Next Steps: OHT Acceleration

October 12, 2023 | 9:00am-12:00pm

Ontario Health

Land Acknowledgement

Ontario Health

Today's Agenda

Item	Speaker	Time
Introduction & Land Acknowledgment	Adrienne Spafford	9:00-9:05
Building OHTs to Last & Demonstrating Patient Impact	Rhonda McMichael & Sacha Bhatia & Susan deRyk	9:05-9:20
OHT Reflections	Anne Wojtak	9:20-9:30
Introduction to Clinical Priority Areas	Adrienne Spafford	9:30-9:45
Primary Care Networks	Zahra Ismail & David Pearson	9:45-10:15
Integrated Clinical Pathways	Dov Klein & Lauren Bell	10:15-11:00
BREAK		***11:00-11:10***
Early Detection & Preventative Care	Amy Mayer	11:10-11:30
System Navigation	Shelley Morris	11:30-11:50
Warp Up • Funding • Timelines • Next Steps	Ian Cummins	11:50-12:00

Ontario Health

Today's session will be recorded.

Building OHTs to Last & Demonstrating Patient Impact

Building OHTs to Last

The Initial OHTs will also be asked to advance key structural priorities that will ensure the teams have strong foundations in place to achieve patient and system impacts

Creating a Not-for-Profit Corporation

Establishing or Aligning a Primary Care Network

Selecting an Operational Support Provider(s)

Working towards Designation under the *Connecting Care Act, 2019*

Under the CCA, a designated OHT is eligible to receive an integrated funding envelop and enter into an accountability agreement with Ontario Health.

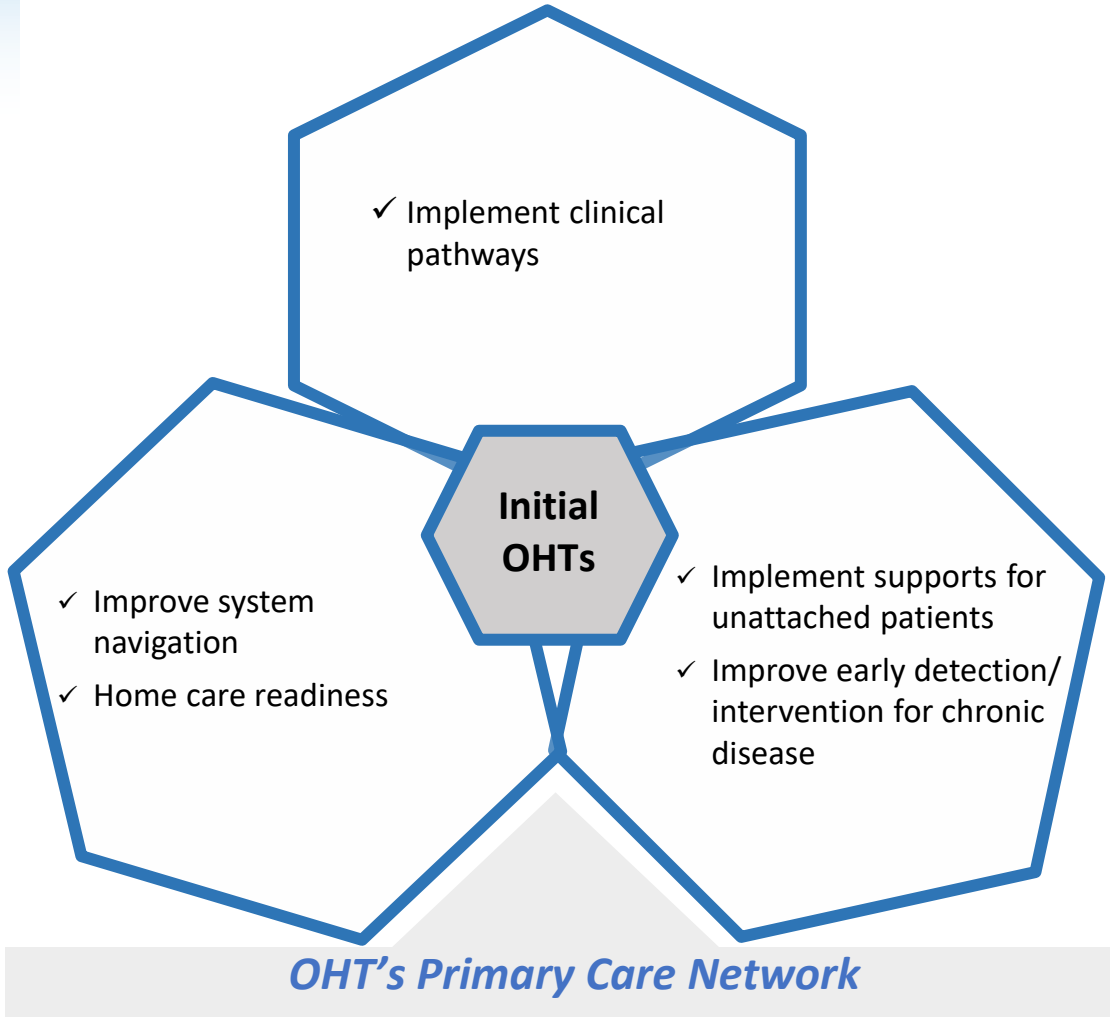
Work ahead:

- In early 2024, the ministry will consult with stakeholders and OHTs to inform designation requirements to be established in a future regulation under the CCA.
- This regulation will, if approved, outline the requirements that an OHT would need to meet to permit a designation by the Minister of Health.
- The first OHTs will be considered for potential designation starting in December 2024.

Ontario Health

Demonstrating Patient Impact

Initial OHTs will be asked to advance provincial clinical priorities and demonstrate improvements to patient experience and outcomes



Improved Patient Outcomes

- Increased early detection of chronic disease
- Improved chronic disease outcomes
- Reduced acute care utilization
- Increased access to primary care services for unattached patients
- Improved system navigation support to find and access care
- Increased access to integrated team-based models of care

Advancing population health management and equity approaches

OHT Reflections

Accelerating Ontario Health Teams

Key messages from the initial 12 OHTs

Noojmawing Sookatagaing

Initial Reflections

- ✓ We are pleased and proud to have been recognized as a group of OHTs that have been chosen to accelerate the OHT model for Ontario
- ✓ We look forward to working in partnership with MOH and OH at both provincial and regional levels (with balance of provincial and local work)
- ✓ There are opportunities to clarify messaging, support all 57 OHTs to accelerate, and continue learning from each other
- ✓ We have concerns about our capacity to take on additional responsibilities, including mentoring/sharing, without adequate resourcing
- ✓ We have many questions and appreciate that you do not have all the answers – service pathways, funding, home care, primary care networks, governance, incorporation, operational service providers - etc., we look forward to figuring out the path forward together

Early identification of enablers

- Timelines and clear expectations for each of the required milestones/deliverables
- Appropriate levels of funding and resources to enable us to deliver – incl enhanced funding and support for provincial/regional learning and development and ability to recruit and retain skilled people in ‘permanent’ roles
- Co-chair approach with simple, optimized working structures and reporting processes that do not bog us down; ensure priorities are aligned across all planning entities
- Consider the pace – balancing need to deliver with a slow enough pace to facilitate thoughtful contribution, essential conversations, and appropriate engagement with advance notice of important meetings and flexible meeting times so that the right voices are around the table at the right time.
- Engagement and support from OH regional staff – how can we better align roles and efforts across OH and OHTs?
- More up to date attribution data and access to more pop health info
- Access to third-party supports, for example centrally procure consultants that can be deployed locally to support each OHT’s needs
- Commit to streamlined and integrated efforts across MOH/OH to support us; partner with us on policy redesign, e.g. PHIPA, home care

Introduction to Clinical Priority Areas

Session Objectives and Participation

Objectives

- Provide more information about the clinical priorities that initial OHTs will be asked to achieve
- Outline immediate next steps and upcoming engagement opportunities

Participation

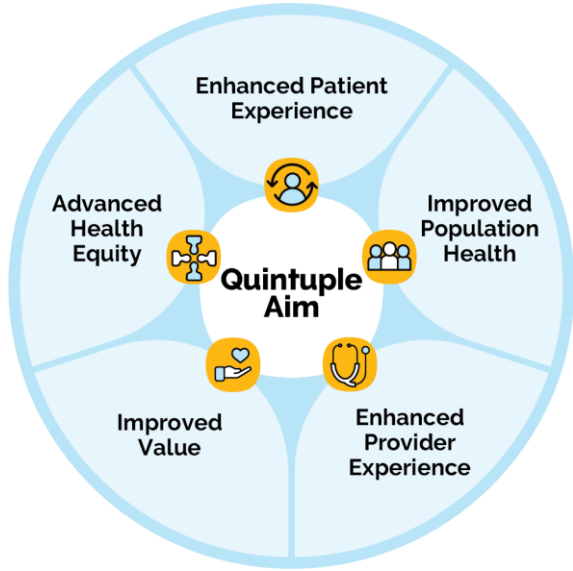
- We encourage OHT participants to actively participate during the presentations by:
  - Adding questions in the chat during the presentations
  - Highlighting existing OHT work or interest in further engagements

Principles for Advancing Shared Priorities

- Advancing the *Quintuple Aim,* with a continued focus on integrated care, population health management and health equity across all shared priorities

- Shared focus on demonstrating improvements to patient experience and outcomes
- Flexibility to tailor implementation to local contexts while ensuring requirements are achieved
- Continued opportunities to advance local priorities

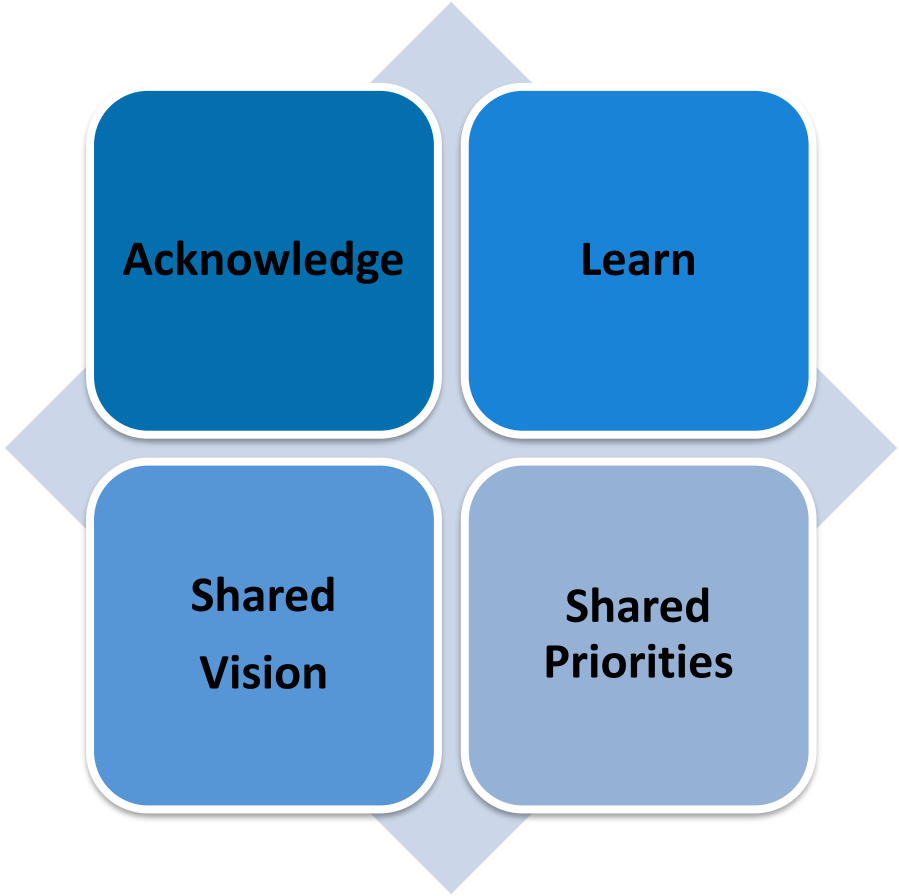
- Create structures that support collaboration, shared learning and peer leadership
- Continued emphasis on knowledge exchange with all OHTs



Ontario Health

Priority Area: Primary Care Networks

Primary Care Networks (PCNs): Background

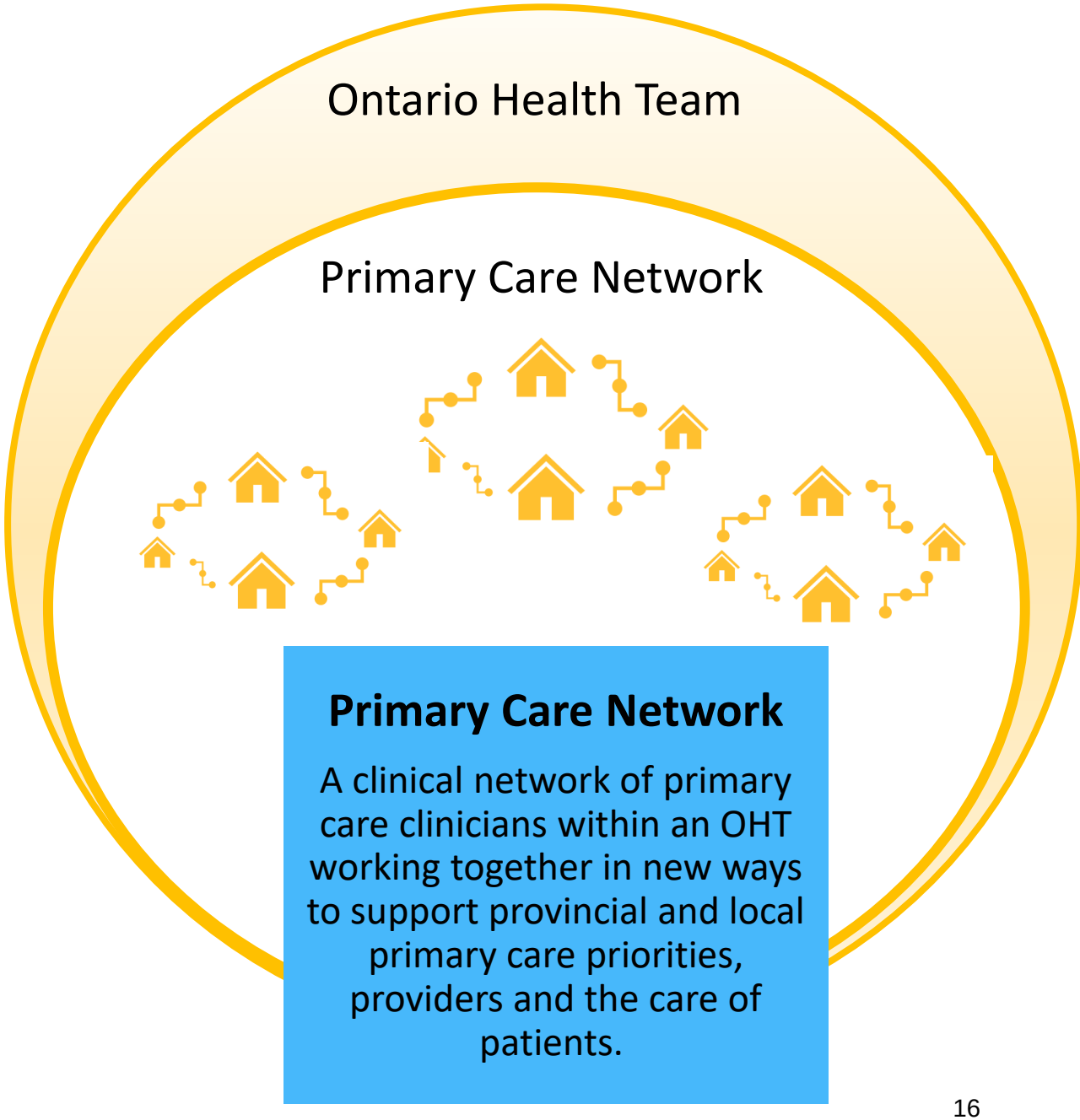


- OHTs have made significant progress in partnering with local primary care clinicians through the development of PCNs or similar structures.
- By understanding the successes/learnings of early PCNs, there is an opportunity to advance the spread and scale consistently throughout the province.
- Following the November 2022 Path Forward announcement, in consultation with key stakeholders the Ministry and OH have been developing a shared vision for PCNs.
- This vision includes five key functions that PCNs will ultimately be expected to perform, as well as two key clinical priority areas.
- Development of a PCN is expected to be a requirement for OHT designation.
- Initial OHTs will play a key role in advancing the vision for PCNs across Ontario, by sharing learnings and best practices.

Ontario Health

Primary Care Advancement: Foundation for Change

Together **Primary Care Networks** form the foundation of an advanced and integrated health system.



Ontario Health

PCN Objectives and Functions Overview

The objectives of PCNs are to provide the primary care sector a voice in OHT planning and decision-making, while serving as a vehicle to support OHTs in the implementation of provincial and local primary care priorities.

The following **five functions** are proposed by the Ministry and OH to support consistency in what an OHT's PCN moves towards:

1. **Connects primary care members within the OHT**
2. **Acts as primary care voice in OHT decision-making**
3. **Supports primary care members to advance OHT clinical change management and population health management approaches that relate to primary care**
4. **Facilitates access to clinical supports and improvements for primary care**
5. **Can / may support local primary care HHR planning with the OHT**

OHT Clinical Priorities Advanced through PCNs

PCNs are not an additional layer of system administration, rather, they will intentionally connect primary care providers within an OHT to improve clinical outcomes for patients using population health approaches.

OH has identified priorities for OHTs to advance through their PCN:

- Access and attachment to comprehensive primary care, with a focus on equity-deserving populations
- Integrated chronic disease prevention and management, with a focus on equity-deserving populations
- Additional local priorities as defined by the OHT and local Primary Care sector

Ontario Health

Next Steps for PCN Development

- All initial OHTs will be expected to have a PCN in place that meets minimum requirements

- OHTs will be expected to complete the following activities within FY 23/24:
  - Complete PCN readiness assessment template
  - Participate in optional design sessions on models for unattached patients (Fall 2023)
  - Develop an action plan to create or modify your OHT's existing primary care structure to align with PCN guidance (when available)

- More information will be shared about expectations for PCN clinical priorities (e.g. unattached patients)

PCN Readiness Assessment

To date, some OHTs have made significant strides establishing Primary Care Networks and/or similar structures.

- To enable the initial OHTs to understand how their current structures align with MOH/OH expectations for PCNs, initial teams will be receiving a **PCN Readiness Assessment template** as their first deliverable of the OHT acceleration agreement for this priority area.
- OH staff will support teams in completing this readiness assessment.

We expect the Readiness Assessment template to be shared with teams by **November 2023**, for completion by end of **January 2024** (as part of the OHT acceleration agreement).

The readiness assessment will also explore existing or planned OHT initiatives aimed at supporting unattached patients. ***Initial OHTs may be invited to participate in engagements in Fall 2023****, including on the Health Care Connect Program, to co-design potential models and pathways.*

Please share in the chat if your OHT has already identified unattached patients as a priority

Ontario Health

Discussion

1) What supports would be helpful for your OHT to meet the objectives and functions for PCNs?

2) What would make a CoP successful for primary care?

3) Any advice on how to advance attachment of patients as a priority for initial OHTs?

Ontario Health

Introductions

Dov Klein, Vice President, Value Based Care

Lauren Bell, Director, Integrated Care & Value Based Programs

1. Provide an overview of Integrated Clinical Pathways (ICPs), including:
   - Relationship between ICPs and Population Health Management framework
   - Opportunity and success stories to date
   - Goals and objectives of the Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD) ICPs

2. Introduce HF and COPD Action Plans, including overview of sections, review process, and upcoming next steps

Priority Area: Integrated Clinical Pathways

What is an ICP?

What is an Integrated Clinical Pathway?

An Integrated Clinical Pathway is an evidence-based approach to coordinating and delivering patient-centered services across a patient's experience of care. Four pathways were identified by government for initial implementation.

- An Integrated Clinical Pathway (ICP) defines the **evidence-based steps taken** to deliver **a care process**, along the **entire patient journey** for the **duration** of their condition/chronic care for a specific disease or condition.
- ICPs help to **ensure person-centered care**, and that patients see the **right provider, in the right order, at the right time, in the right place**.
- *The Path Forward* set out that OHTs would be implementing 4 integrated clinical pathways (ICPs) in stages to support individuals living with chronic conditions:
  1) **Heart failure (HF)**
  2) **Diabetes (Focused on avoiding amputation, through Lower-Limb Preservation: LLP)**
  3) **Chronic obstructive pulmonary disease (COPD)**
  4) **Stroke**
- Implementation of this initial set of clinical pathways for chronic conditions is grounded in leveraging the OHT model and following enablers:
  - Primary and community care with a strong focus on prevention, chronic disease management and avoidance of hospitalizations
  - Transitions from hospital back to the community
  - Virtual and clinical tools to support care in the most appropriate setting
  - Patient Reported Outcome and Experience Measures (PROMs and PREMs) to be embedded into the ICPs to monitor improvements in care, and to enable continuous quality improvement from the patient's perspective

Moving from Episodic Management to Integrated Care

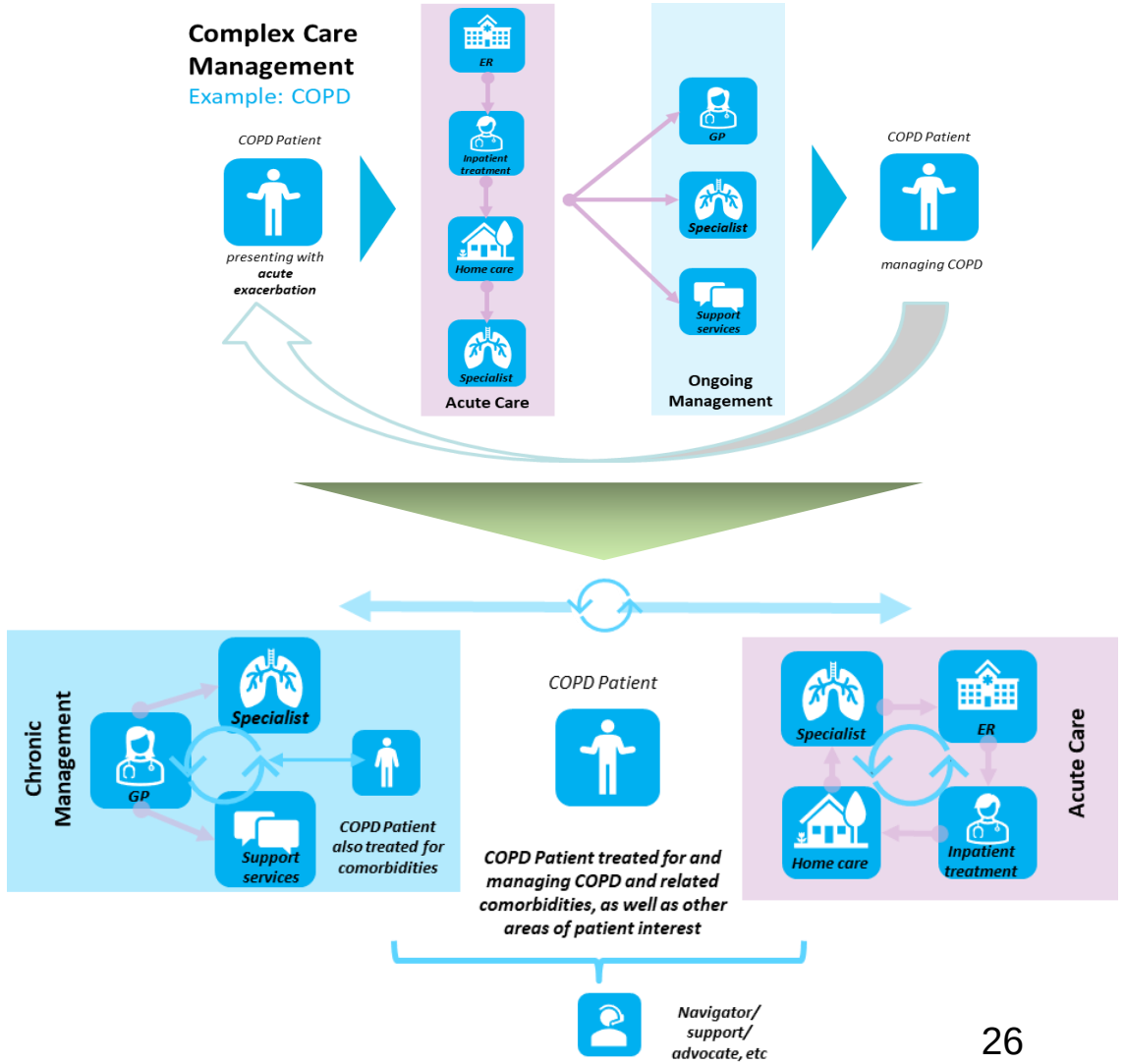
Integrated clinical pathways are designed to fundamentally change the way care is organized and delivered. OHTs are best positioned to work with their providers to organize care around the patient and focus on improving outcomes and experience.

Current Practice

- Best case: **5-6 separate patient records** or forms created, which are not all seen or reviewed by any clinician in pathway
- Patient changes hands **without any hand-off or coordination**
- Provider managing comorbidities **not informed of changes in condition**
- Payment for condition has historically been **only focused on acute intervention**
- Hospitals/physicians **compensated same amount as initial admission** if patient readmitted
- Patient **treated for symptom of disease** – not as a whole patient; little focus on prevention

Integrated Clinical Pathways

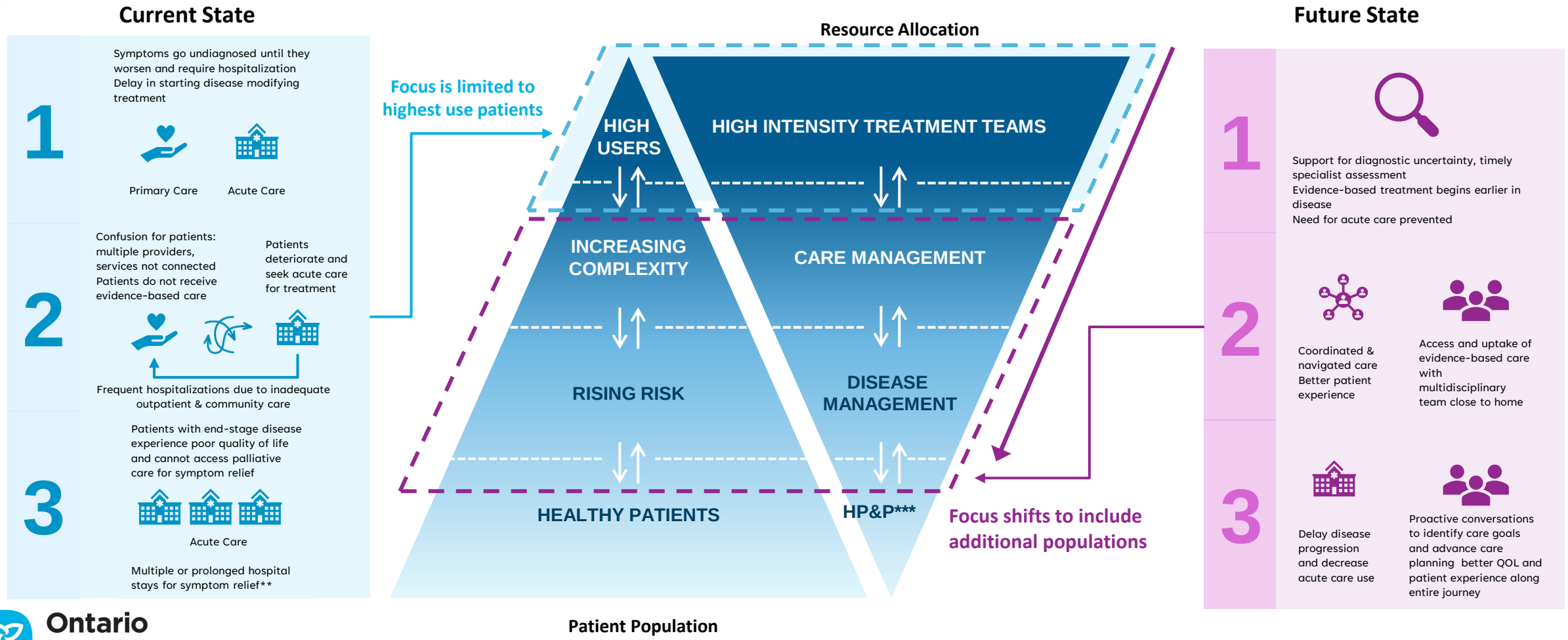
- Treatment with the whole **patient at the centre**
- **Shared patient record** supported by patient navigator **that coordinates handoff** between providers/settings
- **Primary care is organizing** principle of patient's care trajectory
- Focus on **equity deserving populations** and where interventions will have the biggest impact
- Measurement of **patient experience and outcomes**
- **Reduction in degree of variation** across care continuum monitored
- Funding & compensation based on **patient's whole journey** across disease/event, including duration



Ontario Health

Establishing Integrated Clinical Pathways in OHTs

Our goal is to build on existing pathways to reflect the full patient journey to include both upstream and downstream services. Over time the focus of care should be less on the high users, and more on prevention and disease management. *ICPs are a starting point to advance towards population health management and core work for OHTs.*



Ontario Health

The Opportunity

Demonstration Program Selection Process To Date

Several methods have been used to select demonstration programs for the HF and LLP ICPs to date. Moving forward, lessons learned will optimize our approach to the 'High Potential' OHTs.

Goal

Improve outcomes, such as avoidable admission and amputations, and experience of care through integrated care, a greater focus on outpatient management, and by leveraging technology and data

CHF Selection Process Summary

- An open call for proposals went out to **all CHF-QBP hospitals and associated OHTs**
- **28 proposals were received,** and a comprehensive evaluation process was used to review and assess each proposal in line with common criteria
- **Six demonstration programs, involving seven OHTs and nine hospitals**, were selected in spring 2022
- Programs are supported by **funding to reduce acute care utilization by offering appropriate non-acute services**

LLP Selection Process Summary

- Quantitative analysis by OHT population was completed on the **need for lower-limb amputations including amputation volume, amputation risk and degree of marginalization**
- Data was reviewed with the OH regions to **select teams based on the quantitative analysis and qualitative data from OHTs**
- **12 teams were invited to submit an action plan in 2022/23**, and were approved

Region	HF Demonstration Programs: OHT(s) & CHF QBP hospital(s)
West	Partnership between **Huron Perth & Area OHT & Middlesex London OHT** • Stratford General Hospital • London Health Sciences Centre • Middlesex Hospital Alliance-Strathroy
Toronto	**North Toronto OHT** • Sunnybrook Health Sciences Centre
Toronto	**Mid-West Toronto OHT** • Sinai Health • University Health Network
East	**Durham OHT** • Lakeridge Health
Central	**Muskoka & Area OHT** • Muskoka Algonquin Healthcare
Northeast	**Nipissing Wellness OHT** • North Bay Regional Health Centre

Region	LLP Demonstration Programs: OHT (Affiliated Vascular Program)
East	**Hastings Prince Edward OHT** (Kingston Health Sciences Centre)
East	**Ottawa OHT** (The Ottawa Hospital)
Toronto	**Downtown East Toronto OHT** (Unity Health)
Toronto	**Mid-West Toronto OHT** (UHN)
Central	**Barrie and Area OHT** (Royal Victoria Regional Health Centre)
Central	**Central West OHT** (William Osler Health System)
West	**Greater Hamilton Health Network** (HHS)
West	**Middlesex London OHT** (LHSC)
West	**Niagara Health, Niagara OHT & Indigenous Communities** (in development)
West	**Windsor Essex OHT** (Windsor Regional Hospital)
Northeast	**Maamwesying OHT** (Health Sciences North)
Northwest	**Northwestern Ontario Regional Specialized Services Network** (St. Joseph's Care Group/Thunder Bay Regional Health Sciences Centre)

Ontario Health

Please see Appendix 8 for funding amounts provided to each site

ICPs at work

All project teams have reported that **the approach on ICPs to date is the right way to plan, coordinate and deliver patient care.** While still early in implementation, **the HF and LLP ICPs are showing success in managing patients more effectively in the community.**

Key Initial Outcomes

Demonstration programs have **universally reported that the program is leading to better patient care** with early indications that patients normally sent to hospital are receiving care at home and in the community

To date, all patients and providers surveyed agreed or strongly agreed that the approach to integrating Patient Reported Outcome Measures was a valuable part of their care experience, and supported better patient care

*…**we are making it all about the patients**, changing the assumption that the ED and hospital is the 'end all and be all' of care.*

*This **really helped transform clinical decisions and guide our management of patients***

*Patients love the fact that we are **creating a space** for them to **get the care they need without going to the hospital***

(CHF) Source: Monthly project update meetings, TPA reporting deliverables, Quarterly huddles, The Community of Practice

(LLP) Source: "Socks Off" Campaign

The Opportunity: HF and COPD ICPs

A set of initial 12 OHTs will have the opportunity to begin implementation of at least 2 ICPs [HF and COPD] in Q4 FY 2023/24, upon approval of submitted Action Plans.

- HF and COPD ICPs have the strongest common patient population alignment/overlap (compared to Lower Limb Preservation ICP) and are recommended for teams to implement each ICP concurrently as appropriate. Teams will receive funding and supports to assist with ICP implementation, subject to approval of Action Plan.
- Both HF and COPD have a quality standard focused on care in the community
- Chronic disease management is an important aspect of both HF and COPD and there is strong overlap and opportunities for shared programming, specifically at the Primary and Community care level of service provider
- As teams work towards the concurrent implementation of the HF and COPD ICPs, the OH Provincial team is working towards operational efficiencies, i.e., single TPA, common mailbox, shared CoP
- We will work closely with the Regions and Initial 12 OHTs to implement a plan that considers the clinical and operational realities of the team, including the option to choose Lower Limb preservation where this is a strong clinical rationale

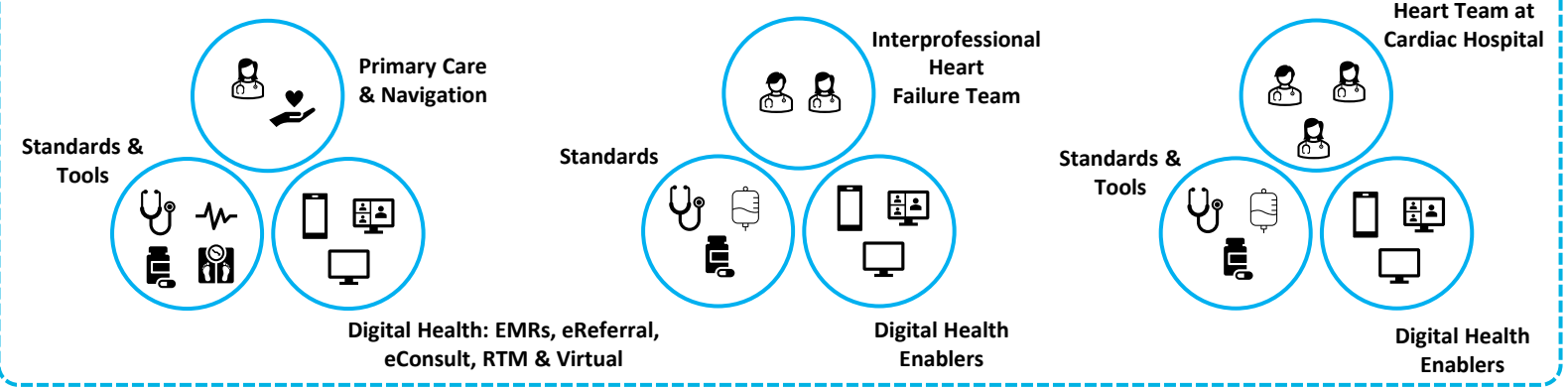
Ontario Health

HF Integrated Care Model and Anticipated Outcomes

The goal of the HF ICP is to improve health care experiences and outcomes (including acute care utilization) through integrated care, and ultimately improve population health for patients with HF through the implementation of two sets of standards; the Spoke-Hub-Node model for organizing care and the HF Quality Standard.

Current QBP funding for CHF is tied to hospital inpatient admissions

Value-Based Care



Expanded QBP will enable more flexible and targeted HF care across the continuum of care that includes outpatient and community-based settings

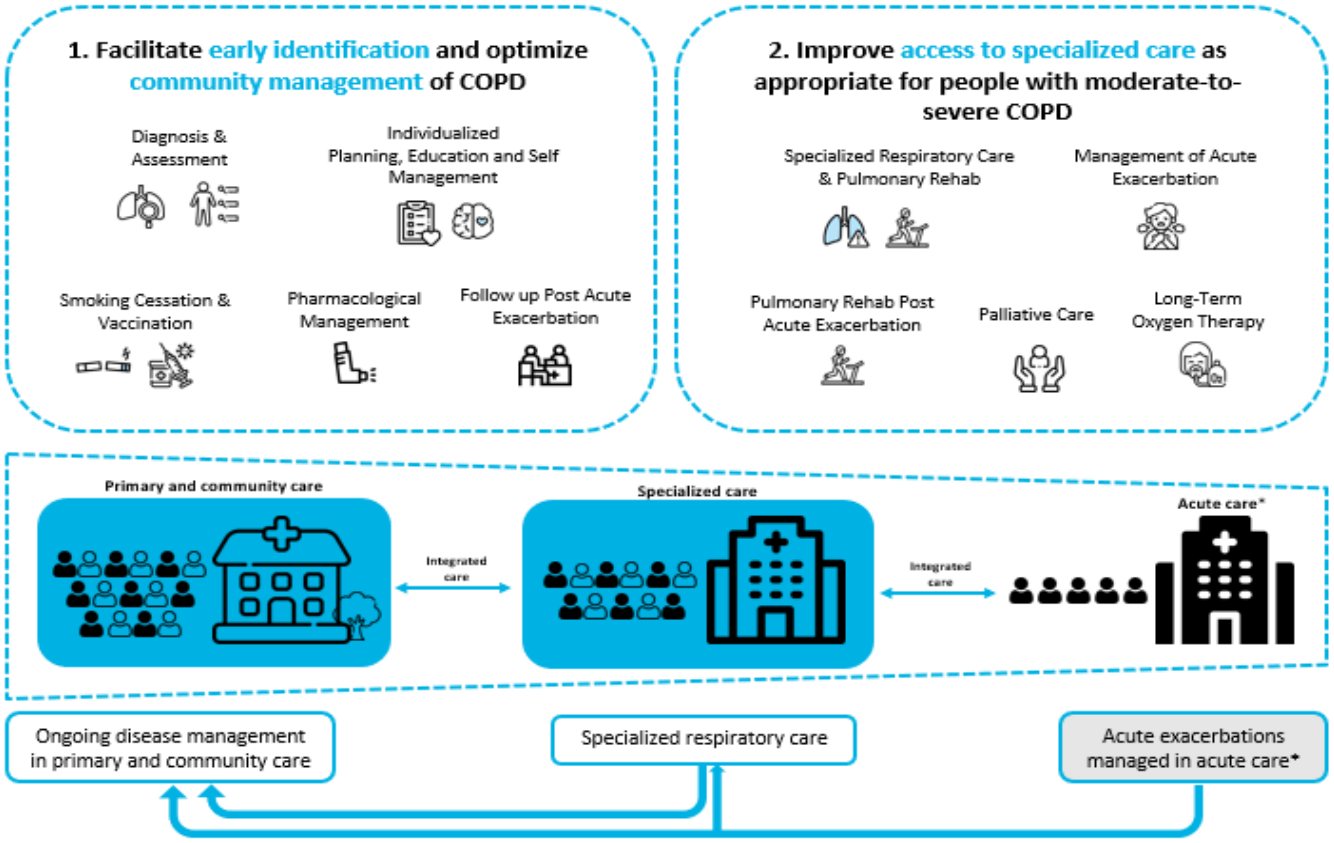
HF Key Outcomes	
System Indicators	↓ Admissions per HF patient ↓ Emergency department (ED) visits ↓ 30-day readmissions post HF discharge ↓ 30-day ED visits post HF discharge
Balance Indicators	→ Length of stay (LOS) for HF admission → 30-day mortality post HF discharge
Sample Local/ Process Indicators*	↑ Patients enrolled in Remote Care Monitoring ↑ Access to interprofessional specialized care near home ↑ % of patients, recently hospitalized or treated in ED for HF who are referred and seen in HF clinic within 14 days of discharge ↑ Improved patient reported experience of care

**Local indicators are team specific indicators that OHTs will be defining and collecting*

Ontario Health

COPD Integrated Care Model and Anticipated Outcomes

The goal of the COPD ICP is to improve health care experiences and outcomes (including acute care utilization) for people living with COPD in Ontario through the delivery of integrated, transformative, and person-centered care in alignment with the COPD quality standard.



* Scope of the COPD QBP

COPD Key Outcomes	
System Indicators	↓ COPD Admissions ↓ COPD Emergency department (ED) visits ↓ 30-day ED visits post COPD discharge ↓ 30-day readmissions post COPD discharge
Balance Indicators	→ Length of stay (LOS) for COPD admission → 30-day mortality post COPD discharge
Sample Local/ Process Indicators**	↑ % of people with COPD referred to specialized care when clinically indicated ↑ % of people with COPD referred to pulmonary rehabilitation programs when clinically indicated ↑ Improved patient reported experience of care ↑ % COPD Confirmation via spirometry ↑ 7-day in-person assessment following COPD discharge → % of people with COPD seen by a respirologist

Ontario Health

The aim is to have teams leverage the entire COPD quality standard to address critical gaps in care, with focus on: Diagnosis via spirometry and appropriate referral and access to specialized respiratory care and pulmonary rehabilitation

***Local indicators are team-specific indicators that OHTs will be defining and collecting*

HF & COPD Action Plan Overview

The Initial 12 OHTs

	CHF ICP		COPD ICP (FY23/24 Start)	LLP ICP (FY22/23 Start)
OHT	FY22/23 Start	FY23/24 Start		
All Nations Health Partners		X	X	Underway
Burlington OHT		X	X	
Couchiching OHT		X	X	
Durham OHT	Underway		X	
East Toronto Health Partners OHT		X	X	
Frontenac, Lennox & Addington OHT		X	X	
Greater Hamilton Health Network OHT		X	X	Underway
Middlesex London OHT	Underway		X	Underway
Mississauga OHT		X	X	
Nipissing Wellness OHT	Underway		X	
Noojmawing Sookatagaing OHT		X	X	Underway
North York Toronto Health Partners OHT		X	X	

Ontario Health

HF & COPD Action Plan Development

OHTs and their system partners are required to complete an action plan, outlining evidenced-based initiatives that require knowledge translation and implementation. The focus is on linking upstream community-based care, prevention and escalation of services to improve patient outcomes and experience of care.

The purpose of the Action Plan is to:

- Guide OHTs on the critical pieces for building and implementing an ICP that aligns with the related Quality Standards and best practice documentation and can be launched in FY 2024/25
- Provide OHTs with insight into the roles, responsibilities and program requirements for participating as an Initial OHT Acceleration Site

The action plan for the ICP for the provincial team is intended to:

- Ensure teams have the necessary vision and willingness to identify and implement the necessary resources, infrastructure, and process for building, implementing an ICP that aligns with the Quality Standards and related best practice documentation and can be launched in FY 2024/25
- Provide insight into the degree to which a team may need additional coaching or provincial team support to enable success

Action Plan – Expectations for OHTs

Teams will be asked to complete an action plan that is reviewed by Ontario Health which includes:

- A **participation requirements list** which sets out consistent administrative and clinical criteria to ensure programs have met all requirements, and have considered core elements (e.g. clinical guidelines) before participating. The requirements outline the central pillars of integrated care as the foundation for the HF & COPD pathways.
- A **description of initiatives** which includes the following sections:

Part 1: Assessing the Current State of Care in Your OHT	Teams describe the current state of HF/COPD care in their communities. Teams will identify current gaps and barriers.
Part 2: Proposed Change Initiatives	Teams are asked to describe proposed change initiatives and articulate an ideal future state of care in alignment with best evidence with an overarching goal to work towards an integrated model of care for COPD and HF respectively.
Part 3: Partner Engagement Plan	Teams are to identify all OHT partners that are or will be actively involved in collaborating to design and implement change initiatives.
Part 4: Forecasted Costs	Teams outline how they intend to use seed funding to support proposed change initiatives.
Part 5: Declaration of OHT Collaboration	Teams indicate they are ready to participate, having completed the action plan and have designated respective leads for each pertinent setting.

Ontario Health

Teams are encouraged to leverage supports from the OH provincial team and regional partners in completing their Action Plans, including supports from RISE coaches, as brokered by the Ministry of Health.

Patient Reported Measures (PRMs)

Patient Reported Outcome/ Experience Measures (PROMs/PREMs) are a key measurement for the success of ICPs.

	23/24 Expectations	24/25 Expectations
Heart Failure	• Teams currently implementing or planning for Heart Failure PROMs collection will continue with established implementation plans for 23/24 • Teams starting net new with Heart Failure PROMs collection as part of the initial 12 will complete a readiness assessment as an early TPA deliverable (timing TBD)	Teams starting net new with COPD and/or Heart Failure PROMs collection will be prioritized for implementation using a phased approach, and informed by teams readiness assessments (timing TBD)
COPD	• There will be no specific PRM TPA deliverable for COPD, as work proceeds to identify the COPD PROM tool	

Available Funding

Teams will be provided with seed funding, in addition to a QBP no-loss provision [TBC] for each ICP. Amounts will be proportionate to required planning and implementation efforts.

NOTE: Higher seed funding may be approved in exceptional circumstances, with sufficient justification.

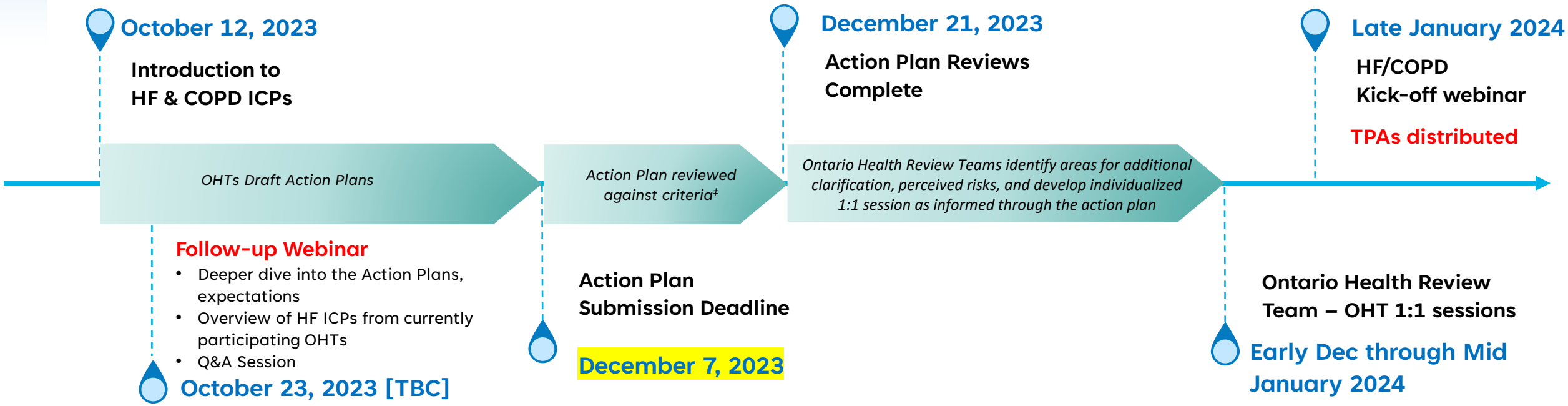
Action Plan Proposals will be reviewed in detail by the Ontario Health Provincial Team with the following considerations specific to assessing funding appropriateness:

- Any requests for additional HHR resources in the budget should be matched with in-kind resources from partners. This will help to build capacity within the OHT to ensure sustainability of the model without relying on one-time funding in the longer term.
- Appropriateness of scope (i.e., projects should be scoped to fit within the maximum budget guideline)
- Adherence to guidance on funds recovered under the expected QBP no -loss provisions [subject to approval by Ministry of Health] and seed funding (Appendix C & D in the Action Plans)
- Expected impact of dollars spent (i.e., patient outcomes, value for money)

**Any confirmation of funding for FY2024/25 and beyond is subject to approvals by the Ministry of Health for teams currently implementing ICPs*

Timeline and Next Steps

‡ Review Criteria Includes (but not limited to):
- Meeting the Participation Requirements
- Alignment with Clinical Priorities
- Alignment with Population Health Management principles
- Perceived risks which could impact initiative success



- Action Plans will be distributed shortly after this webinar. Teams will have ~7 weeks to complete both Action Plans
  - HF & COPD Project teams are available to answer questions. If any support is required during any stage of the Action Plan drafting process please **contact** OHTSupport@OntarioHealth.ca
- A fast follow-up webinar providing a more granular look at the Action Plans with additional time for Action Plan-specific Q&As is currently being scheduled
- **For any questions you wish to be answered in the webinar, please send ahead of time to the e-mail above**

Ontario Health

Questions & Answers

Questions & Answers

Can we choose a population within the pathway to focus on?

- Teams selected as part of the initial 12 OHTs know best, the needs of their population segments. While the hope is to maximize reach in the implementation of ICPs, OHTs with a compelling reason to focus on a subset of the HF or COPD population can outline this rationale as part of their Action Plan.

What tools will be used for COPD - will the pathway come with guidance and performance linked to the tools on the pathways?

- Tools and clinical best practices to support the implementation of COPD will be outlined in the Action Plan and were shared with OHTs in advance of today's webinar.

Because we currently receive CHF funding, should we only expect to receive COPD funding?

- Initial 12 OHTs who are already implementing HF will receive funding per prior commitments for in flight pathways, and will receive additional seed funding to implement new pathways for COPD.

Questions & Answers

Do you expect that we will add palliative and MHA pathways in the next three years?

- Ontario Health is continuing to explore opportunities for additional pathways, but no commitments will be made at this time as to timing for implementation.

Will we be expected to implement both CHF and COPD pathways simultaneously? What are the timelines? Can we be able to carry over funds received this fiscal year?

- Initial 12 OHTs are expected to implement two or more integrated clinical pathways, beginning in fiscal year 2023/24. Funds cannot be carried over, but teams will have two years of implementation funding.

What are the timelines for implementation?

- Initial 12 OHTs will begin implementation work in fiscal year 2023/24 for HF and COPD, as outlined in timelines shared today.

Questions & Answers

Would there be an opportunity to work with other initial OHTs that have strong ICP work already in place?

- Yes, teams are encouraged to leverage the work of previous OHTs who have already implemented an ICP. This will be facilitated by Ontario Health through existing Communities of Practice.

Would OH consider allowing OHTs to implement either HF or COPD and a different pathway?

- The focus for the initial 12 OHTs is on the implementation of HF and COPD. Teams interested in implementing another pathway [LLP] are encouraged to reach out to Ontario Health through the regional partners, to discuss.

Will we be provided with flexibility when it comes to designing the pathway and considering innovative approaches?

- Yes, clinical innovation in pathway implementation is encouraged, to the extent it is still linked to clinical best practices.

Questions & Answers

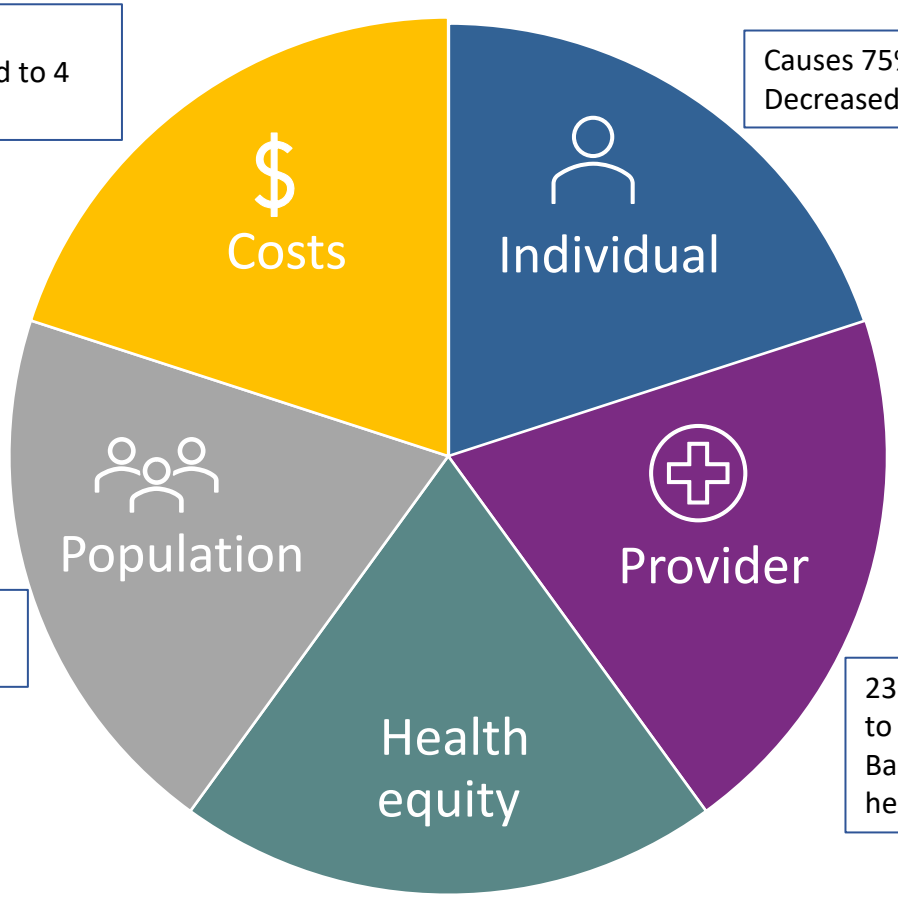
We have been assuming that our initial ICP planning should be based on the Hospital QBP. Is this the correct approach?

- While the QBP is important in supporting a no-loss provision alongside seed funding, to help support implementation of the pathway and its associated costs, the clinical model is expected to focus on moving care both upstream and as appropriate, downstream, and out of acute care settings.

Priority Area: Early Detection and Preventative Care

Chronic Disease Burden and the Quintuple Aim

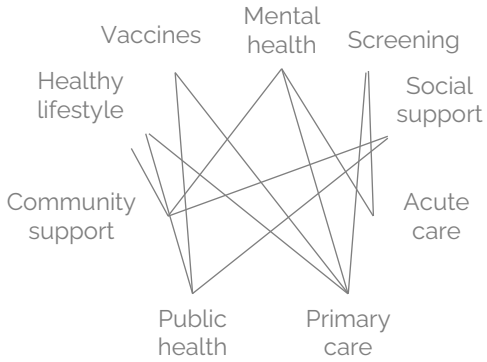
About 80% of chronic diseases are preventable



Ontario Health

Current state:

Multiple touchpoints



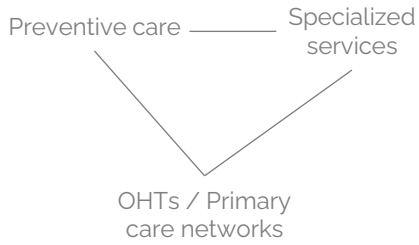
Disease-specific

- Cancer prevention
- Diabetes prevention
- Cardiac prevention

One size-fits all that misses some populations

Future state:

Fewer touchpoints



Comprehensive

- Chronic disease prevention (including social determinants of health)

Co-designed programs for specific populations

Ontario Health

Cancer Screening

OBSP
~700K mammograms across 241 sites

OCSP
~1M Pap tests

CCC
1.3M FIT kits mailed

Ontario Health Teams (OHTs)

Through cQIPs, many OHTs have focused on:

- ✓ **Improving cancer screening participation** for breast, cervical and colorectal screening
- ✓ **Using data to understand the current state** of their population (e.g., Screening Activity Report)
- ✓ **Education and outreach** for providers, patients and/or the public/community
- ✓ **Establishing partnerships** within the community including with Regional Cancer Programs (RCPs)

In 2023-24, areas of focus include:

- **Improvement targets** for % up-to-date with Pap, mammography and colorectal screening
- **Support for unattached participants** with cancer screening access and abnormal follow-up (e.g., through PCN)
- Strategies and initiatives to **engage and support underserved populations** with low screening rates

Ontario Health

Partners & Engagement

Regional Cancer Programs (RCPs):

Areas of collaboration to-date:

- cQIPs for cancer screening
- Regional and local cancer screening initiatives
- Primary care engagement
- Unattached participants
- Building partnerships across the region

Opportunities:

- Alignment of regional and local initiatives
- Expanded reach → primary care, community partners, hard to reach populations
- Leverage RCP cancer screening resources and training
- Improve role clarity

1. How are you currently engaging with your RCP for cancer screening?
2. Do you have feedback, opportunities or lessons learned to share?
3. How can we support you in building a relationship with your RCP?

Next Steps

- Work is in earlier stages to determine specific deliverables for early detection and preventative care for the initial OHTs.
- We will follow up with a subsequent meeting/session to gather input and ideas from the initial OHTs on a consistent approach to this initiative that will support achievement of the common clinical and population health priorities identified by Sacha earlier.

Priority Area: System Navigation

2019 Premier's Council Recommendations

"*Patients and their families find it difficult to navigate the health care system. For some, it's a matter of not being able to find timely health care, due to long wait-times or inconvenient service hours. For others, it can be difficult to know where to go for the right kind of care.*"

"*The system continues to struggle with transitions in care due to a lack of system-wide integration.*"

Problem Statements

"*Caregivers and health care providers are both looking for one clear point of contact that ensures patients' needs are met at every segment of their health care journey.*"

"*Improve patients' and providers' ability to navigate the health care system, simplify the process of accessing and providing care in the community, and improve digital access to personal health information*"

Recommendations

"*Measure patient experience and patient engagement along each stage of a health care journey by collecting and using standardized and digitally-enabled Patient Reported Experience Measures (PREMs)*"

Ontario Health

Sources

Hallway Health Care: A System Under Strain - First Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine

A healthy Ontario: Building a sustainable health care system: The 2nd report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine

Proposed Role of Provincial, OHT and Local Navigation Supports

Health811

Digital Front Door for Ontario

Focused on episodic needs and symptom assessment, high level navigation

Available 24/7

OHT Navigation

Information and referral service (should include needs assessment, however symptom assessment/advice not in scope)

In depth knowledge and established relationships with local/OHT service providers

Provides warm transfers to appropriate local health care and social services

Supports available for complex and/or unattached patients

Service available during business hours

Health Service Provider

First point of contact for most patients

Embed navigation supports into clinical pathways for target populations

Ensure patients know who to contact on their care team

Ontario Health

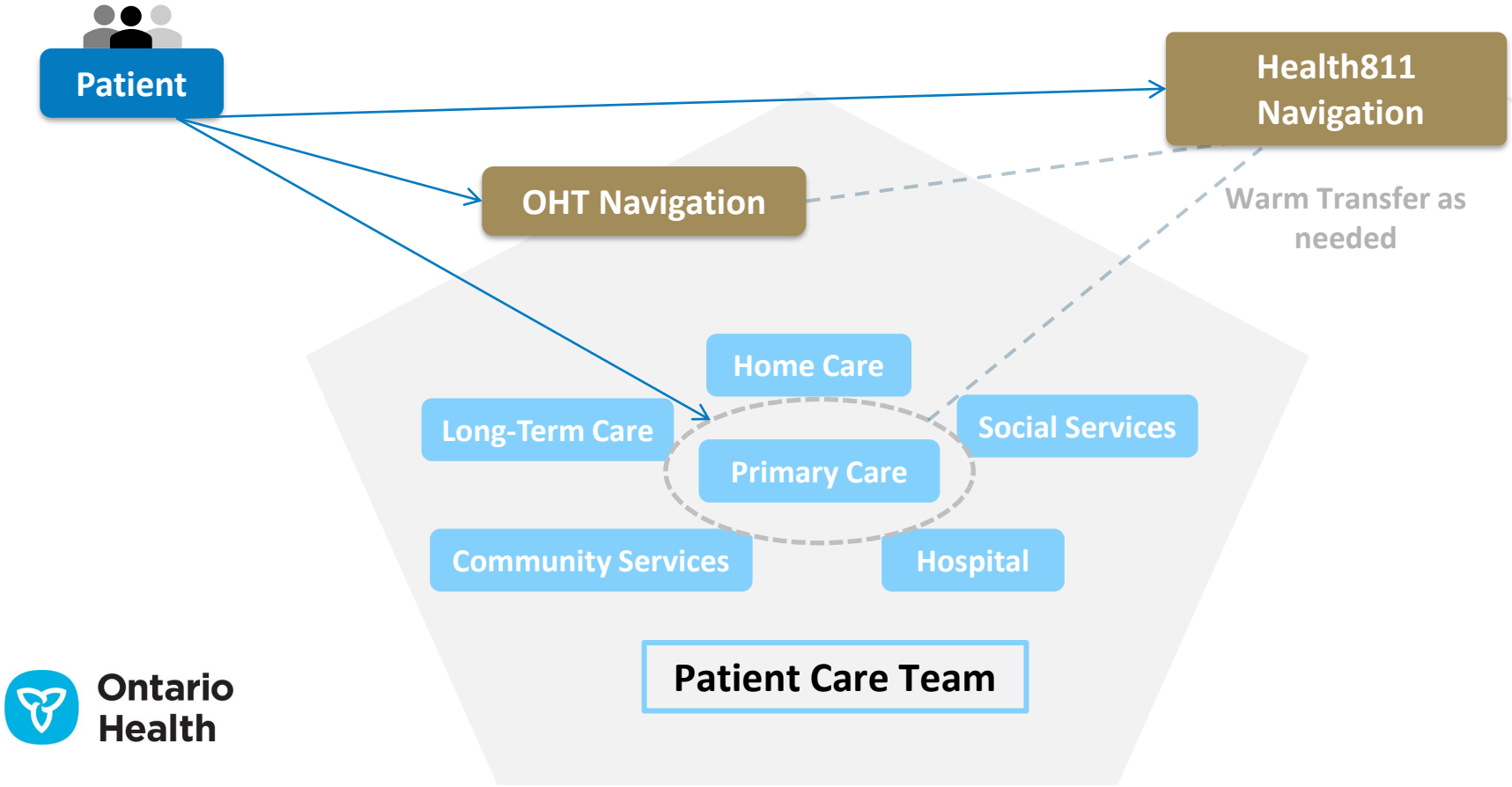
Proposed OHT Navigation Service Delivery Model

Definition:

- The OHT's navigation service delivery model outlines how the OHT, inclusive of its member organizations and providers, will work together to ensure patients receive support finding and accessing the health and social services they require.

Key Principles

- Patients should know who to contact for assistance with their care needs.
- OHT navigation services must coordinate closely with health service providers to help patients identify and access the services they need along their care journey



- Registered Nurse advice for symptoms
- Health Services Directory
- Health Education Resources
- Symptom Assessment Tool & Health Care Advice

Ontario Health

System Navigation Priorities

- Continued focus on local navigation improvements
- Implement a standardized service delivery model integrated with Health811
  - Partnership with an information and referral service to receive Health811 warm transfers
  - Integration with primary care navigation resources
- Integration with Provincial Health Service Directory (PHSD)
- Measure impact of navigation improvements

OHTs will be engaged in the development of refreshed navigation guidance, which is expected in early Q4

Ontario Health

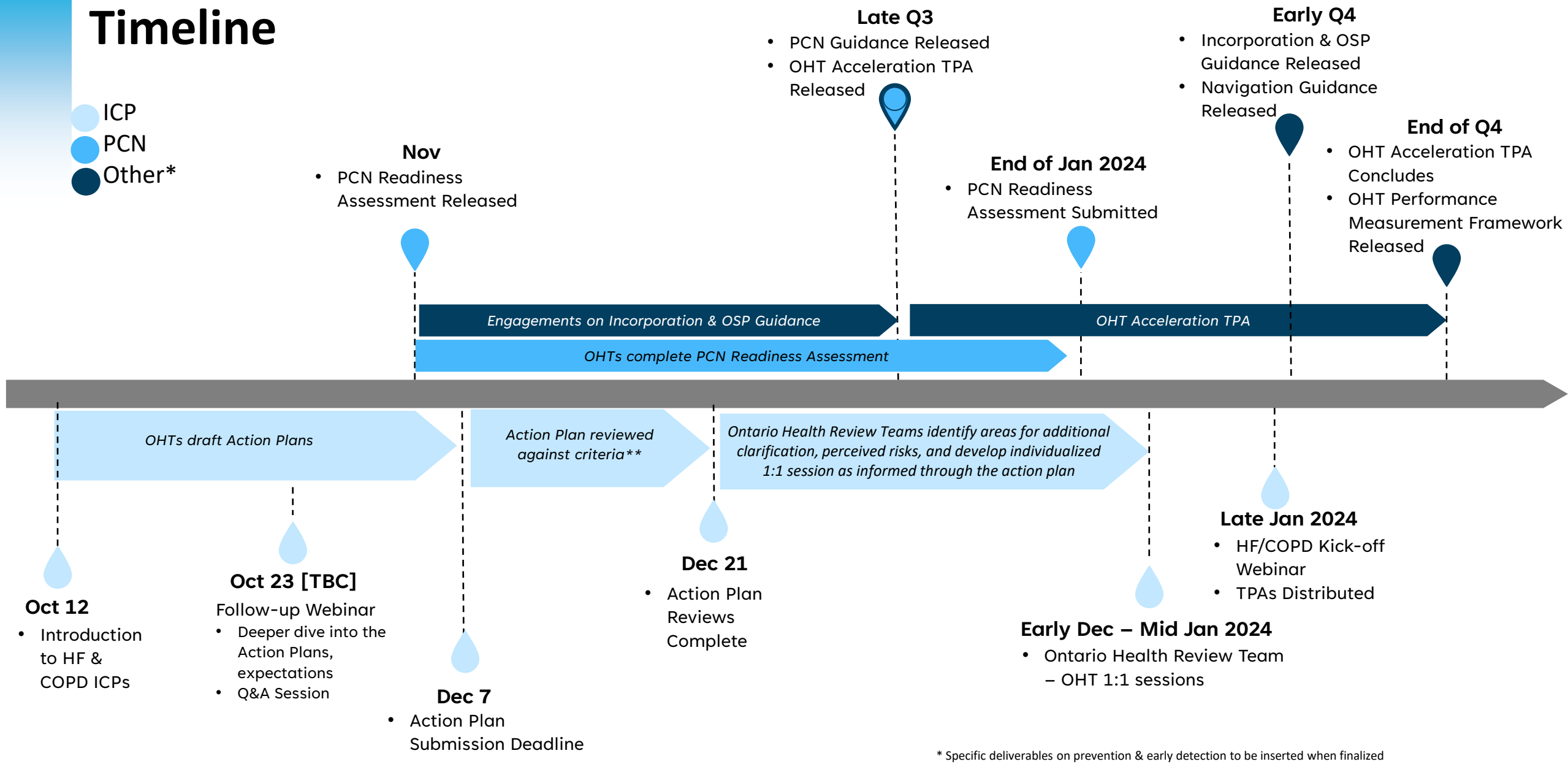
Wrap Up and Next Steps

Summary of Approved FY23/24 Funding Streams

Goal is to develop a single set of TPA deliverables and reporting requirements across all funding streams.

Funding Stream	Description	Amount for FY 23/24
Implementation Funding	Support all OHTs with completion of deliverables, including population health management and equity plan	**$750,000/OHT**
Acceleration Funding	Support 12 initial OHTs with completion of FY23/24 deliverables relating to clinical and governance priorities	**$300,000/OHT**
Integrated Clinical Pathways (ICPs) Funding	Support 12 initial OHT (and other selected OHTs) to implement ICPs for specific chronic illnesses. Funding will also support PROMs/PREMs implementation for ICPs	**Up to $200,000 per ICP for planning (pro-rated for Q3 and Q4)**

Timeline



* Specific deliverables on prevention & early detection to be inserted when finalized

**Review Criteria Includes (but not limited to):

- Meeting the Participation Requirements
- Alignment with Clinical Priorities
- Alignment with Population Health Management principles
- Perceived risks which could impact initiative success

Ontario Health

Upcoming Engagements

- Engagement with OHT Leads on discuss approaches to engagement and supports
- Engagement with Integrated Clinical Pathway teams on action plans
- Survey on implementation supports
- Circulate other Fall 2023 engagement opportunities (e.g. incorporation guidance, supports for unattached patients)

APPENDIX: OH Digital Supports

The OHTs are the transformation structure in an evolving provincial digital ecosystem. Ontario Health has worked closely with the MOH, health service providers and other stakeholders to define capability models and processes to support OHTs on their digital journey.

- 12 Ontario OHTs have been chosen to accelerate their work to deliver care in their location communities starting in 2025. These teams will focus on seamlessly transitioning people experience chronic disease through their primary care, hospital and home and community care needs. These 12 OHTs will share lessons learned to help inform the process and guidance other OHTs will follow
- OHTs will build into digital plans the use of provincially available assets, both today and near term
- OHTs should plan for partnership and consolidation of local digital capabilities through services to drive efficiency and effectiveness opportunities
- OH will provide supports to the 12 OHTs Digital Leads to review and approve digital plans. A follow up digital guidance session will be planned in November. Prior to making investments into digital health, OHTs should consult MOH/OH.

For any questions and concerns, contact your local Ontario Health Regional Digital Lead.

Thank you!

Appendix

Preliminary Characteristics of PCN Functions

Function	Minimum Characteristics	Advanced Characteristics* *(Unless indicated, includes all min. characteristics)*
1) Connects Primary Care Members within the OHT	• Individual primary care provider membership is voluntary • Membership is open to all family physicians, primary care pediatricians, and primary care NPs. Opening membership to primary care providers beyond the above is optional (minimum characteristic only) • Has established processes to recruit PCPs to become involved, communicate with PCPs, and respond to concerns of local providers • Leads communication to local primary care providers	• Membership is open to all local primary care providers, including primary care administrators and interprofessional healthcare providers working in primary care (e.g., RNs, RPNs, OTs, SWs, Pharmacists, Midwives, etc.) • Membership is open with significant coverage of primary care providers in the OHT's attributed population • Membership in the PCN equates to membership in OHT • Hub for local primary care communication, connections and information
2) Primary Care Voice in OHT Decision-Making	• Formalized process for selecting clinical leadership within PCN • Process for selecting PC leaders to provide advice on primary care on OHT governance tables	• Supports the selection of PCPs to OHT working groups / committees / clinical change management projects • PC leads involved and support OHT-related decisions on behalf of PC membership at OHT Council/Board.
3) Supports OHT Clinical Change Management & Population Health Mgmt (PHM) Approaches	• Selects PCP leaders to support OHT clinical change management activities (e.g. implementation of integrated clinical pathways) • Leads the implementation of PC-related OHT priorities (e.g., access and attachment, local priorities, etc.)	• Supports change management with PCPs to adopt PHM tools and approaches to care delivery and planning • Provides project and program management support for local primary care programs for the local OHT attributed population
4) Facilitates access to clinical supports and improvements for Primary Care	• Facilitates access for members to clinical supports such as clinical supports, digital / virtual tools	• Facilitates access to clinical supports for all local PCPs
5) Can / may support local Primary Care HHR Planning within the OHT	• Identifies primary care HHR capacity constraints locally to OH/MOH	• Has the ability to lead planning for local primary care HHR capacity building in coordination with OH/MOH

The Case for a HF ICP

- The **burden** for patients and the health system:
  - 2.9% of Ontario's adult population are responsible for 20% of acute hospital resource use
- Improved quality of care of heart failure in Ontario needs an **integrated approach to avoid acute care utilization as the 'default' for patients. New system of care should enable:**
  - **Earlier detection and management** of de-novo and worsening HF in the outpatient setting
  - Access to evidence- based interprofessional care **close to home**
  - **Improved transitions** between care providers and locations (e.g, navigation)
  - Advance care and end-of-life planning before symptoms are severe
  - Improved patient outcomes and experience

Support a higher performing system of care for heart failure identification and management, which promotes the principles and goals of **value-based health care** through a focus on prevention and care in the community, with the goal of keeping people healthy, happy and at home

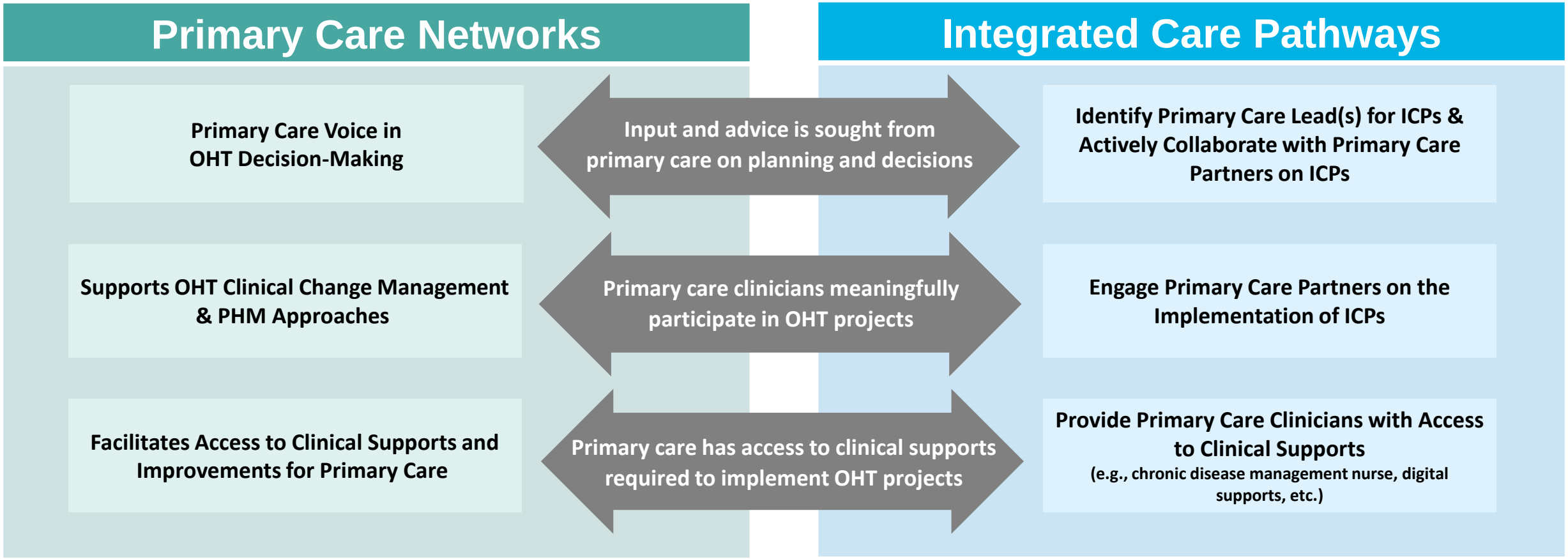
The Case for a COPD ICP

- The **burden** for patients and the health system:
  - COPD is one of the **most common reasons for hospitalization**; people with moderate-to-severe COPD typically experience one or more acute exacerbations per year, accounting for a significant proportion of non-elective inpatient admissions and unscheduled ED visits
- **Examples of identified gaps in COPD care** present an opportunity for better, evidence-based community management:
  - Spirometry is the only way to accurately diagnose COPD; **less than 40% of adults with COPD received spirometry testing** to confirm their diagnosis in 2021/22
  - All **moderate to severe cases** should be referred to **pulmonary rehabilitation** but **capacity of pulmonary rehabilitation in ON can serve less than 2%** of all COPD patients who require it

There is strong evidence that focusing on **accurate and early diagnosis**, **appropriate management and treatment in primary and community care for COPD** will have a significant **impact on patient experience and outcomes**, including **reducing acute exacerbations and associated ED visits/hospitalizations**

Evolving Role of Primary Care in ICPs

Primary care is a foundational element of integrated care delivery. Teams will be expected to partner with primary care providers, increasingly through Primary Care Networks, in the planning, co-design, and implementation of all ICPs.



Ontario Health