An Ontario Health Team for Mississauga

Summary of OHT Readiness Assessment Submitted May 15, 2019

May 23, 2019

Ontario Health Teams

The vision for Ontario Health Teams (OHTs) as set out by the Ministry of Health and Long-Term Care (MOHLTC) 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

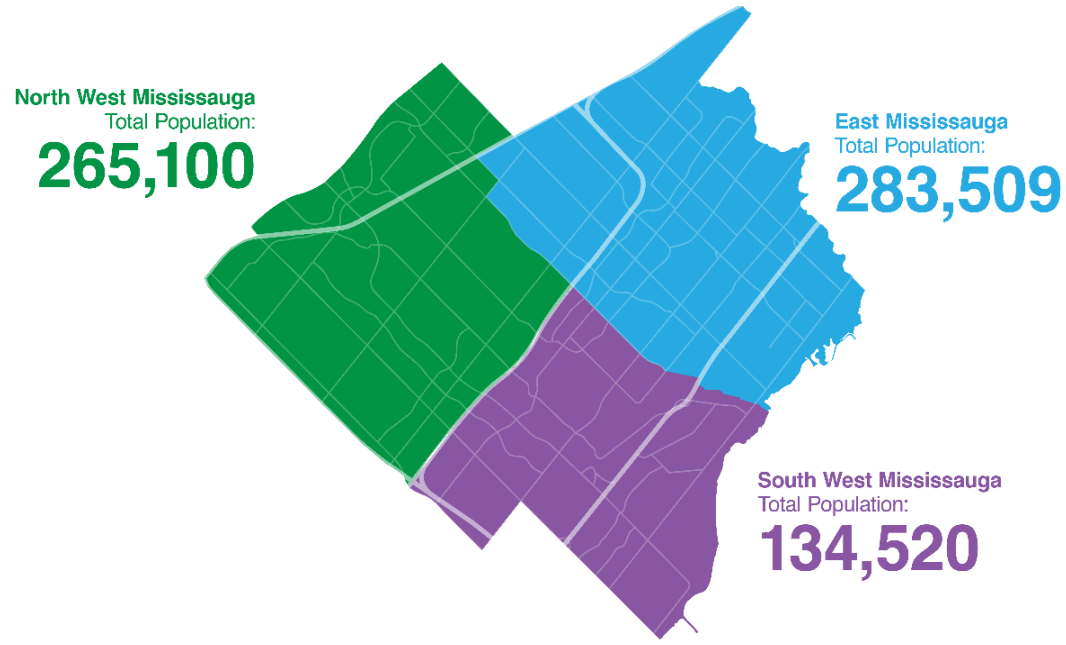
Caring for Mississauga

Mississauga is large, diverse community with many different cultural and ethnic backgrounds. This community is experiencing growth in populations across all ages, as well as increases in significant multimorbidity and social inequity.

On a per capita basis, we have the fewest interprofessional primary care teams in Ontario, no mental health youth beds and the fewest long-term care beds and hospice beds.

Of our population:

- 53% are born outside of Canada, making Mississauga one of the most diverse regions in the world
- 14.3% are seniors, with 6.3% over the age of 75
- 22.5% are children
- Over 28% are living with at least one chronic condition
- In 1980, only 2% of neighbourhoods were low income, while today, low- and very low-income neighbourhoods represent 51% of the community



The population of Mississauga is cared for by community partners who have a history of collaboration and working together.

Through an OHT, there is an opportunity for providers to improve the health of the approximately 680,000 people that live in Mississauga by providing high quality, integrated care across the continuum, from prenatal care to birth to end of life.

Our Collaborative Community: Strong Foundations for an OHT

Primary Care

- Family Health Teams with education
- Model for integrated primary care team (including at CarePoint Health)
- Physician networks

Hospital Care

- *Partnering for Patients*: largest voluntary, Ontario hospital merger creating one hospital for secondary, tertiary and regional care
- Established expanded regional programs
- Institute for Better Health

Patients & Families **Collaboration**

Innovation **Research** **Education**

Home Care

- Seamless Transitions and Home First
- Alignment of care to neighbourhoods
- Health Links
- Bundled care

Community Care

(including Long Term Care & cross-sector supports)

- Metamorphosis and other planning tables
- Healthy City Stewardship Centre (e.g. public health, school boards, police)
- Partnerships to provide culturally appropriate Long Term Care
- Region of Peel services (e.g. transportation)

Our Community Partners

Our Core Partners

Primary Care

- Credit Valley Family Health Team
- Summerville Family Health Team
- Care Point Health (formerly the Mississauga Integration Care Centre)

Home Care

- Home and Community Care

Hospital

- Trillium Health Partners

Community Care

- Metamorphosis Network
- Heart House Hospice Inc.
- Peel Senior Link
- Peel Addiction Assessment and Referral Centre

Our Community Partners

49 community partners have demonstrated support for this OHT including mental health and addictions, palliative and long-term care and social services:

- AbleLiving Services
- Alzheimer Society of Peel
- AstraZeneca Canada Inc
- Bayshore HealthCare
- Beacon
- Canes Community Care
- CBI Health Group
- City of Mississauga
- Closing the Gap Healthcare Group
- Dixie Bloor Neighbourhood Centre
- Dorothy Ley Hospice
- TEACH - Centre for Innovation in Peer Support
- United way of Peel Region
- Dufferin-Peel Catholic District School Board
- East Mississauga Midwives
- ErinoakKids
- Heart House Hospice
- Seniors Life Enhancement Centres
- Links2Care
- March of Dimes Canada
- Midwives of Mississauga
- Mississauga Board of Trade
- Mississauga Halton Palliative Care Network
- West Park Health Centre
- Yee Hong Centre
- Nucleus Independent Living
- Nurse Next Door
- Ontario Telemedicine Network
- Peel Addiction Assessment and Referral Centre
- Peel District School Board
- Peel Public Health
- Punjabi Community Health Services
- Peel Regional Police
- Peel Senior Link
- University of Toronto Mississauga
- The Victorian Order of Nurses
- ProResp
- Region of Peel
- Registered Nurses Association of Ontario
- S.R.T. Med Staff
- Saint Elizabeth Health Centre
- Schlegel Villages
- Sheridan College
- Sienna Senior Living
- Spectrum
- YMCA of Greater Toronto

*Home care will transition to the OHT in Year 1, in alignment with government direction to evolve and modernize these services. We see home care supporting more directly primary care and hospital operations as one opportunity

Our Plan for an OHT in Mississauga

Focus of the proposed OHT:

1. Population health approach

- Use data analytics and clinically significant risk stratification model to focus resources on emerging and high risk patients to improve health outcomes and better coordinate their care
- Simultaneously activating health prevention and promotion for all, including low risk populations
- Support holistic mental and physical health needs rather than solely disease-specific health needs

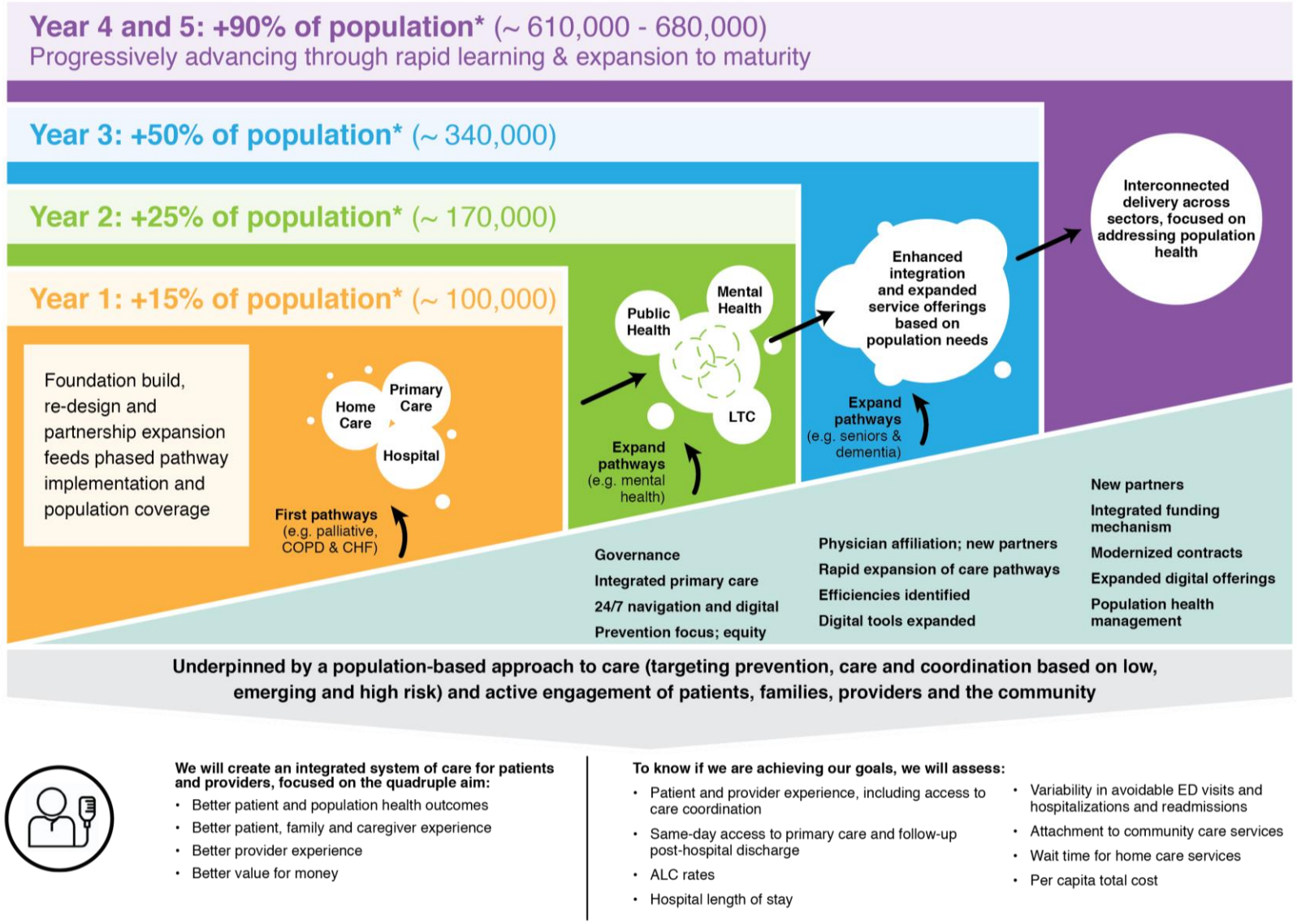
2. Implement integrated primary care model

- Standardized same-day access to primary care and access to 24/7 care coordination and navigation
- Expanded use of virtual care
- Increased access through interdisciplinary team-based care
- Prevention, health literacy and self-management support
- Enhanced integration across primary care, acute, home and community
- Digital portal to allow patients access to their health record across the continuum

3. Integrated continuous care pathways

- In Year 1, particular focus will be placed on implementing existing regional prototypes of continuous care pathways that consider the needs of the whole person in areas such as:
  - palliative care
  - congestive heart failure (CHF)
  - chronic obstructive pulmonary disease (COPD)
- Additional care pathways will be developed based on needs of the population, potentially including seniors' services, children's services and mental health

Roadmap: How we will get there



We will create an integrated system of care for patients and providers, focused on the quadruple aim:

- Better patient and population health outcomes
- Better patient, family and caregiver experience
- Better provider experience
- Better value for money

To know if we are achieving our goals, we will assess:

- Patient and provider experience, including access to care coordination
- Same-day access to primary care and follow-up post-hospital discharge
- ALC rates
- Hospital length of stay
- Variability in avoidable ED visits and hospitalizations and readmissions
- Attachment to community care services
- Wait time for home care services
- Per capita total cost

*Dependent on pace of related government changes (e.g. labour relations and funding) and based on current population

Our Self-Assessment Summary

In completing the OHT Readiness Assessment, we feel we are well positioned to advance the OHT model and vision. We are committed to addressing any challenges that arise through partnership and investment in order to build this model for an improved system of care for Mississauga.

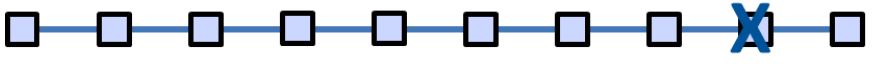
Final submission scales for OHT in Mississauga application:

Model Component 1: Patient Care and Experience

Model Component 2: Patient Partnership and Community Engagement

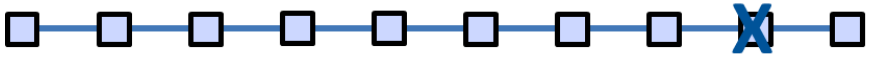
Model Component 3: Defined Patient Population

Model Component 4: In Scope Services

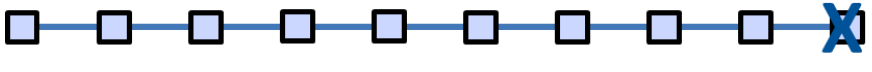


Model Component 5: Leadership, Accountability and Governance

Model Component 6: Performance Measurement, Quality Improvement and Continuous Learning



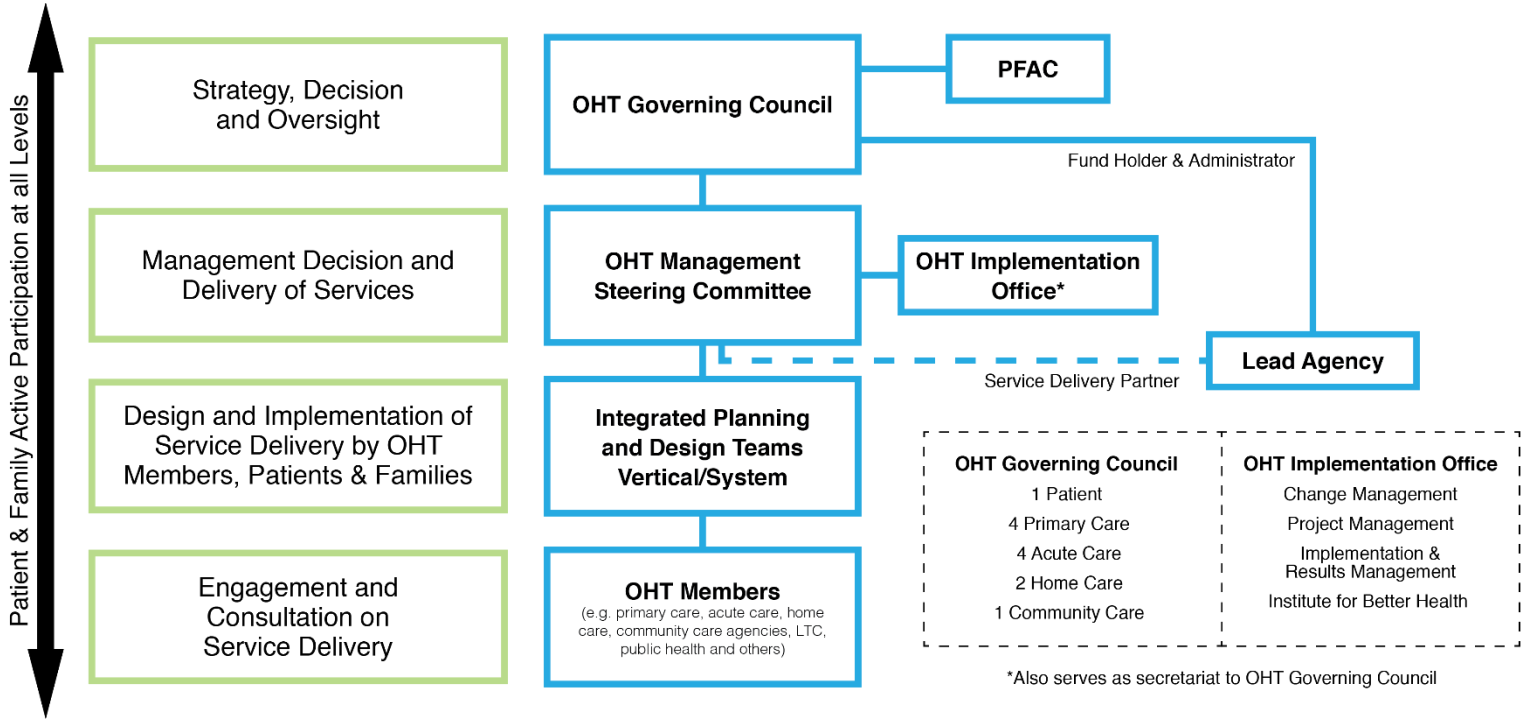
Model Component 7: Funding and Incentive Structure



Model Component 8: Digital Health

Proposed Governance

- An OHT Planning Steering Committee, representing organizations across sectors, came together to complete the Readiness Assessment submission on behalf of the community
- The proposed governance structure below will evolve as the OHT matures
- Patient and family participation will exist at all levels of governance and be representative of our diverse community
- Trillium Health Partners has been proposed as the “Lead Agency” and fund holder accountable to the governance structure



Next Steps as Outlined by the MOHLTC

1 READINESS ASSESSMENT

- On May 15, 2019 the core partners submitted a “Readiness Assessment” on behalf of the community.
- The MOHLTC has received over 150 applications.

2 BUSINESS CASE

- Following review of the Readiness Assessments, a select few will be chosen to complete a business cases
- If invited to proceed with a Business Case, this will be completed in partnership and due in July, 2019.

3 ANNOUNCEMENT OF OHT CANDIDATES

- Fall 2019

Appendix

Integrated and Accountable Care Systems

Essential Features of an Integrated and Accountable Care System:

1. Shared vision and goals for a common destiny – co-design and co-lead
   Clinical leadership to enable all steps and distribute ownership
2. Trusting relationships – between providers, hospitals and other care settings
3. Primary Care involvement and focus
4. Defined population with adequate risk pooling
5. Patient engagement and self-management support
6. Effective care coordination and coordinators
7. Rapid-cycle and reliable audit and feedback – including feedback to physicians
8. eHealth supported care – technology to support integrated care

Fisher ES et al. Health affairs (Project Hope). 2012;31(11):2368-78
Gittell JH et al. Journal of interprofessional care. 2013;27(3):210-3.

OHT Planning Steering Committee

Organization	Sector	Representative
Metamorphosis Network	Community Network	Ray Applebaum
Heart House Hospice Inc.	Hospice and Palliative Care	Theresa Greer
Peel Senior Link	Seniors Services	Ray Applebaum
Peel Addiction Assessment and Referral Centre	Addictions	Karen Parsons
Trillium Health Partners	Hospital	Michelle DiEmanuele
Credit Valley Family Health Team	Primary Care	James Pencharz
CarePoint Health (formerly the Mississauga Integration Care Centre)	Primary Care	Cal Gutkin
Summerville Family Health Team	Primary Care	Andrea Stevens
Primary Care Leader/ Physician Engagement Lead	Primary Care	Mira Backo-Shannon
Home and Community Care (proxy)	Home Care	Sharon Lee Smith