



Mississauga
Health
Partnering for your health

Overview of Mississauga Ontario Health Team
Full Application
October 17, 2019

Where we are now

- The Ministry of Health invited the Mississauga OHT to submit a Full Application for October 9, 2019, along with 30 other applicants.
- Thanks to the engagement and support of many in its development, we have successfully submitted our plan for an OHT in Mississauga.
- The purpose of this presentation is to provide an overview of the Full Application content, including our model and vision for the future, the members of our team, and where we are going together.

Ministry's 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

How we got here

- Over 200 people, including patients, families and local providers, shaped our submission for an OHT in Mississauga
- Over 100 individuals attended the stakeholder information sessions on August 23rd and September 23rd to hear updates, provide feedback and discuss membership
- Approximately 75 people attended co-design sessions on August 27th, including patients and family, primary care, acute care, home care and community partners
- Over 40 patient and family advisors were engaged, along with community associations and organizations, including cultural centres and organizations representing vulnerable groups
- Primary care providers were engaged to develop an organized primary care network
- We engaged experts in population health, implementation science, innovation, IT and ethics
- Over 80 individuals provided a detailed review of the Full Application across five partner locations



Thank you for helping to shape the future of health in this region!

Who we are - members to date

Our founding partners

Primary Care

Credit Valley FHT
Summerville FHT
CarePoint Health

Hospital

Trillium Health Partners

Home Care

Home care

Community

Metamorphosis Network of 45
Agencies

Our members include those who intend to be involved in day-to-day operations and deliver services for the OHT.

Acclaim Health and Community Care Services
Alzheimer Society of Peel
Bayshore HealthCare Ltd.
Calea Ltd.
Canadian Addiction Treatment Centres
CarePartners
CarePoint Health
CBI Health Group
Centre francophone du Grand Toronto
Closing the Gap Healthcare Group Inc.
Comprehensive Care FHG
Credit Valley FHT
Dixie Bloor Neighbourhood Drop-In Centre
The Dorothy Ley Hospice
Epilepsy South Central Ontario
Etobicoke Services for Seniors

Health Espresso Inc.
Heart House Hospice Inc.
Home Care Proxy
Hope Place Centres
iCare Home Health
Kingsbridge FHO
March of Dimes
Mindbeacon Health Inc.
MyHealth Partners Inc.
North Oakville FHG
Nucleus Independent Living
Peel Addiction Assessment and Referral Centre
Peel Cheshire Homes Inc.
Peel Senior Link
Polycultural Immigrant and Community Services

Regional Municipality of Peel
S.E.N.A.C.A. Seniors Day Program Halton Inc.
SE Health Care
Seniors Life Enhancement Centres
Sienna Senior Living
South Oakville FHO
Spectrum Home Care Corporation
SRT MedStaff
Summerville FHT
Think Research Corporation
Thrive Group
Trillium Health Partners
Trillium Health Partners ProResp
VHA Home HealthCare
Victorian Order of Nurses for Canada - Ontario Branch

Who we are - affiliates to date

Affiliates include those that have endorsed, supported or provided advice to the OHT but are not central to day-to-day operations of the OHT. This may include contracted services.

AstraZeneca
Canadian Mental Health Association Peel
Dufferin
CANES Community Care
Cardiovascular Health Awareness Program
(CHAP)
City of Mississauga
Community Foundation Mississauga
Dufferin-Peel Catholic District School Board
Hypercare
The Indigenous Network
The Institute for Better Health
Lakeshore Area Multi-Services Project (LAMP)
- East Mississauga Community Health Centre
Lifemark Health
Links2Care
Medigas / Praxair Canada Inc.

MICBA Forum Italia Community Services
MINT Memory Clinics
Mississauga Board of Trade
Mississauga Halton Diabetes Support Group
Mississauga Halton Local Health Integration
Network Patient and Family Advisors Network
Mississauga Halton Palliative Care Network
Mississauga West, Oakville and Burlington
Diabetes Support Group
MOYO Health and Community Services
Nurse Next Door
Ontario Community Support Association
Ontario Telemedicine Network
Paramed Inc. / Extendicare
Pediatric Urgent Care Centre
Peel District School Board

Peel Multicultural Council
Peel Newcomer Strategy Group
Peel Police Services
Peel Public Health
Regional Geriatric Program of Toronto
Services and Housing in the Province
Sheridan College
Support & Housing Halton
Shifa Health
Trillium Health Partners Division of Palliative
Care
United Way of Greater Toronto
University of Toronto Mississauga
Services and Housing in the Province
West Park Healthcare Centre
Yee Hong Centre for Geriatric Care
YMCA of Greater Toronto

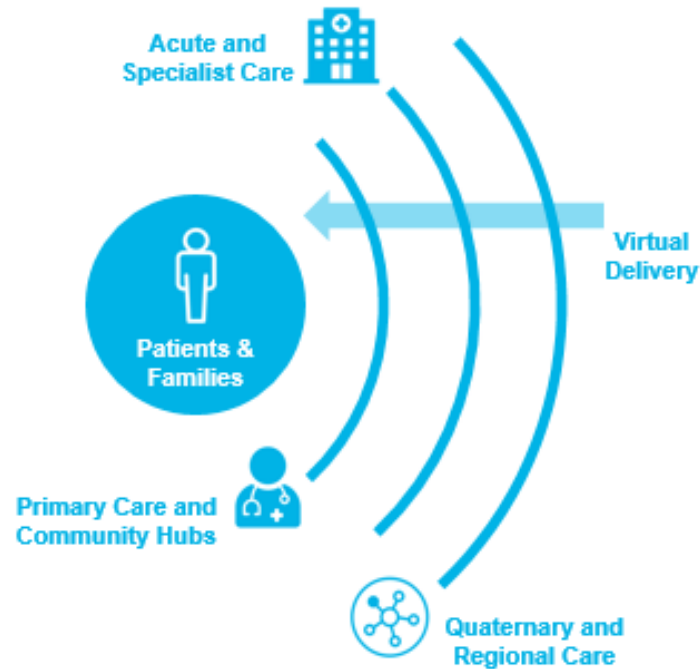
Affiliate organizations are listed above. Affiliates also include collaborating physicians and individual patient and family advisors. Affiliations are non-binding at this time and subject to procurement rules.

Our model for an Ontario Health Team in Mississauga

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 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
- Another 35% live in neighbouring communities (e.g. Toronto, Brampton, Oakville) with 5% from other regions

Design principles for the Mississauga OHT



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, provide targeted services, and apply a health equity lens



2. Create one **seamless** system

- One vision and brand and a culture of 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 and specialists
- 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**

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 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

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

Note: The three selected sub-populations have been shown in the columns above

Subpopulations 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, feasible opportunity for impact so we can build a foundation of trust over time.



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

- At some point in their lifetime, most people will be diagnosed with a life-limiting illness and would benefit from a palliative approach.
- However, **46% of people who die in our region do so without receiving any palliative care.**¹ Only a third of people who are palliative received a physician home visit(s) in the last 30 days of life.²
- **About two-thirds of Ontarians would prefer to die at home**, yet over 55% of people who are palliative in our region had one or more ED visits in the last 30 days of life and 65% died in hospital.^{1,2}
- 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.¹
- This presents an opportunity to build the foundation of a holistic approach to care, focusing on the whole person and crossing disease-states, and building upon existing, evidence-based work in the region.



Rationale: People presenting with minor acute issues (e.g. gastrointestinal and genitourinary conditions) (Phase 1)

- **Over 60% of our population has at least one minor acute health care-related visit in a given year.**¹
- These highly prevalent issues can often be effectively managed in the community. However, due to a lack of access to supports or diagnostics, people are often required to visit the ED and/or incur duplicate visits and tests. In fact, 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 acute GI/GU issues.**¹
- In addition to fragmented care, per year, millions in ED costs for the full population are incurred as a result.¹
- This presents an opportunity to improve experiences and strengthen care in the community - a critical foundation for OHTs



Seniors with dementia (Phase 2)

This will be a key area of focus in the longer-term, leveraging prototypes developed in Phase 1.

¹ICES Administrative Data Holdings, 2019.

²Health Quality Ontario. Palliative Care at End of Life, 2016.

Current and future state

Subpopulation #1: 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, Congestive Heart Failure (CHF).

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 continues her care being led by the 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 care coordination and navigation**. After hours, navigation and access to urgent care is provided through her primary care team on-call service. 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.

Current and future state

Subpopulation #2: People with minor acute needs (e.g. GI/GU)



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 through her primary care office.
- 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.

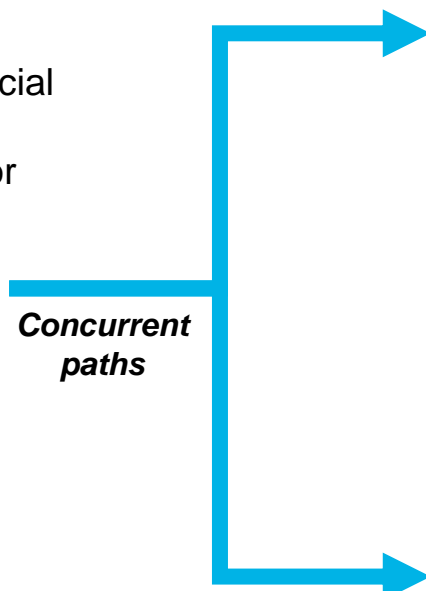
Enabling a seamless system through digital tools

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

Concurrent paths



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:

- Solution to support sharing of care plans for palliative patients between M-OHT team members, leveraging 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

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

Year 4: Addressing the needs of our population at maturity (~878,000)

Year 3: Rapid expansion of care pathways and partners to cover more of our population

Year 2: Expanded partners and primary care membership based on need

Year 1: Population of ~60,000 (rostered with OHT primary care)

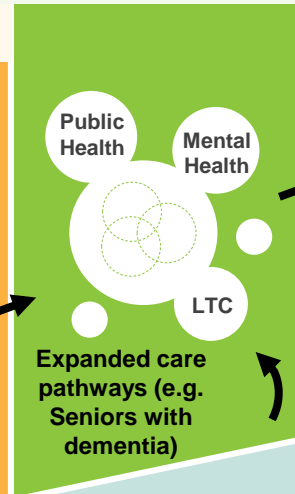
In our first year, we will focus on implementing integrated care pathways for:

1. People who would benefit from a palliative approach to, and
2. Relatively health people experiencing minor acute issues (e.g. GI/GU)

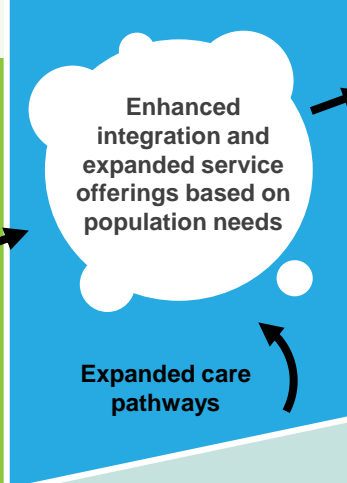
We will also expand our digital offerings to enable broader and deeper reach of services across the population



- Governance
- Integrated primary care
- 24/7 navigation and digital
- Prevention focus; equity



- Physician affiliation; new partners
- Rapid expansion of care pathways
- Efficiencies identified
- Digital tools expanded



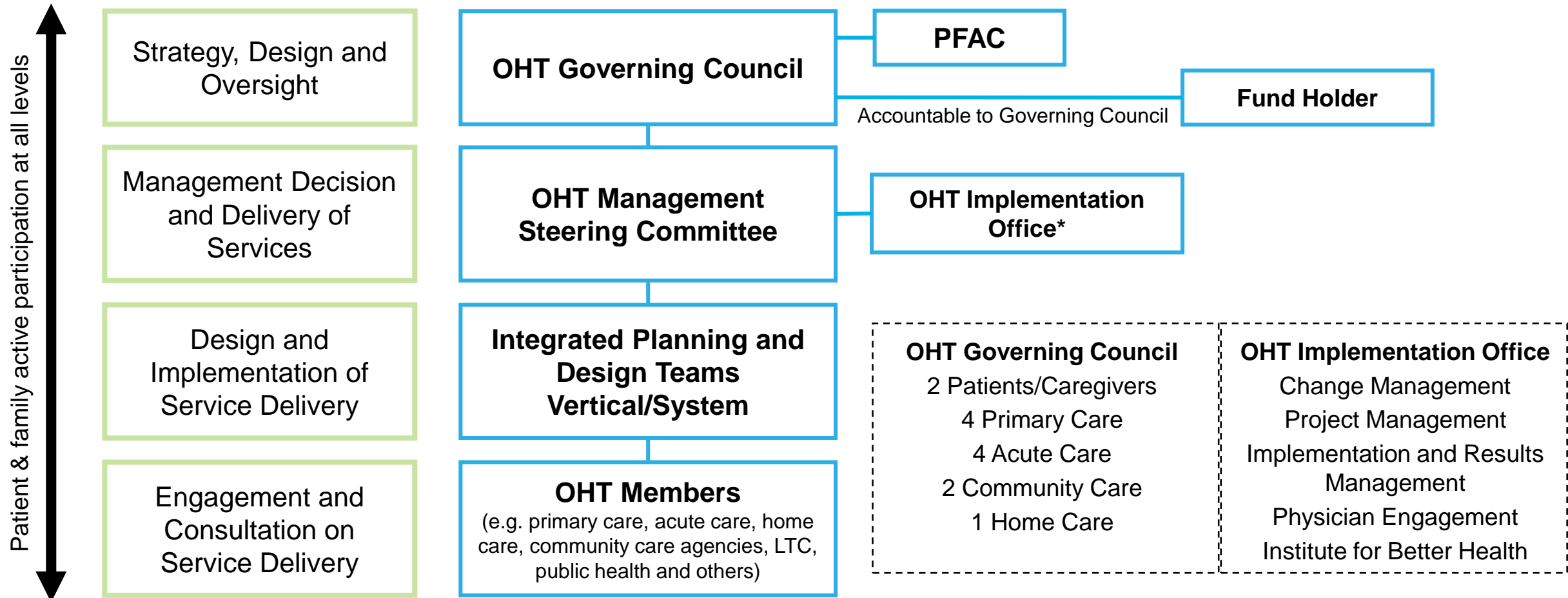
- New partners
- Integrated funding mechanism
- Modernized contracts
- Expanded digital offerings
- Population health management



Underpinned by a population-based approach to care (targeting prevention, care and coordination based on low, emerging and high risk) and active engagement of patients, families, providers and the community

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

M-OHT governance structure



*Also serves as secretariat to OHT Governing Council

Proposed year 1 outlook

Year 1 Begins

60 Days

- Define agreements between Year 1 members (e.g. data sharing)
- Establish decision-making framework
- Set up Patient/Family Advisory Council
- Planning for change management
- Ongoing population health and health equity analysis

6 Months

- Begin prototyping of new care models in palliative and minor acute populations, including system navigation
- Implement digital coordination tool for palliative care patients
- Rapid cycle learning and continuous improvement

Year 1 Evaluation

30 Days

- Establish Governing Council and leadership
- Set up Implementation Office and Working Groups
- Initiate detailed implementation and clinical plans

90 Days

- Carry out ongoing detailed partnership planning and design engagement strategies
- Design detailed workflows, and pathways for implementation, including navigation and patient relations process
- Establish key performance metrics
- Initiate development of digital solutions (resources required) and planning for future
- Establish service-level agreements, as needed

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

Next steps

1) Ministry Process

- Ministry plans to announce successful OHT candidates in fall 2019
- This will outline next steps for OHTs across the province
- We will inform all members and affiliates as we know more

2) Your Ongoing Support

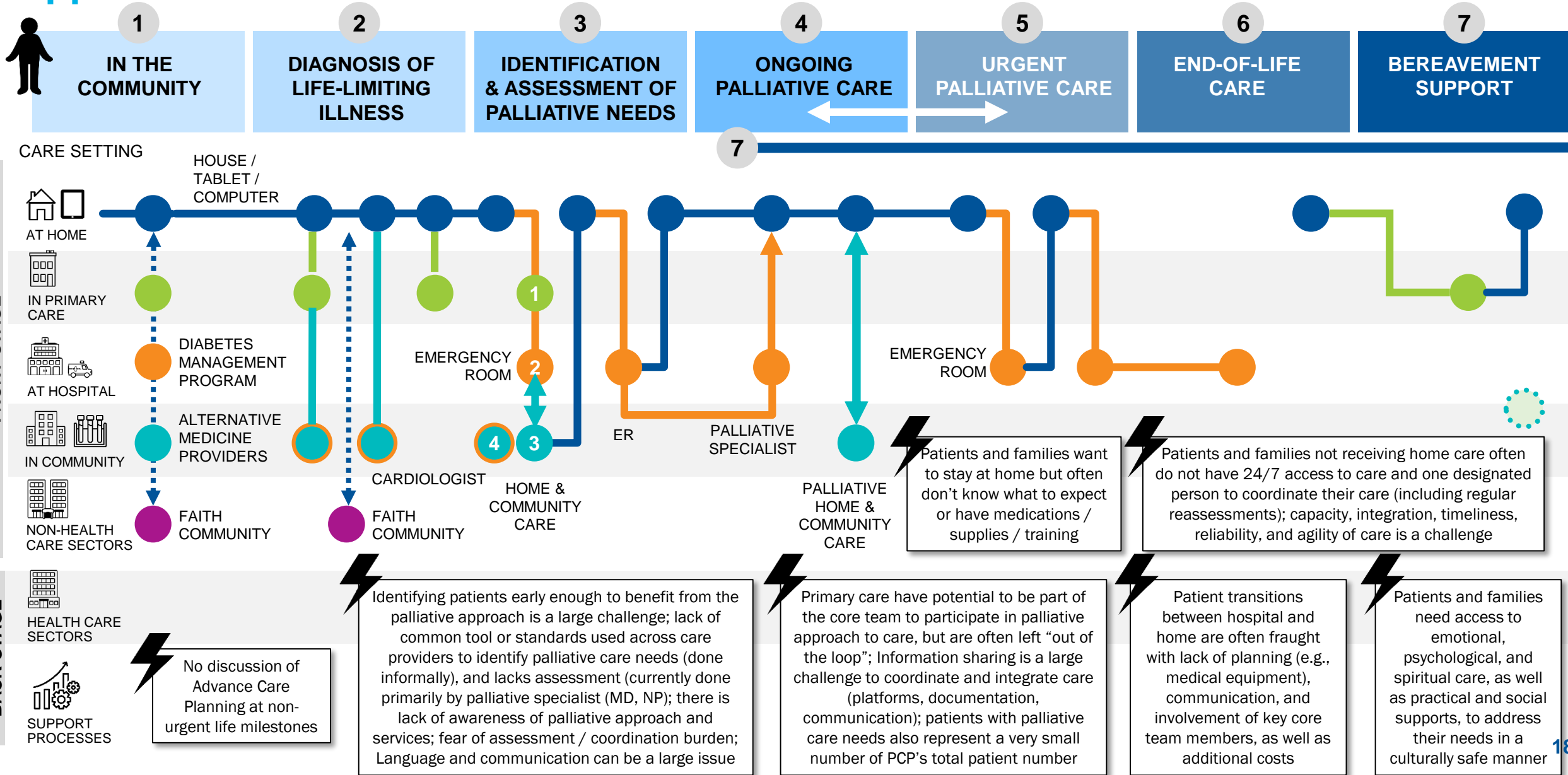
- Please continue to share your feedback, comments, questions and ideas with us
- Contact us at info@moht.ca or visit moht.ca to learn more

Appendix

Year 1 Service Blueprints & Change Ideas

Service blueprints were designed to understand how patients interact with each sector of the health care system and to understand the challenges inherent in the current state and opportunities for the future state

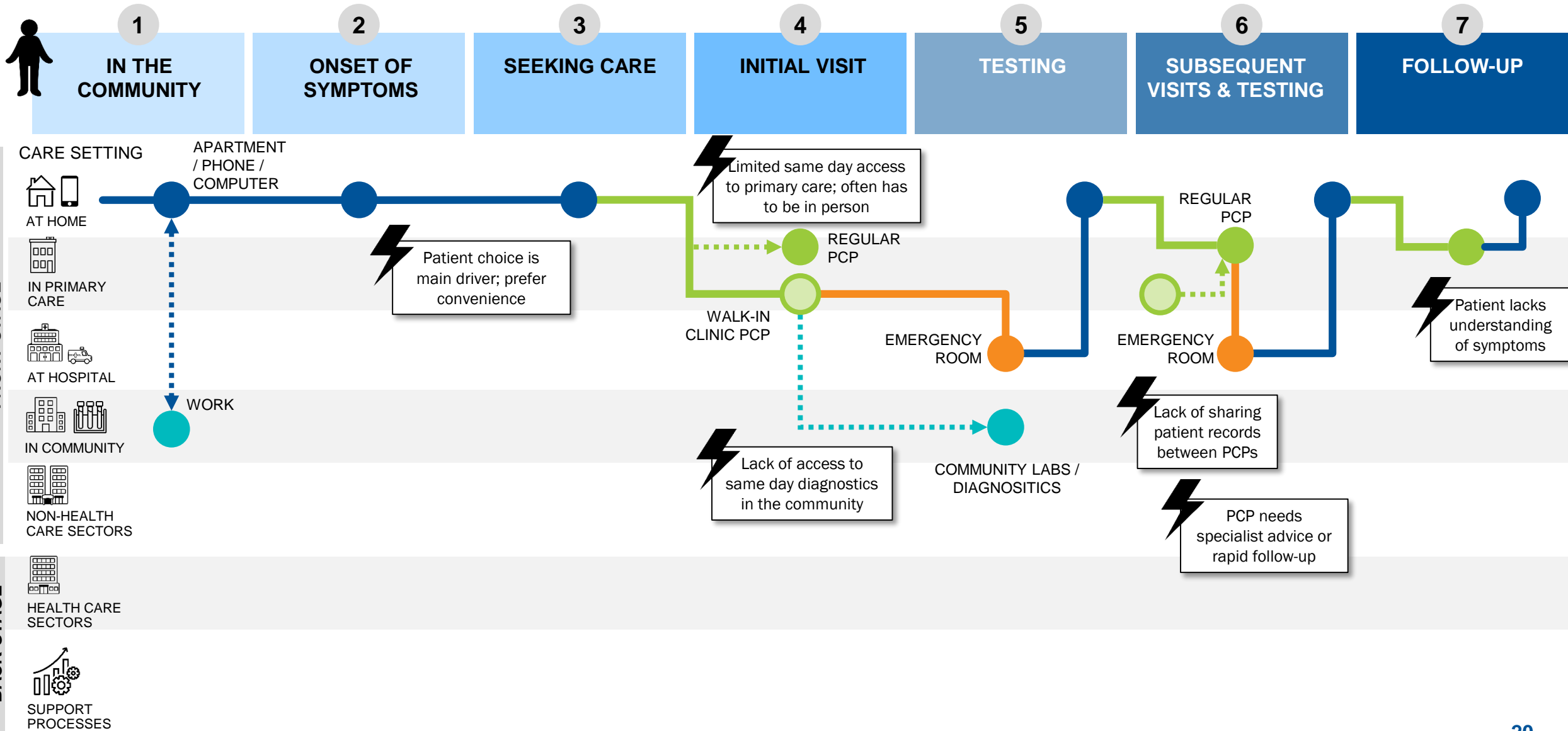
Current state service blueprint, for people who would benefit from a palliative approach to care



Year 1 change ideas: people who would benefit from a palliative approach

- **Advance Care Planning:** Use digital tools to prompt individuals rostered with primary care, with a focus on those with chronic conditions, to engage in advance care planning with their providers. This would include a prompt to speak to loved ones and clinicians about wishes and values informing end-of-life care; identify a substitute-decision-maker.
- **Early Identification:** Work with primary care providers to implement standardized triggers within EMRs to enable early ID of potential palliative care needs. All members of a patient's core team would be expected to play a role in early ID.
- **Integrated, Team-Based Care:** Link patients in the Year 1 population who would benefit from a palliative approach to care to a core interdisciplinary team in primary care. The team would work with patients to develop goals of care and support end-of-life planning. Identify a member of the core team to serve as a key contact. While all core members support care coordination, key contact holds overall accountability for seamless care coordination, supported by the team including administrative supports. Extended services would be included as an extension of the core team, including palliative care specialists and a bundled approach to home care.
- **Digitally-enabled Shared Care Plans and Communication:** Ensure all patients with palliative care needs have shared care plans. These will be living documents that are standardized, cumulative and digitally modifiable and accessible by patients and care teams. Digital solution, building on existing tools in year 1, will enable information to be shared across the core and extended teams, including patients.
- **Rapid Access:** Ensure all patients rostered with primary care have access to 24/7 care navigation. For patients with medically complex needs (i.e. palliative population), provide a phone number to a designated member of the care team (key contact), who can be reached directly for rapid access with 24/7 coverage.
- This will be knit together in an integrated care pathway with clear roles, responsibilities and warm hand-offs.

Current state service blueprint, for people with minor acute (e.g. GI/GU) needs



Year 1 change ideas: people with minor acute (e.g. GI/GU) needs

- **Access to Modernized Primary Care:** Enable people to quickly and easily schedule appointments with primary care providers for urgent issues, including using digital options for virtual visits. Identify designated after-hours primary care services and provide navigation services to help people visit there when their own providers' office is closed. Ensure warm handovers take place for patients visiting after-hour services to enable follow-up and documentation.
- **Access to Timely, High Quality Diagnostics:** Streamline access for primary care providers to timely, urgent diagnostics through partners (i.e. acute care) or contracted services in the community. Develop agreements to ensure contracted service providers are accountable for timely results interpretation, quality standards, and accreditation. Over the long-term, diagnostic and lab records could be uploaded directly to the EMR to enable timely access to results in primary care and could include point of care diagnostics.
- **Urgent Access to Specialist Advice (with Virtual Options):** Enable primary care providers to access urgent advice from specialists through e-consults or phone for urgent situations. Explore the possibility of booking patients into ambulatory care clinics, when needed (e.g. when triaging is needed for acute diagnostics).