Ministry of Health

OHT Provincial Learning and Improvement Forum

Southlake Community OHT

February 19, 2019

Ontario

Our Vision

Southlake Community
ONTARIO HEALTH TEAM

Our overarching OHT goal is to address the most pressing challenges in the current system and make significant improvements to each element of the Quadruple Aim

Aim	Current strengths to leverage in the system	Biggest opportunities for improvement
Improve health outcomes	▸ Dedicated provider organizations with talented and compassionate staff	▸ Redesign processes to facilitate point-of-care integration and real-time information transfer
Enhance patient experience	▸ Long history of organizations partnering to provide seamless care ▸ Providers strive to offer the best patient experience possible in today's system, despite a system that has fundamental systemic challenges and barriers	▸ Current system of dividing care amongst multiple health care professionals who have no awareness of each other's involvement fragments care, overwhelms patients and creates gaps in care ▸ Patients and caregivers are left to repeat their story multiple times and act as the communication liaison between the various providers
Reduce cost/ improve value	▸ Provider organizations do their best to operate efficiently within the limitations of today's system	▸ Redesign to include community/neighbourhood-based teams to increase efficiency and effectiveness ▸ Outcome-based contracts with shared risk and gains
Improve provider satisfaction	▸ Provider organizations are committed to their staff and attempt to provide the best experience possible in today's system	▸ Southlake@home has shown that our transitional, bundled, integrated care between hospital, community and primary care improves morale and provider satisfaction

Ontario

Southlake Community OHT

Southlake Community
ONTARIO HEALTH TEAM

Priority Populations for Year One

1) Seniors with multiple comorbidities
2) Individuals with complex Mental Health and Addictions

Area of Focus

1) Integrate hospital transitions: home care and community care, primary care, mental health, and addictions care
2) Leveraging home and community care to delay premature admission to long-term care and prolonged institutional based care
3) Reviewing CSS eligibility, access, and wait-list management functions and resources
4) Redesigning intake process to eliminate waste, and explore improvement opportunities
5) Driving down acute utilization (ED visits, hospital admissions)
6) Resource shifts from acute to community and primary care

Our Partners

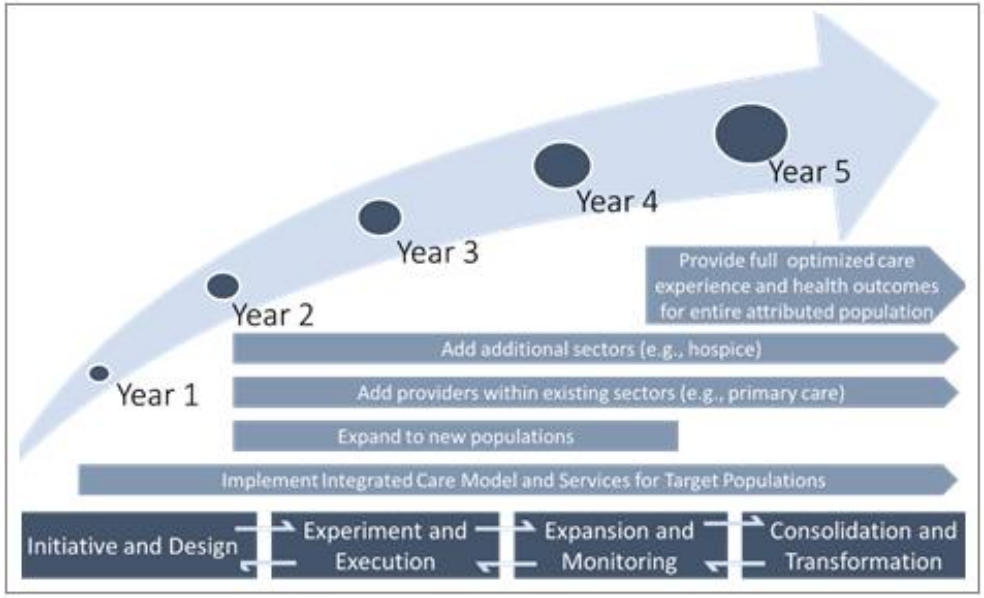
SOUTHLAKE REGIONAL HEALTH CENTRE
Aurora-Newmarket Family Health Team
Bayshore HealthCare
Canadian Mental Health Association York and South Simcoe Mental health for all
CHATS Community & Home Assistance to Seniors
Enhanced Care Clinic Healthy · Quickly · Safely
EXTENDICARE ... helping people live better
Georgina Nurse Practitioner-Led Clinic
LOFT
Health
Southlake Academic Family Health Team
York Region EMS

Ontario

Building the Foundation

Southlake Community
ONTARIO HEALTH TEAM

Our five-year maturity model will guide the expansion of our OHT to include the entire continuum of care and provide integrated care for our entire attributed population



Early initiatives (Year 1) to delivery home and community care (selected):

- ☑ Southlake@home expansion
- ☑ Admission avoidance and more timely discharge via rapid access to specialist services and homecare (Urgent Geriatric Clinic)
- ❑ Improved access to homecare services via expansion of the community nursing clinic
- ❑ Expansion of S@h learnings to mental health transitions

Ontario

Southlake@home

Southlake Community
ONTARIO HEALTH TEAM

Patient Partners – Integrated Care – Population Bundle – Outcomes Measured

Patient Partners

- S@h coordinators quarter-back patients from hospital to home
- Care-plans are customized to each patient and focus on activation and restorative care in the community
- Patients know who is coming and what the person will do
- Blended care model- less disruption in the home
- Flexible and nimble care to quickly adapt to changing care needs
- 24/7 phone line

Population Bundle

- 16 week transitional care program for patients experiencing medical complexity, socially complexity and frailty
- Inclusive of all ages and clinical presentations
- All home and community supports are available
- Investing in a core hospital-based team for active case management and provider management
- Visible and active engagement of physicians and frontline teams

Integrated Care One Team

- Patients see providers as ‘one team’; single care plan based on individual patient care needs
- Shared accountability and continuous learning
- Primary care kept informed
- Providers work at full scope of practice
- Community supports part of the team

Outcomes Measured

- Focus on outcomes over transactions or service volumes
- Real-time issues management
- Agility to evolve program based patient and provider feedback
- Provider and patient experience measured in real time
- Built-in incentives for quality care, including gain and risk sharing

Barriers and Solutions

Southlake Community
ONTARIO HEALTH TEAM

- HCC policy and process modernization (e.g., redesign referral, intake, assessment, reassessment, waitlist processes, etc.)
- Legislative and policy modernization (e.g., PHIPA, Home and Community Act, etc.)
- Modernized accountability agreements
- Labour relations
- Privacy and cybersecurity program/policy harmonization
- Shift to focus to outcome measures based on the IHI Quadruple Aim

Ontario

Tools and Platforms

Southlake Community
ONTARIO HEALTH TEAM

CURRENT

- Inter RAI Tools
- Electronic scheduling tools
- Phone visits
- Passive remote monitoring
- Daily virtual rounds with integrated care team
- Fax machines 

FUTURE

- Full access to CHRIS (more than read only)
- Expanding read only access to the hospital EMR to other partners
- Expand patient access to health record
- Integration engine to produce a common platform where all providers can view and add information

Ontario

Results

Southlake Community
ONTARIO HEALTH TEAM

Southlake@home

Since launching in early March 2019, over 200 patients have safely transitioned home The program is achieving progress on each element of the Quadruple Aim:

Patient Outcomes	Patient Experience	Provider Satisfaction	Value and Cost
65% of patients identified during acute stay → **0 ALC days**	**100%** of patients received first home visit within 24 hours of discharge	**100%** of homecare providers agreed and strongly agreed they felt part of a health care team	**2,123** ALC days avoided
77% had primary care visit/contact within 7 days of discharge	**87%** patients agreed and strongly agreed they had been provided with enough information prior to discharge	**100%** of patients have their new prescriptions filled at 48 hours	**Reduction** in average ALC days by **12.7 days**
			10 patients were supported through Southlake@home directly from ED

*data as of Dec. 2019

Outpatient Geriatric Clinic

Since launching in early December 2019, over 50 patients have visited the clinic, with a total of approximately 96 visits. To support a safe transition home, 13 people have been placed on the Southlake@home program. Further results coming soon.

*data as of Feb. 2020

Ontario

Thank you

Question or Comments?

Ministry of Health

OHT Provincial Learning and Improvement Forum

Guelph & Area OHT

February 19-20, 2019

Ontario

The Guelph & Area OHT Vision for Integrating Home & Community Care into Integrated Primary Care Teams (IPCTs)

Guelph & Area Ontario Health Team





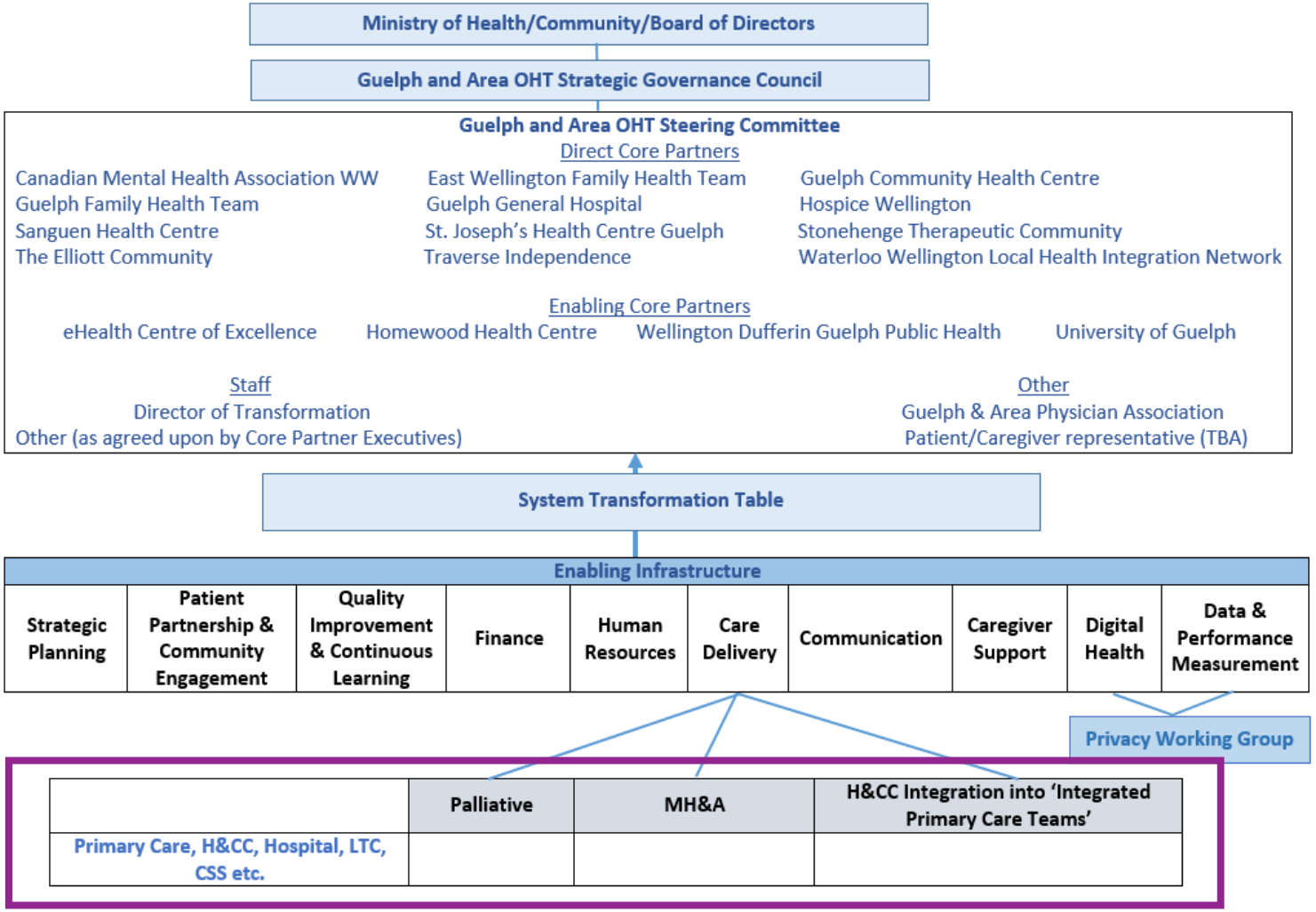







Guelph & Area
Ontario Health Team

Building the Foundation



Ontario

Guelph & Area
Ontario Health Team

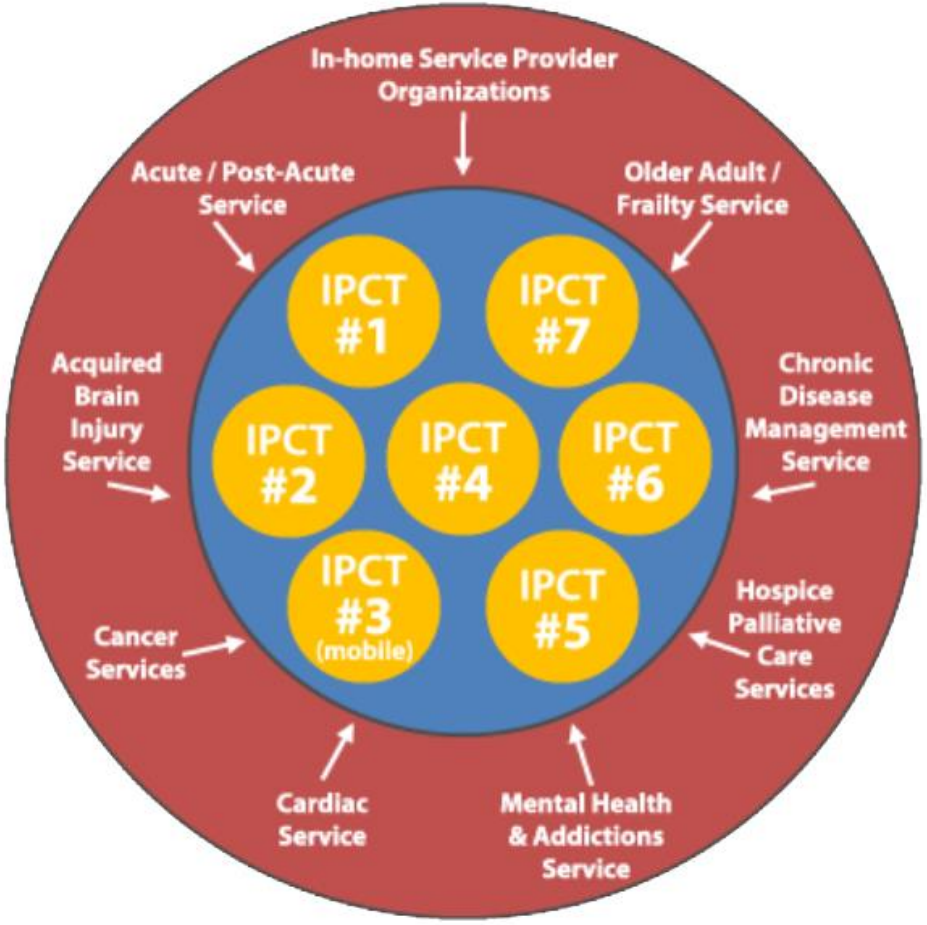
Building the Foundation

1. Defined the **FUNCTIONS** of an Integrated Primary Care Team (IPCT) including the **FUNCTIONS** of care coordination and functions of in-home care delivery
2. Identified existing primary care teams (~8000-10000 rostered patients each) that will be supported to evolve to an IPCT
3. Completing a survey / current state assessment of the current **FUNCTIONS** of each team relative to the envisioned functions of a mature IPCT.
4. Collecting data to understand the health outcomes and utilization of each PC team/IPCT
5. Working with OHT partners to quantify what IPCT **FUNCTIONS** are currently being delivered outside of primary care (w focus on Year 1 priority populations i.e. MH&A, palliative, H&CC)
6. Once all current state data/information is collected, OHT partners will collaboratively identify opportunities to integrate services to enable each IPCT to deliver the full suite of IPCT **FUNCTIONS.**

Ontario

Guelph & Area
Ontario Health Team

Building the Foundation



Functions identified as being most appropriately at the OHT level (because the specialized knowledge or critical mass doesn't reasonably exist at the IPCT level) will be invited to join the patient's care team when their needs require that level/type of care

Ontario

Guelph & Area
Ontario Health Team

Barriers and Solutions

- No path/mechanism to develop or execute plans to transition H&CC functions or resources to OHT / OHT partners for either clinical care delivery or OHT development
- Dual roles (OHT and OH/LHIN) in system planning and design with no clarity/expectations how the dual roles should support/compliment each other
- Capacity to transform the system with no resources to support leadership, coordination, change management

Ontario

Guelph & Area Ontario Health Team

Tools and Platforms: Digital Health Enablers

Commitment to streamline and simplify:

- **eReferral and eConsult.** IPCT concept has focused on inviting people into care rather than referring away. Electronic referral embedded into PC EMRs that includes two-way messaging enables this relationship. HCC including SPOs are already on eReferral in Guelph and Area. Will continue to refine use in the vision of IPCT function.
- **Virtual Care.** Guelph and Area clinicians were involved in the 'Enhanced Access to Primary Care' pilot of virtual care. We will grow use of these technologies and the OTN suite of services to enhance IPCT care functions.
- **Care Plan Sharing.** Using robotic process automation (RPA), we are integrating information from existing EMRs, CHRIS and the local HIS to have an updated, actionable care plan.
- **Evaluation of needs at maturity.** We are evaluating and seeking investment on:
  - Online booking (primary care and system-wide)
  - Mobile access to PC records and sharing
  - Consumer digital health portal
  - Optimal data sharing (One HIC; One Health Information Network Provider (HINP))

Ontario

Ministry of Health

OHT Provincial Learning and Improvement Forum

Guidance on Home and Community Care in the OHT Context

CONFIDENTIAL – NOT FOR CIRCULATION

February 19, 2020

Ontario

Purpose

- Ontario is delivering on its commitment to end hallway health care and build a connected and sustainable health care system centred around the needs of patients.
- In your applications, OHTs described innovative plans to connect home and community care into broader integrated service plans.
- OHTs have requested the ministry to help reduce barriers to achieving your plans and to provide guidance on key areas.

The ministry is seeking your feedback to determine what guidance and resources would be helpful for OHTs to break down barriers, provide flexibility, and ensure consistent and equitable access to home and community care

Strategic Goals for Modernization

Along with Ontario's broader **health system transformation**, advance the Quadruple Aim by modernizing Ontario's home and community care sector, and enabling the shift to Ontario Health Teams and other innovative models of care.

Meet rising demand for home and community care through investments and better use of home and community care resources as well as other assets in the health system through improved integration.

Quadruple Aim

Patient and Caregiver Experience

- Meet public expectations that the care they need in the community is available by providing more care in the community, without lengthy waits.
- Prevent clients from having to repeat their health histories.
- Provide clients access to their health information and have more control over care planning.

Provider Experience

- Allow flexibility for providers to respond to changing client needs, without going through a middleman.
- Empower providers to spend less time on administration and more time treating clients .
- Move away from per-visit delivery that makes recruiting and retaining staff more challenging.

Value and Efficiency

- Improve efficiency of care coordination processes.
- Update procurement model to incent high quality care, innovation and system improvements.
- Reduce duplication and barriers through the introduction of Ontario Health Teams.

Patient and Population Health Outcomes

- Reduce unnecessary ED visits and hospital admissions by improved access to HCC.
- Reduce the number of patients designated as ALC in hospitals by providing alternative residential and rehabilitative options.

Supporting Equitable, High-Quality Care

The ministry is looking to engage with OHTs to determine what specific information, guidance and supports are needed to enable you to realize your short and longer term objectives.

Key Areas Identified to Date by OHTs:

- Contracts and Provider Selection
- Care Coordination
- Access and use of CHRIS
- Operational Support Resources
- Service Allocation
- Common assessment tools

The focus of today's discussion will be on:

- Contracts and Provider Selection
- Care Coordination
- Access and use of CHRIS

However, at your tables we have provided additional details on operational support resources, service allocation, and common assessment tools.

Contracts and Service Provider Selection

Context

- Contracted service providers play a key role in the provision of home care.
- There are over 100 service providers that are prequalified and who have home care contracts with the LHINs for the provision of nursing, personal support and therapy-based services.
- Many OHTs have partnered with service providers as part of their planning and engagement work.

What You've Asked

- What parameters should OHTs work within to develop service provider partnerships designed to address short and long-term objectives?
- Flexibility in service provider partnerships and contracts

Where can we help?

- Define how the parameters of provider selection processes is undertaken for both planning and service delivery
- Identify the range of potential partnership models from which OHTs can choose.
    - Example: Detailed contractual agreements vs. flexible funding arrangements (such as the current Health Service Provider model).
- Identify key provincial priorities and define outcomes to guide OHT performance management.

Care Coordination

Context

- Care coordination is an important feature of home and community care delivery that helps get clients the care they need and helps them navigate an often complex system.
- The *Home Care and Community Services Act, 1994* lays the foundation for current care coordination functions to be performed by an approved agency. Key functions include intake, assessing and determining eligibility, care planning, service allocation and case management.

What you've asked

- Remove barriers that restrict how care coordination functions can be distributed across partners and who can perform these functions.
- Remove requirements in legislation, regulation, policy or contracts that contribute to duplication in care coordination functions across partners.

Where can we help?

- Support changes to existing legislative and regulatory barriers that restrict models of care coordination within OHTs.
- Define core care coordination functions for home and community care, leaving flexibility in the delivery of these functions.
- Provide guidance on key areas of care coordination that support equity and consistency for home care e.g. service allocation, care planning.

CHRIS

Context

- CHRIS is the provincial digital health asset that supports the delivery of home and community care services.
- Data in CHRIS is leveraged by LHINs and the Ministry for care delivery, analytics and public reporting – including required federal reporting.
- CHRIS also includes provincial LTC placement and Ontario Drug Program Benefit authorization functions.

What you've asked

- Direction from the ministry on whether direct access to CHRIS will be made available to OHTs including home and community care service provider organization partners.
- Flexibility in using CHRIS functions in a way that makes sense for them

Where can we help?

- Provide parameters to OHTs on the use of CHRIS including considerations for minimum data set for home and community care reporting, requirements on the use of functions with provincial scope e.g. LTC placement.
- Work with partners at Ontario Health to develop an implementation plan for direct access to CHRIS for OHTs.
- Provide guidance on the Health Information Custodian (HIC) status of home and community care service provider partners to support information sharing within OHTs including for sharing into CHRIS.

BREAK-OUT Session:

At your tables we have worksheets available to facilitate the discussion, which includes options for guidance.

The break-out session will focus on three key areas you have identified:

- Contracts and Provider Selection
- Care Coordination
- Access and use of CHRIS

We are looking for your initial reactions, advice on how to determine the right balance of flexibility and consistency, and to identify prioritization.

Following the session, the worksheets will be collected to inform the development of a guidance document to support OHTs in the planning and delivery of home and community care.

A separate worksheet is available for you to provide feedback on the other three key areas you have identified if you choose to. Please return the worksheet to a member of the Integrated Care Branch, or scan and email to your point of contact.

Report Back

Thank you

If you have further questions, please do not hesitate to reach out through your ministry point of contact. They will be able to connect you to a member of the Home and Community Care Branch.