Ontario Health Teams

Presentation to the Long-Term Care COVID-19 Commission

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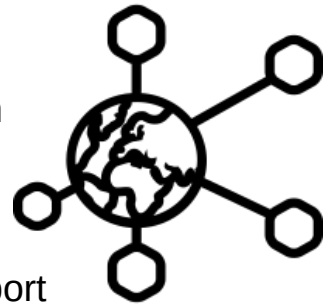
Learning from Jurisdictions, Setting our Own Path

Across the industrialized world, governments face similar challenges:



- Many providers across multiple care sectors, results in gaps in care, duplication and lack of coordination
- Over-reliance on hospitals and under-reliance on primary care
- Little attention to self-management and preventative health care
- Poorly aligned financial incentives that locks value into silos, and does not support care integration

In response, Integrated and Accountable Care Systems have been emerging that share the following features:

- Organizations share financial and clinical accountability for quality of care, experience and total costs of care for their patients
- Services are integrated, focused on and driven by primary and community care
- Payment methods and incentives are built to deliver value, not simply pay for volume
- Flexible approach that allows for innovation and tests of changes

In Ontario, we have been learning from other jurisdictions' implementation of these integrated systems and created an Ontario-based model of care called **Ontario Health Teams**

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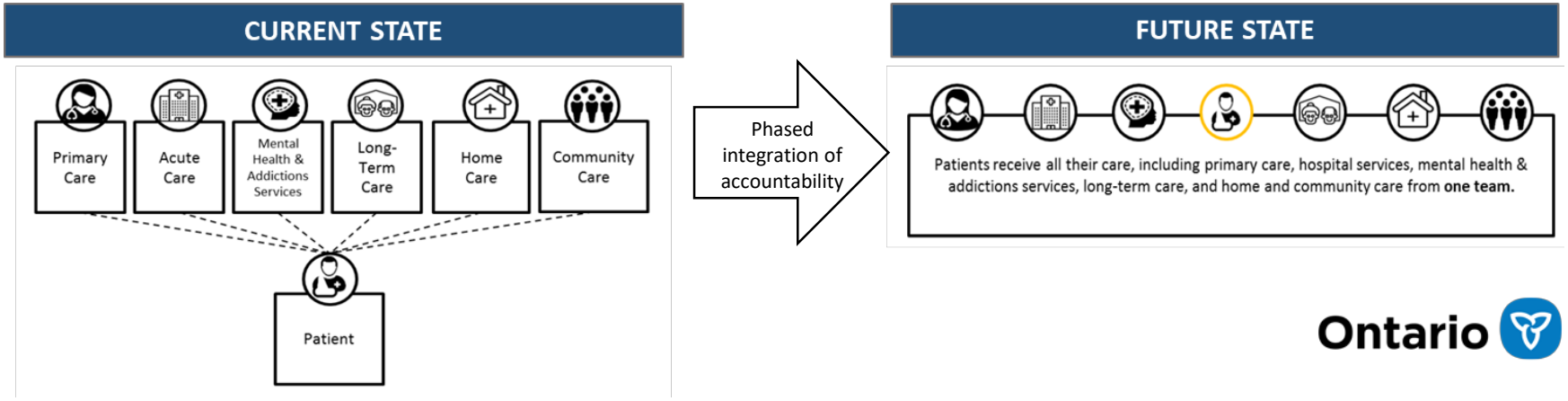
Ontario Health Teams: An Overview

In April 2019, *The People's Health Care Act, 2019* received Royal Assent. The legislation enacts a new statute (the *Connecting Care Act, 2019)* which establishes Ontario Health Teams as a new model of health care organization, funding and delivery.

- Ontario Health Teams (OHTs) are a new model of integrated care delivery that will enable patients, families, communities, providers and system leaders to work together, innovate, and build on what is best in Ontario's health care system.
- Through this model, groups of health care providers will work together as a team to deliver a full and coordinated continuum of care for patients, even if they're not in the same organization or physical location.
- As a team, they will work to achieve common goals related to improved health outcomes, patient and provider experience, and value.
- Current funding and accountability mechanisms (e.g. service accountability agreements between LTCHs and LHINs) will remain in place for the near term.
    - In addition to fiscal and clinical accountability to funders, OHT members are accountable to each other under the terms of their preliminary OHT governance arrangements (Collaborative Decision-Making Arrangements)
- The goal is to provide better, more integrated care across the province.



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Ontario Health Teams Vision for Integrated Care

At maturity, every Ontarian will have access to an OHT that will:

- ✓ Provide a **full and coordinated continuum of care** for an attributed population
- ✓ 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 performance framework based on the 'Quadruple Aim'
- ✓ Operate within a **single, clear accountability** framework and funded through an **integrated funding** envelope
- ✓ Have better access to secure digital tools, including online health records and **virtual care options** for patients

Successful OHTs will be defined by their ability to provide fully-integrated care to a distinct patient population in a way that delivers on the quadruple aim:

Better patient & population health outcomes

Better patient, family, & caregiver experience

Better provider experience

Better value & efficiency

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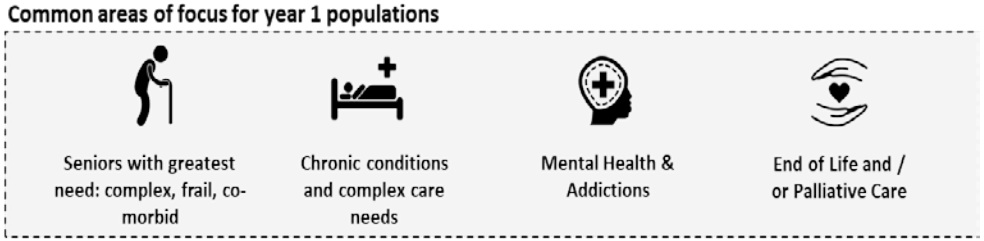
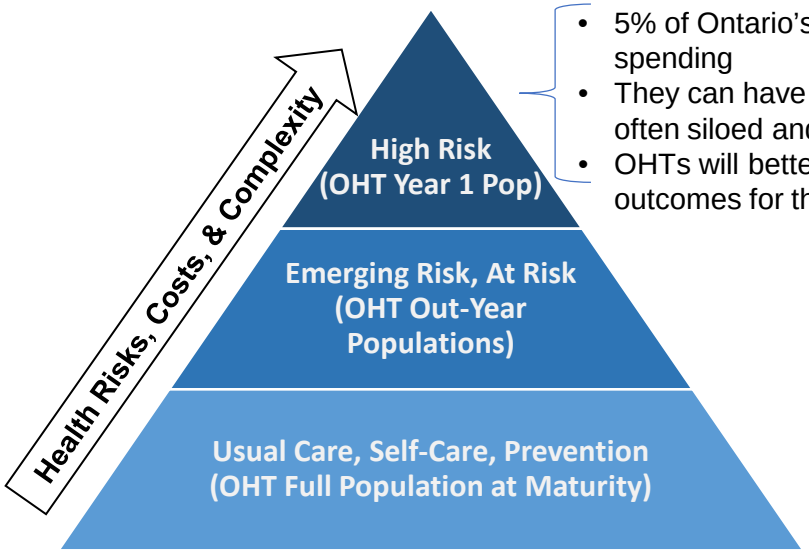
OHTs and a Transition to Population Health Management

OHTs will transition from siloed, sector-based approaches, to managing the health of a population.

- OHTs will work to achieve specific targets related to the care experiences and health outcomes for their year 1 priority populations
- They will then build on these experiences by **steadily expanding** their reach in later years, with the goal of eventually optimizing care experiences and outcomes for their full population





Modified Kaiser Permanente Population Health Management Pyramid

- 5% of Ontario's patients account for 65% of health care spending
- They can have **16+ different** health care providers who are often siloed and disconnected
- OHTs will better connect care to improve experiences and outcomes for these patients

Strengthening Partnerships Through OHTs

Groups of providers will work together as one team to deliver a full and coordinated continuum of care and will be responsible for the health outcomes of their patients.

- Building collaborative governance and accountability relationships requires trust and takes time.
- Under the OHT model, sectors that may not have always worked closely together are expected to come together formally around a shared vision for the health of their population.
- Collaborative decision making structures, shared clinical pathways, unified strategic plans, and integrated quality improvement and patient engagement plans are just some of the common elements that OHTs are expected to put in place.
- The maturity of these partnerships and the formal arrangements that govern them will influence the timing of moving to a fully integrated model of funding and accountability. At this mature state, which will be phased in over time, the accountability relationship will be between Ontario Health and each OHT.
- Enabling OHTs to develop these partnerships is critical to ensuring collaborative relationships and decision-making across providers so that, at maturity, OHTs can provide a full and coordinated continuum of care and be responsible for the health outcomes of the entire population that they serve.
    - The ministry has issued guidance related to collaborative decision making that sets out expectations of OHTs based on their current formative stage of their journey (see appendix).

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OHTs & Long-Term Care

- As set out in the *Ontario Health Teams: Guidance for Health Care Providers and Organizations,* at maturity, OHTs are expected to provide a full and coordinated continuum of care for a defined patient population, including long-term care (LTC) home placement services.

- 26 of the 29 approved OHTs* have identified one or more LTC partners.

- The Ministry of Health recognizes that the involvement of LTC homes in OHTs can be strengthened.
  - Many teams that have identified LTC partnerships would continue to benefit from increased LTC participation
  - Some teams have noted systemic barriers for change that exist within the LTC sector

- The Ministry of Health continues to work with its partners, including the Ministry of Long-Term Care (MLTC), to identify opportunities to support OHTs in expanding/increasing their LTC partnerships and capacity.
  - For example, the MLTC has been and continues to be involved in the review of new OHT applications.

**See Appendix A for the list of current OHTs*

Ontario Health Team Journey to Date

- In early 2019, OHTs were introduced as a new model to integrate health care delivery.
- By early January 2020, 24 OHTs had been approved to begin implementation and over 50 teams were actively advancing their readiness to form OHTs.
- The Ministry of Health has undertaken a review of 15 recently submitted applications and will announce new teams shortly.

April 18, 2019 – Bill 74 passed and receives Royal Assent

February 26, 2019
The Ontario government introduces Bill 74: *The People's Health Care Act*, 2019

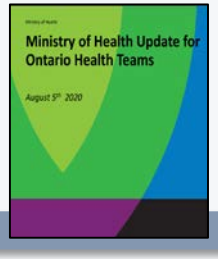
May 15, 2019
First call for OHT applications; Over 150 submissions received from across the province

November 25 – December 9, 2019
24 approved OHTs announced

March 2020 - COVID-19 Pandemic hits Ontario

December-February, 2020
New submissions & progress reports received

July 2020
17 teams invited to full application, 5 additional teams approved, Implementation, funding announced, Ministry releases guidance on collaborative decision-making



Aug 5, 2020
Minister's webinar to reaffirm commitment to achieve provincial coverage

November 2020
Announce new OHTs

24 Teams

29 Teams

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OHTs' Response to COVID-19

The OHT model will evolve over time based on learnings from those first implementing the model.

- Over the past several months, OHTs have demonstrated remarkable responsiveness to the COVID-19 outbreak.
- OHT-based partnerships have been leveraged to support a variety of COVID-19 response activities within the LTC sector, including:
  - Collaboration between partners to share hospital learnings about Infection Prevention and Control with LTC homes, which proved essential when responding to COVID-19
  - Creating and mobilizing volunteer emergency response teams to support LTC homes in need of staffing support
  - Establishing local COVID-19 tables to bring together and strengthen relationships across sectors, including the LTC sector
  - Collaborating across sectors to develop evacuation plans to support rapid and safe transfer of patients in the event of a large-scale outbreak in LTC homes
  - Establishing regional warehouses to coordinate the supply of personal protective equipment (PPE) across sectors, including LTC
  - Providing support to ascertain critical staffing needs and access to necessary supports and associated training for LTC staff
  - Expediating the implementation of virtual care initiatives for LTC (and other sectors).
    - Transitioning to virtual and phone appointments for those discharged from ED or inpatient units, referrals from the community (GPs) and LTC homes
    - Transitioning hospital ED visits to virtual visits for patients from LTC homes who present with certain conditions (e.g. heart failure, fever)

OHTs' Response to COVID-19: Key Takeaways

Feedback from the field (some noted below) has reinforced widespread commitment to the OHT model, with teams indicating a desire to move forward with OHT implementation. Teams have all shared the various ways in which their OHT partnerships enabled an integrated COVID-19 response.

Cross-provider partnerships and innovative methods of care delivery are critical success factors, e.g.:

- The formation of partnerships across sectors have been a key success factor in OHTs' ability to effectively respond to the COVID-19 pandemic and has affirmed their planned partnerships.
- The initial OHT structures that teams had in place allowed physicians to collaborate much more strongly and feel more supported by local partners.
- COVID-19 has emphasized the importance of primary care engagement and has highlighted examples of effective primary care partnerships and leadership.

Resources and partnerships established through the five Regional tables supported a coordinated approach for COVID-19 response, and OHT implementation, by:

- Leveraging local and regional partnerships to streamline acquisition and distribution of pandemic supplies.
- Moving and keeping patients outside of hospitals via partnerships with home and community care and primary care providers.
- Creating new care pathways and care patterns for at-risk patients.

The ministry has heard that it should remain flexible with work planning in recognition of the uncertain trajectory of COVID-19, and offer implementation supports. As a result the ministry is:

- Reassessing implementation expectations in light of the ongoing pandemic response and the sector capacity that will be critical to preserve moving forward.
- Developing tailored supports to address the immediate needs of teams at all levels of readiness. These may include activities such as communities of practice, webinars, physician engagement, knowledge translation, and coaching.

Applying Lessons Learned: OHT Implementation Policy and Program Updates

Lessons learned from teams to-date have informed refinements to OHT implementation considerations. This has included:

I. Adjusting the application process to become an approved OHT to:
   - Reflect current sector capacity constraints and priorities due to COVID-19, including simplifying the full application to make it less burdensome.
   - Through the revised full application, encourage teams to explore efforts to engage with public health and congregate care settings, including long-term care, that will allow them to leverage partnerships that support regional responses to COVID-19 and deliver the entire continuum of care for their patient populations.

II. Publishing MOH Guidance on OHTs' establishment of Collaborative Decision Making Arrangements (CDMAs) and set expectations for those CDMAs (see appendix).

III. Providing one-time funding of up to $1.125M to each approved team to support OHT capacity and help build momentum for implementation.

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Appendix

Appendix A: Ontario Health Teams with Long-Term Care Partners

The following approved OHTs identified one or more LTC partners in their Full Applications

Cohort 1 OHTs

1. Connected Care Halton OHT
2. Hills of Headwaters Collaborative OHT
3. Northwestern Toronto OHT
4. Western York Region OHT
5. North York Toronto Health Partners
6. Southlake Community OHT
7. Couchiching OHT
8. Guelph and Area OHT
9. Mississauga OHT
10. Muskoka and Area OHT
11. Brampton/Etobicoke and Area OHT
12. Peterborough OHT
13. Ottawa OHT
14. Ottawa East OHT
15. Northumberland OHT
16. Durham OHT
17. All Nations Health Partners
18. Near North Health and Wellness OHT
19. Algoma OHT
20. Hamilton OHT
21. Burlington OHT
22. Huron-Perth and Area OHT
23. Western Ontario OHT
24. Chatham-Kent OHT
25. Cambridge North Dumfries OHT
26. Niagara OHT

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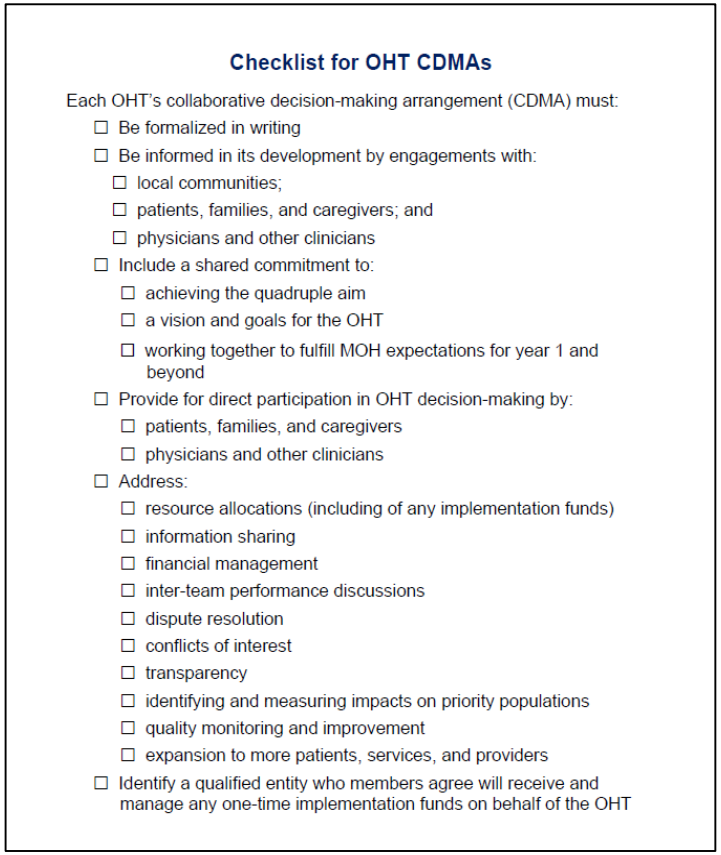
Appendix: Supporting OHTs to Establish Collaborative Decision-Making Arrangements

- On July 24 the MOH issued *Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System* ('CDMA Guidance Document').
- The CMDA Guidance Document set outs MOH expectations of OHTs in their early phases of implementation, and supports OHTs in establishing and documenting effective, self-determined, and fit for purpose decision-making arrangements.
- The development of CDMAs will enable leaders from different organizations to successfully engage in deliberative, consensus-oriented decision making to achieve shared goals, accountabilities, and opportunities for improving patient care.
- Establishing CDMAs is an early step in the maturation of relationships between OHT members, and OHTs' internal governance arrangements are expected to progress over time in preparation for integrated accountability, which will be phased in over time based on the maturity of OHTs and Ministry/OH readiness.



Checklist for OHT CDMAs

Each OHT's collaborative decision-making arrangement (CDMA) must:

- ☐ Be formalized in writing
- ☐ Be informed in its development by engagements with:
  - ☐ local communities;
  - ☐ patients, families, and caregivers; and
  - ☐ physicians and other clinicians
- ☐ Include a shared commitment to:
  - ☐ achieving the quadruple aim
  - ☐ a vision and goals for the OHT
  - ☐ working together to fulfill MOH expectations for year 1 and beyond
- ☐ Provide for direct participation in OHT decision-making by:
  - ☐ patients, families, and caregivers
  - ☐ physicians and other clinicians
- ☐ Address:
  - ☐ resource allocations (including of any implementation funds)
  - ☐ information sharing
  - ☐ financial management
  - ☐ inter-team performance discussions
  - ☐ dispute resolution
  - ☐ conflicts of interest
  - ☐ transparency
  - ☐ identifying and measuring impacts on priority populations
  - ☐ quality monitoring and improvement
  - ☐ expansion to more patients, services, and providers
- ☐ Identify a qualified entity who members agree will receive and manage any one-time implementation funds on behalf of the OHT

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