OHT Update

Association of Municipalities of Ontario (AMO) | August 22, 2023

Ian Cummins, Director, OHT Strategy, Ontario Health

Ontario Health

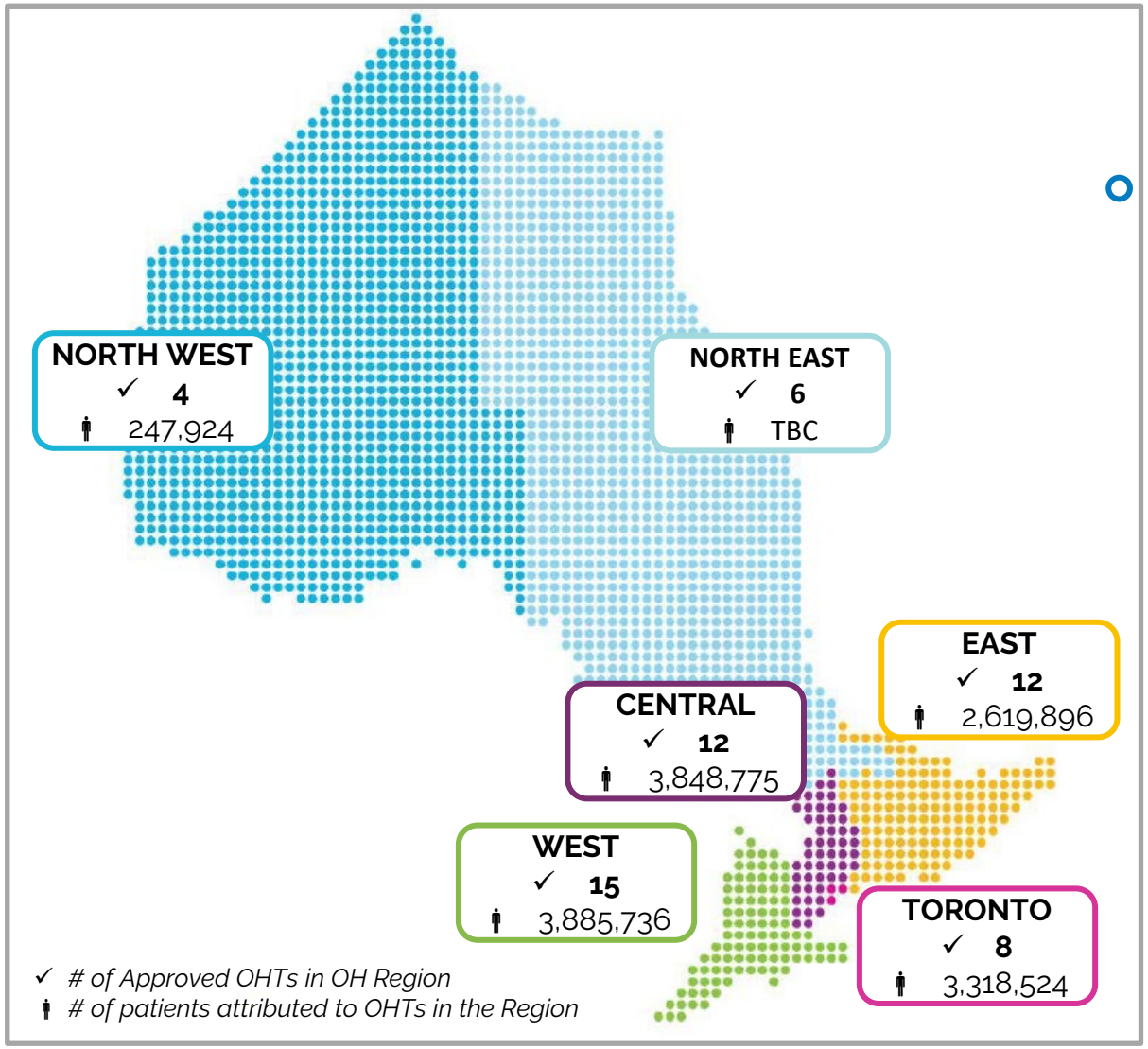
Ontario Health Teams (OHTs) Overview

OHT Overview

57 Approved OHTs

(Three just approved (in NE)

- Introduced in 2019, Ontario Health Teams (OHTs) are a model of integrated care delivery where groups of health care providers and organizations work together as a team to deliver a full and coordinated continuum of care for patients, even if they're not in the same organization or physical location.
- OHTs are comprised of sectors including primary care, home and community care, community care, public hospitals, mental health and additions, patient, families & caregivers
- The goal is to provide better, more integrated care across the province.



Ontario Health

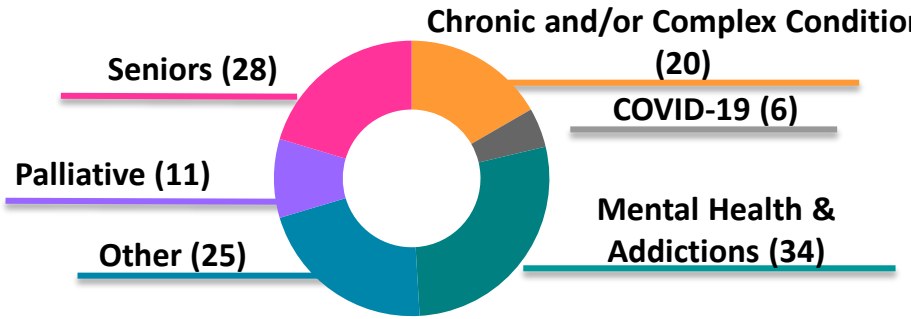
Progress To Date

OHT Partnerships

1,000+ providers involved
All teams include hospitals, primary care, and home and community care.

Beyond these required partners, OHTs include Mental Health and Addiction Services, Community Social Services, Public Health Units, Municipalities, etc.

Common Areas of Focus for Initial Target Populations



In some cases, OHTs are supporting more than one target population.

Focus on: Population Health Management

OHTs are working to achieve specific targets related to the care experiences and health outcomes for their initial target populations. They will build on these experiences by steadily expanding their reach in later years, with the goal of eventually optimizing care experiences and outcomes for their full population.

Ontario Health

* *Data represents all cohorts of OHTs, based on Full Application submissions and subsequent reporting where applicable. (As of May 2023)*

4

Ontario Health Teams: The Path Forward

Building OHTs to Last

Common Structure to Progress to Full Implementation
Establishing a New Not-for-Profit Corporation

Consistent Collaboration in Decision-Making
Standardizing Groups That Must Be Involved in Decision-making

Sustainable Operational Capacity
Identifying an Operational Support Provider for Back-Office Functions

Consistency in OHT-Led Public Communications
Setting a Consistent and Recognizable Approach to Communications

Delivering Better Care

Clinical Pathways to Improve Patient Care
Implementing Common Integrated Clinical Pathways for OHTs

- Congestive Heart Failure
- Lower Limb Preservation
- Stroke
- Chronic Obstructive Pulmonary Disease
- Begin development on MH&A and Palliative

Home Care Leading Projects

OHT Membership

New OHT Membership Requirements

In *The Path Forward,* the Ministry of Health expanded the number of sectors that must be represented in OHT decision-making

- **Primary care providers**
- **Home and community care providers**
- **Community care providers**
- **Public hospitals**
- **Patients, families and caregivers**
- **Physicians and other clinicians**
- **Mental health and addictions**

OHTs continue to be encouraged to include additional sectors, including public health units, municipalities and long-term care homes, in OHT decision-making

Ontario Health

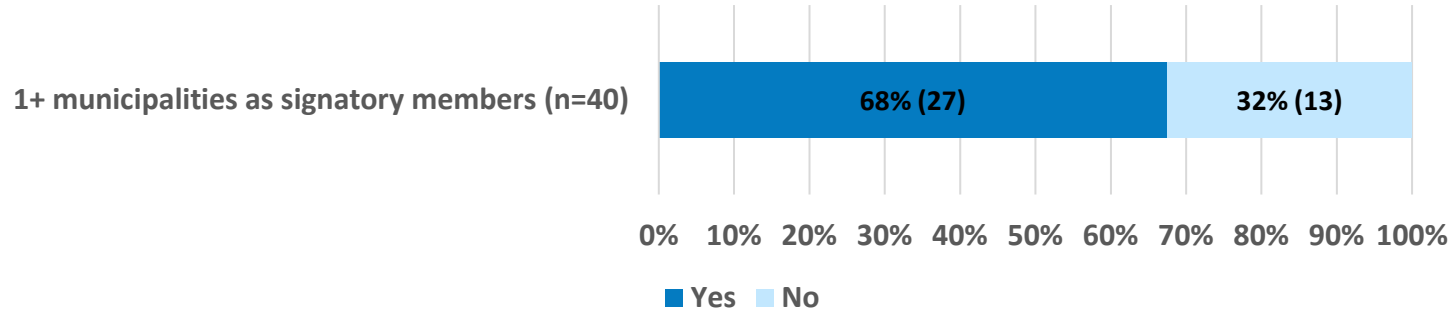
Municipal Engagement

This year, OHTs were optionally asked to report on municipal engagement (n=40)

Municipal Representatives

- Human services, Housing, Community Services, Strategy Policy and Performance Directors
- Paramedics
- Communication and Marketing Directors
- CEO
- Associate Medical Officer of Health

Collaborations



Examples of Municipal Engagement

Themes:

- Municipal leadership in emergency response for new paramedic led programs (e.g., Community Mental Health and Addictions Clinics) or COVID related initiatives.
- Municipal engagement in decision making, funding, and expert consultation for expansion of programs or services (e.g., Community Wellness Hub)
- Municipal resources are being leveraged for data collection and analysis initiatives.

Delivering Better Care through Improved Transitions in Care

- Home Care Leading Projects
- Integrated Clinical Pathways

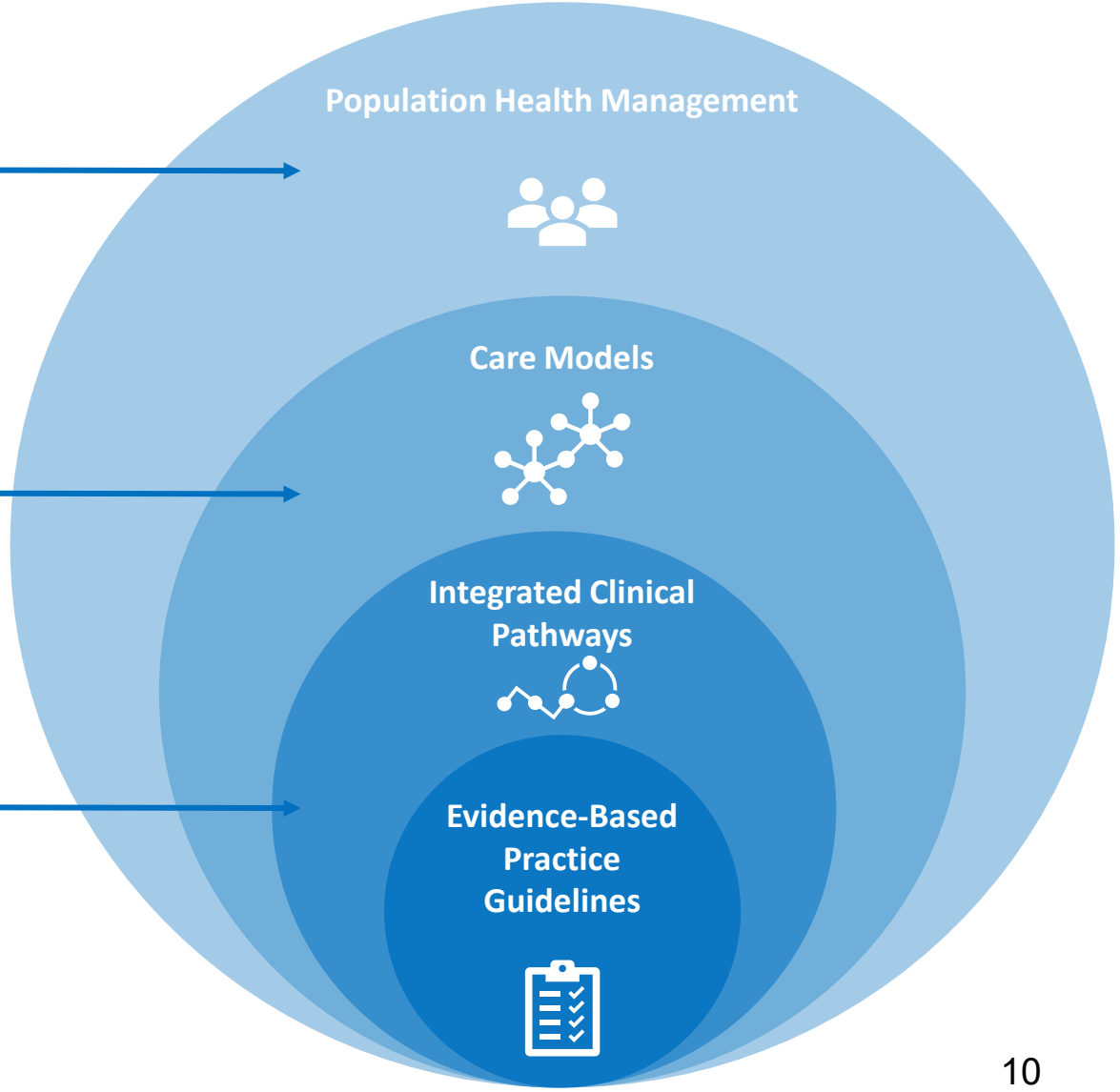
Integrated Clinical Pathways (ICPs)

Population Health Management includes

1. Population Identification
2. Segmentation for Needs, Risks & Barriers
3. Co-Designing Person-Centred Care Models & Service Mix
4. Implementation & Reach
5. Monitoring & Evaluation

Care Models are equitable systems of care with multiple care pathways and processes inside. They are person-centered and include other components to enable integrated clinical pathways (e.g., decision support, patient self-management support) to occur for whole person care (e.g., multiple diseases)

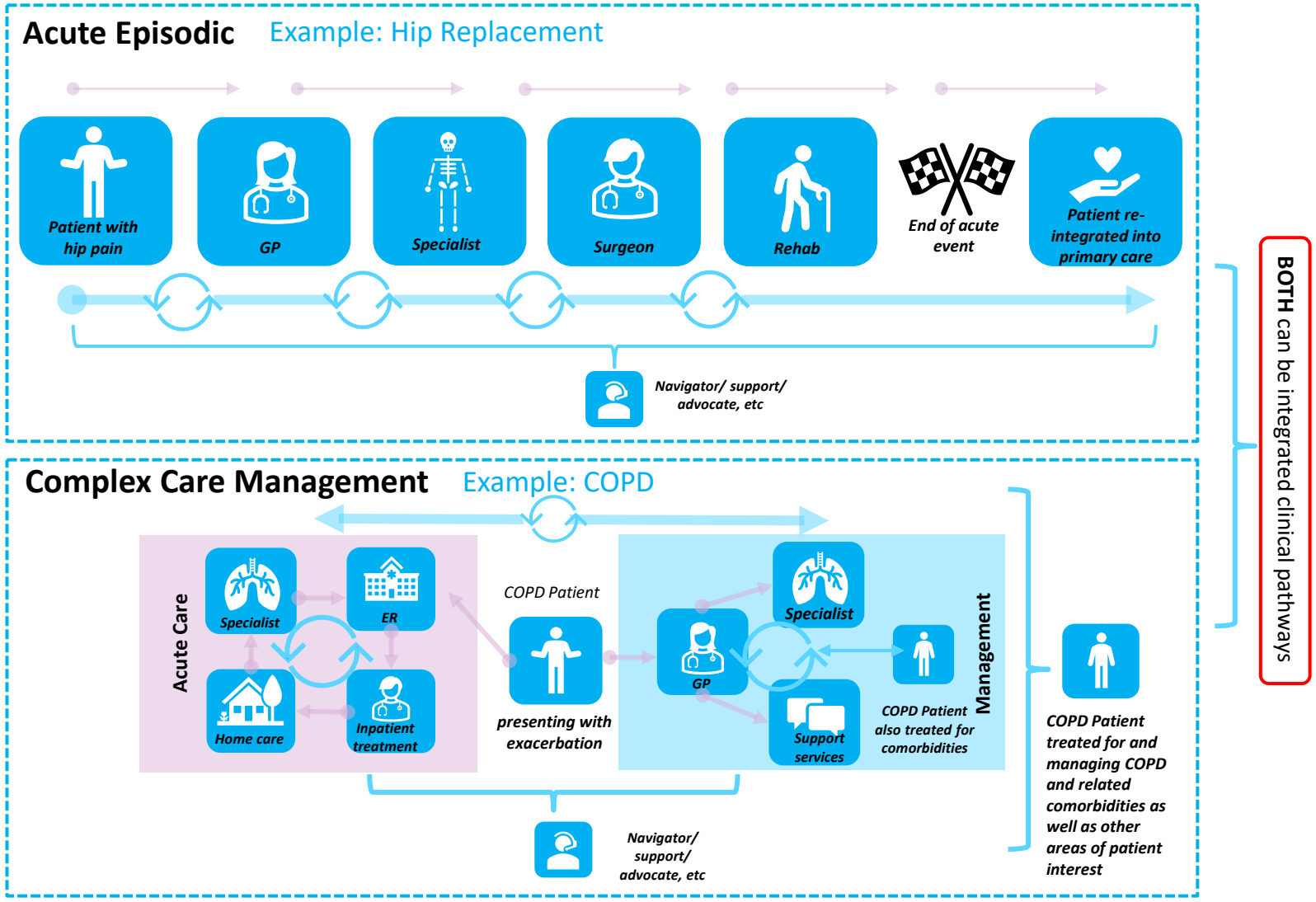
Integrated Clinical Pathways are the steps taken to deliver a care process (including social care) along the entire patient journey for the duration of their condition/chronic care for a specific disease or the multi-comorbid. They are undergirded by evidence-based guidelines/quality standards.



Ontario Health

Adapted from RISE "Population-health management and care pathways", February 2023

ICPs & Care Management – Desired State



Integrated Clinical Pathways

- **Single patient record** supported by **patient navigator** that coordinates handoff between providers/settings
- **Primary care involvement with ideal focus being on patients care organized through primary care**
- **Focus on equity deserving populations**
- Patient **experience** and **outcomes** are measured including equity measures
- Degree of variation **across care continuum monitored** via leading practice
- Funding & compensation based on **patient's whole journey** across disease/event, including **duration**
- Treatment with **whole patient at the centre.** Patients are grouped, monitored, and provided for as a **population** leading to **better population health management**

Ontario Health

Note: Current ICP pathways more focus on complex care. Future ability to scale to acute episodic care

Home Care Leading Projects

Seven OHT-led Leading Projects have been launched to model innovations in integrated home care services within OHTs. Project objectives include:

1) Test and evaluate OHT-led home care models that improve care integration, access, and patient outcomes and experience

- Improve timely access to home care services through streamlined and equitable referral and care processes, including expanding access to SPO and MES ordering
- Implement patient-centred, team-based care models that includes primary care, care coordinators, SPOs, and other OHT members to improve patient experience and outcomes
- Transform the care coordinator role and care coordination function based on patient risk factors.
- Test indirect care coordination approaches
- Improve collaborative care planning and information sharing by integrated patient care team and patients supported by digital solutions
- Additional local project objectives

2) Build OHT capacity for home care planning, delivery, and integration

- Support the integration of HCCSS care coordinators into integrated patient care teams
- Design and implement processes for home care intake, referral and patient transitions
- Design and test an innovative funding model for SPO services
- Test OHT-led SPO contract and performance management (via Lead Health Service Provider Organization)
- Develop a governance and accountability model for OHT-led home care, including quality, risk and complaints management
- Additional local project objectives

Appendix

Overview of OHTs by Cohort and Region

Cohort 1 Approved OHTs

1. All Nations Health Partners OHT
2. Nipissing Wellness OHT
3. Algoma OHT
4. North Toronto OHT
5. East Toronto Health Partners OHT
6. North Western Toronto OHT
7. North York Toronto Health Partners OHT
8. Peterborough OHT
9. Ottawa OHT/Équipe Santé Ottawa
10. Northumberland OHT
11. Durham OHT
12. Archipel OHT/ESO Archipel
13. Greater Hamilton Health Network OHT (Previously Hamilton OHT)
14. Burlington OHT
15. Huron Perth and Area OHT
16. Chatham-Kent OHT
17. Cambridge North Dumfries OHT
18. Guelph Wellington OHT
19. Niagara OHT
20. Middlesex London OHT
21. Muskoka and Area OHT
22. Connected Care Halton OHT
23. Hills of Headwaters Collaborative OHT
24. Southlake Community OHT
25. Couchiching OHT
26. Eastern York Region and North Durham OHT
27. Mississauga OHT
28. Central West OHT (Previously Brampton, Etobicoke and Area OHT)
29. Western York Region OHT

Cohort 2 Approved OHTS

1. Rainy River District OHT
2. West Toronto OHT
3. Downtown East Toronto OHT
4. Mid-West Toronto OHT
5. Scarborough OHT
6. Frontenac, Lennox & Addington OHT
7. Lanark, Leeds and Grenville OHT
8. Kawartha Lakes OHT
9. Oxford and Area OHT
10. Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT
11. Brantford Brant Norfolk OHT
12. Sarnia Lambton OHT
13. South Georgian Bay OHT

Cohort 3 Approved OHTs

1. Great River OHT (Previously Upper Canada, Cornwall, and Area OHT)
2. Ottawa West Four Rivers OHT
3. Ottawa Valley OHT (Previously Network 24)
4. Hastings Prince Edward OHT
5. Elgin OHT
6. Grey Bruce OHT
7. Windsor Essex OHT
8. North Simcoe OHT
9. Barrie & Area OHT

Cohort 4 Approved OHTs

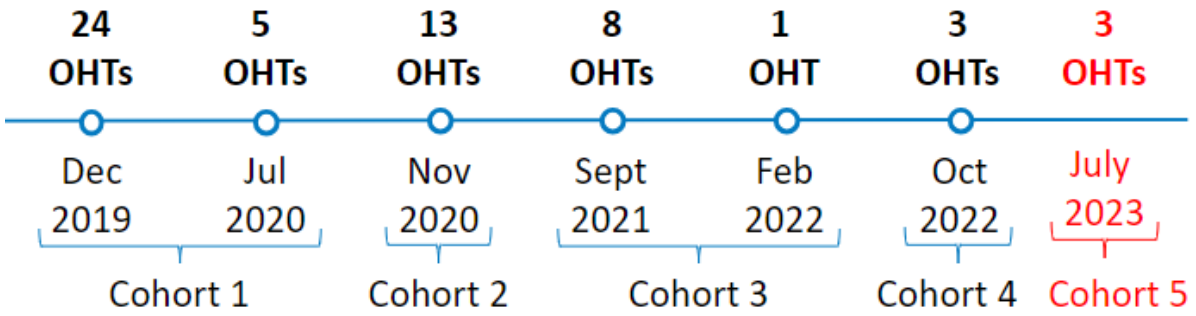
1. Noojmawing Sookatagaing OHT (Healing Working Together) (Previously City and District of Thunder Bay OHT)
2. Kiiwetinoong Healing Waters OHT (Previously Sioux Lookout/Red Lake/Dryden Team).
3. Maamwesying OHT

Cohort 5

1. Équipe Ontario Cochrane District Team
2. Équipe Sudbury Espanola Manitoulin Elliot Lake Team
3. Équipe des regions d u Timiskaming Area Team

Full Application Submitted Intake & Assessment by MOH

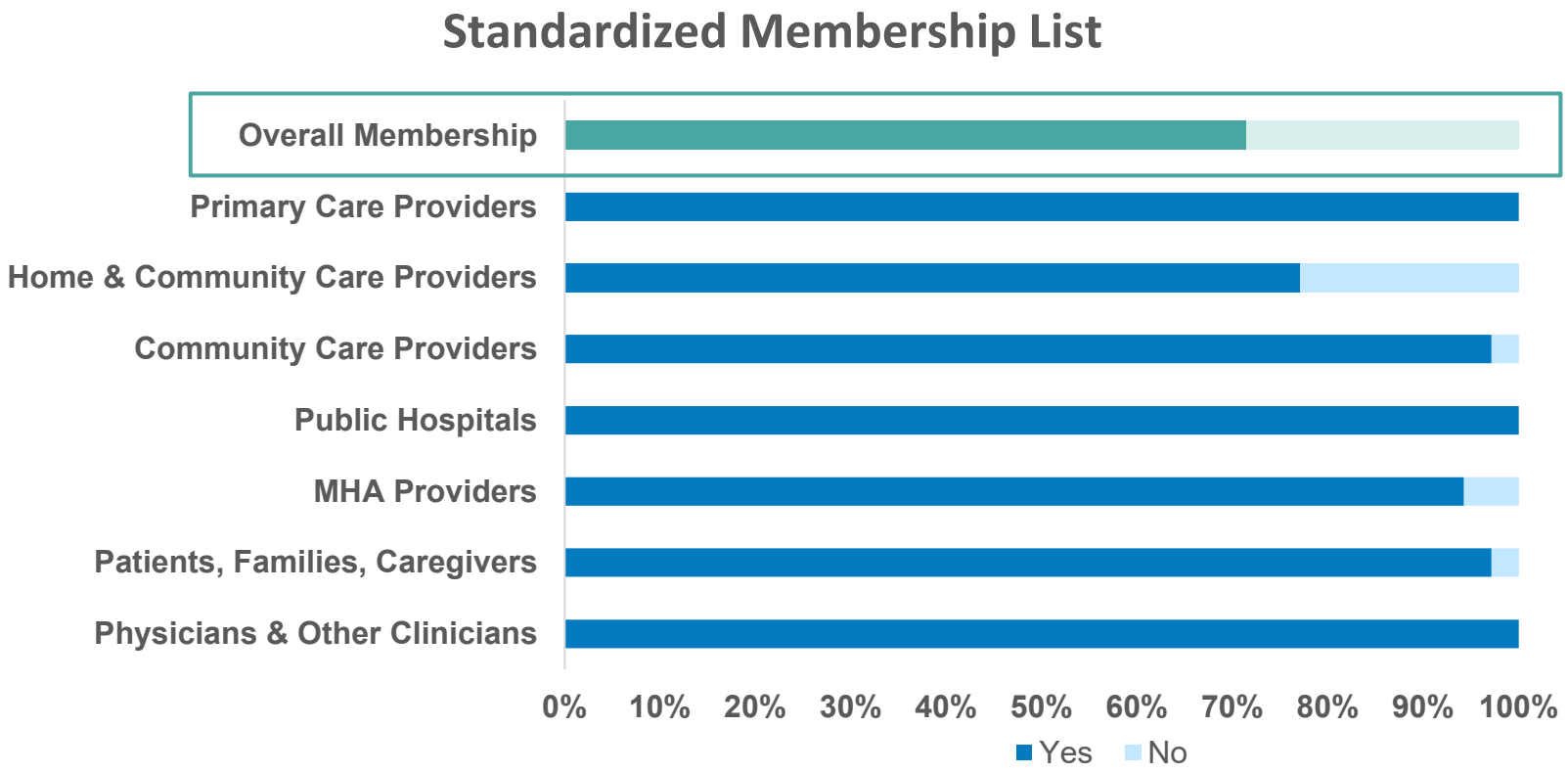
1. West Parry Sound Team



Legend
Northwest
Northeast
Toronto
East
West
Central

Required OHT Membership

Teams were asked to complete an optional membership self-assessment to identify which partners are represented in the OHT's collaborative decision-making. Below are the responses from Cohort 1 (n=26 answered) and Cohort 2 OHTs (n=9 answered), ***Total N=35***

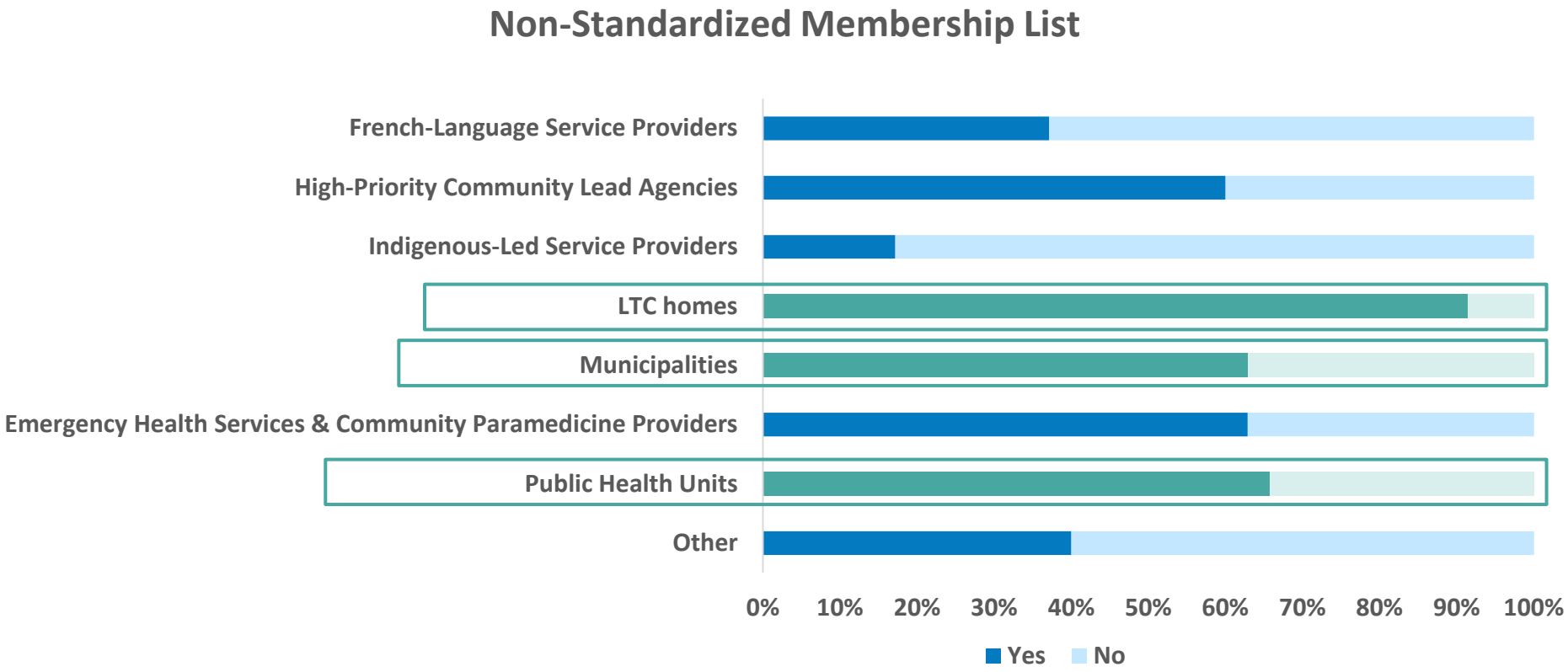


- **71%** (25) of OHTs have representation from all standardized members in their decision-making

In those OHTs who do not have all standardized members engaged, the majority are missing participation from **Home & Community Care Providers** (8/10)

Optional OHT Membership

Teams were asked to complete an optional membership self-assessment to identify which partners are represented in the OHT's collaborative decision-making. Below are the responses from Cohort 1 (n=26 answered) and Cohort 2 OHTs (n=9 answered), ***Total N=35***



Ontario Health