population (current estimates suggest 9%)
- ✓ As many as 18% of people will have access to some form of their health information digitally

Note: Proposed year 1 successes dependent on pace of related government changes (e.g., labour relations and funding)

Supports from the Ministry and other partners

Financial and Human Resources

Two rounds of OHT design and development have required both financial and in kind investments during a time of unprecedented service pressures. We believe strongly in this opportunity, but need a sustained approach to resourcing further phases. We are keen to work with government to identify existing regional and community based resources that could be leveraged to achieve the OHT model.

Resources are particularly required to support the following:

Primary Care: To free up existing primary care capacity for 24/7 coordination, re-prioritization of existing work may be required; additional human resources are needed to enhance service navigation (leveraging existing HR capacity in the system).

To expand the Integrated Primary Care Centre model beyond Year 1, additional investments will be needed.

Digital: $450,000 in initial seed funding would be needed to leverage existing assets and accomplish the changes outlined in our proposal.

Virtual care options are contingent on MOH ensuring that OTN's Home Video Visits program is sufficiently resourced to enable physicians to be reimbursed for virtual care.

Management Capacity: If OHT is ultimately meant to hold contracts and distribute funding for all health service providers in region, significant infrastructure will be required.

If responsibility for home care moves under the OHT, similar resources will be needed to manage capacity.

Supports from the Ministry and other partners (continued)

Structural and System Changes

The pacing and financial costs of implementation will both be contingent on fundamental changes to the system, including to legislation, asset transfers, existing delivery structures, funding and procurement models.

Labour Legislation: Our current health human resource complement in the system is sufficient, but existing labour legislation will pose challenges in implementing integration.

Data Sharing: To enable sharing, collecting and retaining PHI for purposes of administering an OHT, the Ministry should consider amendments to PHIPA.

Information, Guidance and Communications

Increased Clarity: Further guidance on decision-making, reporting and funding is needed. This includes both how existing agreements/structures will be managed through transition, and information about desired future state.

Clarity on accountability required to inform organizations as they make decisions on membership. Understanding of potential impacts to organizations' charitable status would also be helpful.

Communications and Engagement: During this time of transition, the Ministry's support for communications and engagement would be helpful.

For the broader public:

- Communications and messaging to understand OHTs.

To support clinician engagement:

- a greater understanding of the providers in the OHT network and support for outreach.

Toolkits/Resources: Useful tools and resources to support implementation include: draft agreements, privacy impact assessments, and decision-making frameworks. Support on best practices/strategies to manage funding will be integral.

From other OHTs, sharing lessons learned and best practices to enable coordination and standardization.

A continued point of contact with MOH.