Ontario Health Team Readiness Assessment: In-Person Visit

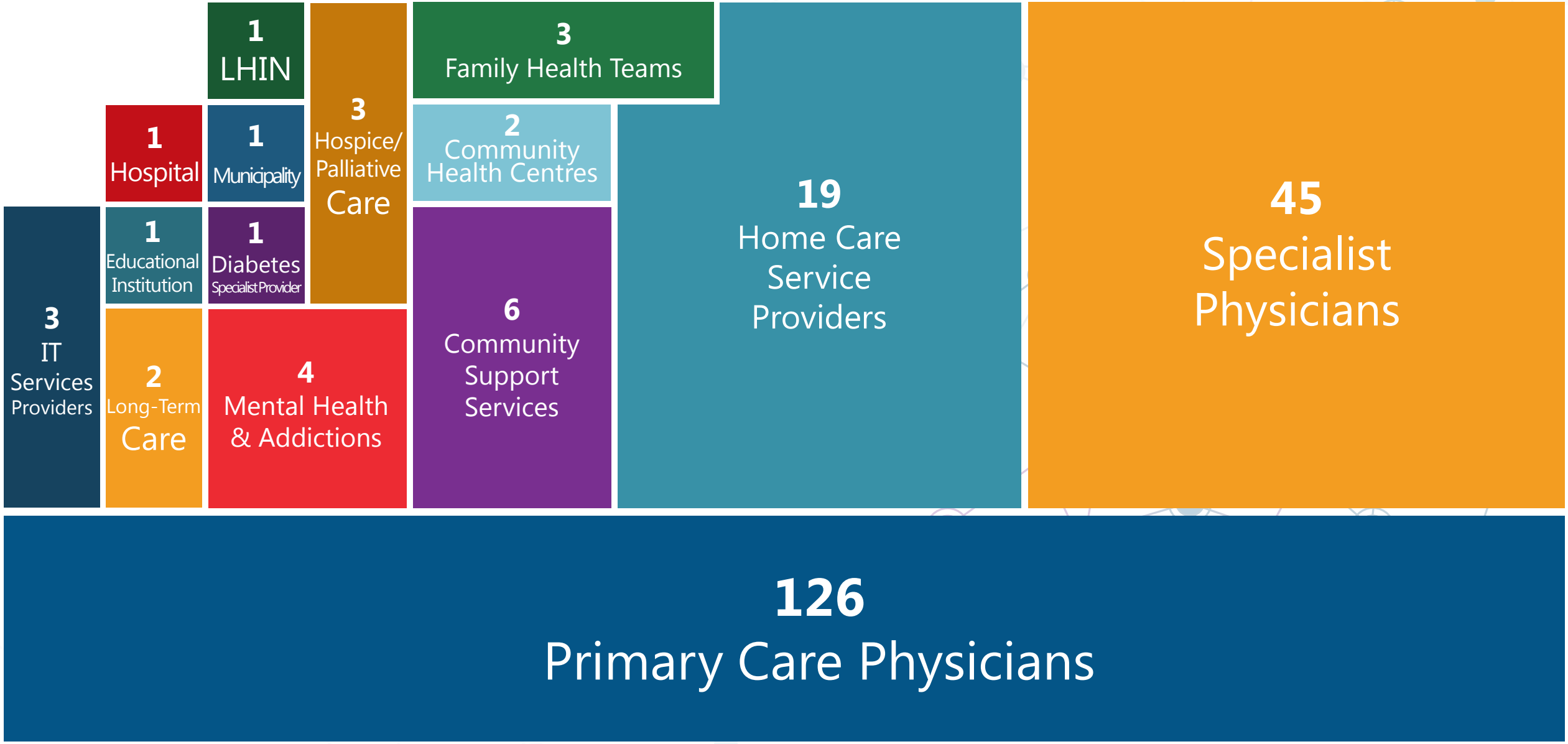
Ontario Health Team Name: Brampton/Etobicoke and Area OHT

Date: 04 November 2019

Team Members Attending Visit: Please see hand-out

SETTING THE STAGE

HOW WE GOT HERE



WHAT WE LEARNED FROM EACH OTHER

Improved Transitions

Clients, patients, families and caregivers need their care to be **better connected** so they can receive better supports, experience less of a burden with **transitions** and are treated as **individuals** in the process.

Capacity for Team-Based Care

Primary care physicians need **equitable access to interprofessional care** to provide comprehensive services that meet the needs of patients.

Connected and Coordinated Care

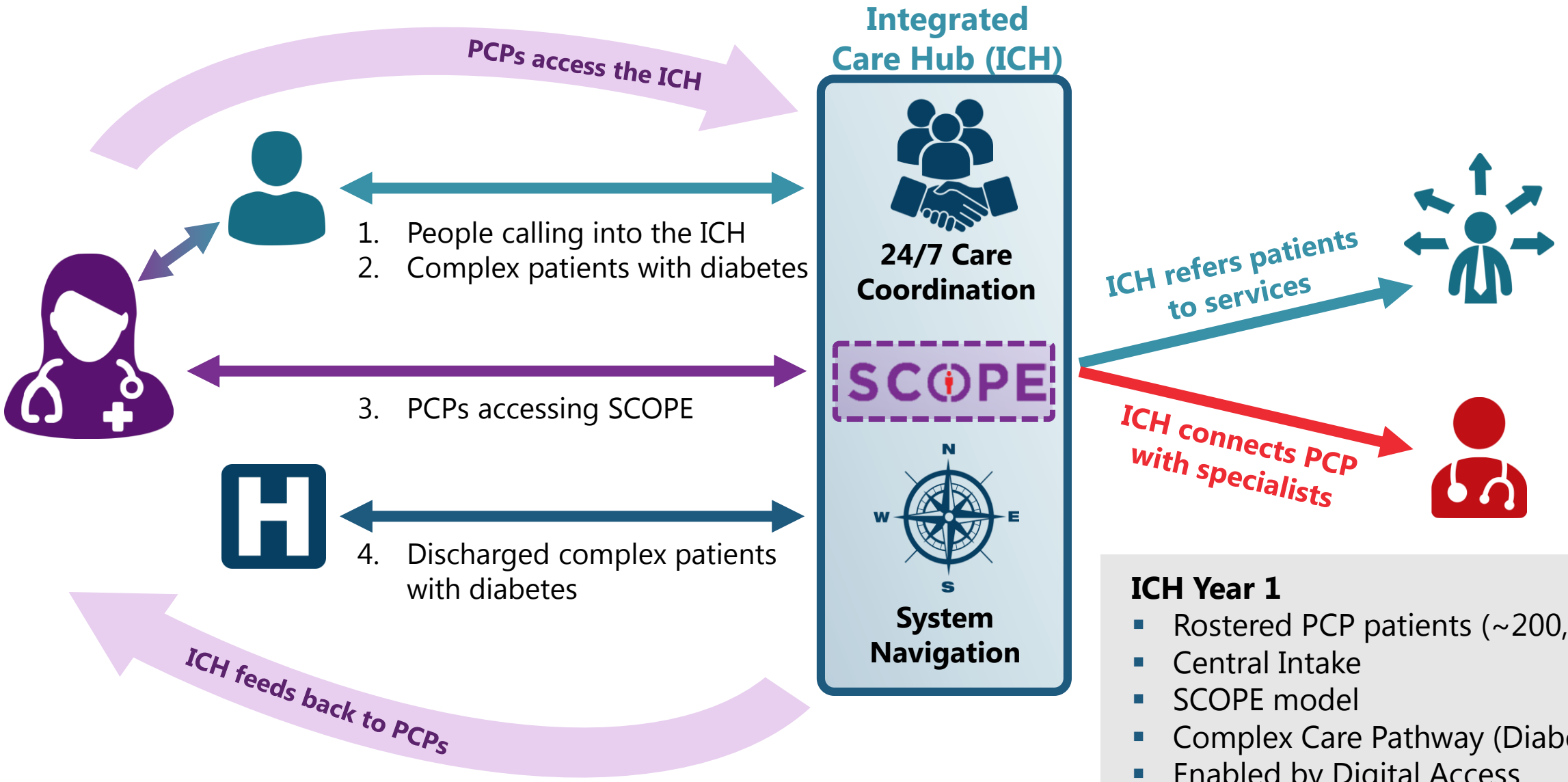
Community organizations want to better connect to one another to know **who we serve collectively, reduce redundancy and coordinate** the right services at the right time for patients, clients, families and caregivers.

WHAT WE ARE DOING ABOUT IT: A COMMON VISION

As partners, we share common foundations for collaboration and reaching agreement:

1. **We are working towards integrated care that puts clients / patients at the centre**
2. **We are one team sharing resources to optimize outcomes for our clients / patients, families and caregivers**
3. **We believe that health promotion and disease prevention keep people healthy and at home longer**
4. **We will build on our strengths to improve health care in the region**
5. **We embrace high-quality standards in delivering care**

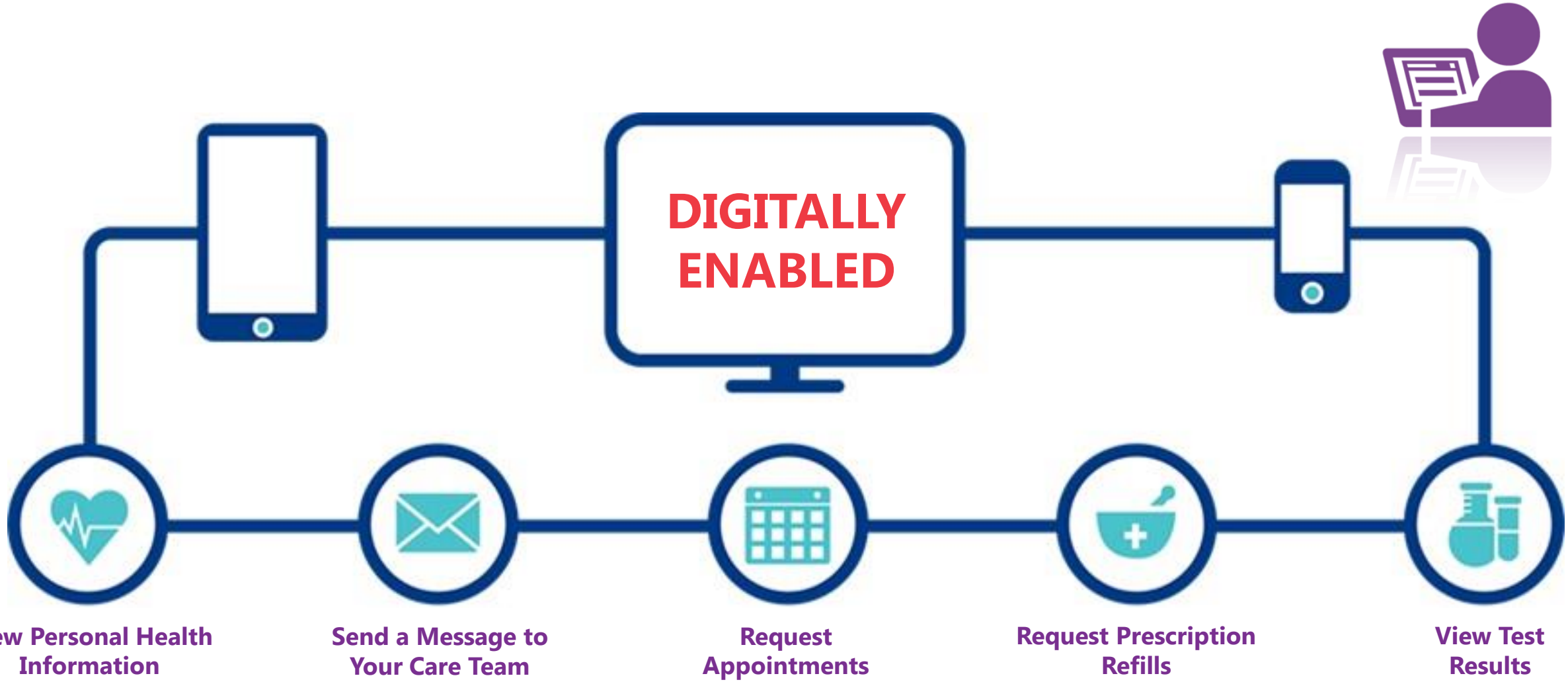
WHAT WE ARE DOING ABOUT IT: THE INTEGRATED CARE HUB



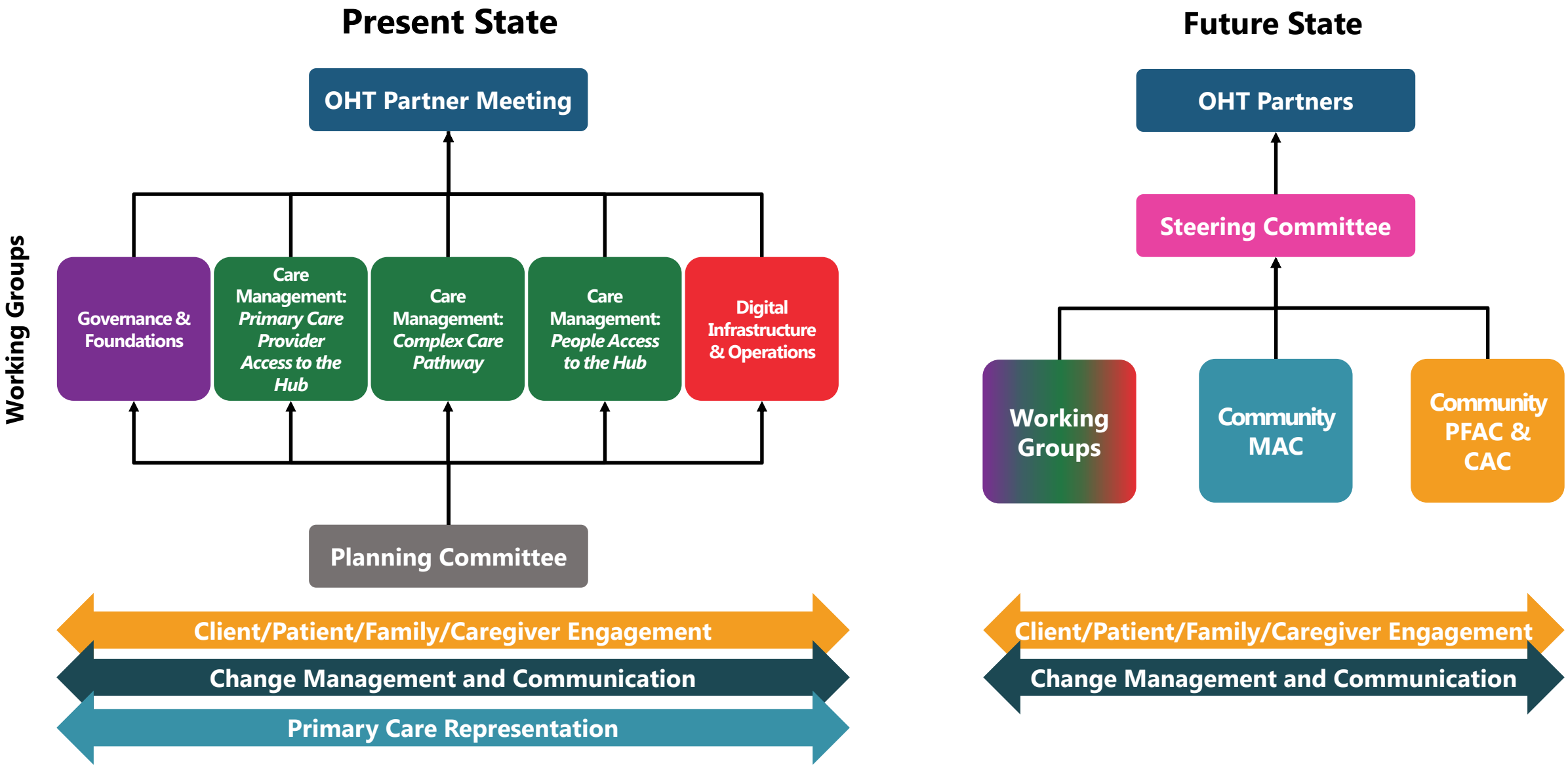
ICH Year 1

- Rostered PCP patients (~200,000)
- Central Intake
- SCOPE model
- Complex Care Pathway (Diabetes)
- Enabled by Digital Access

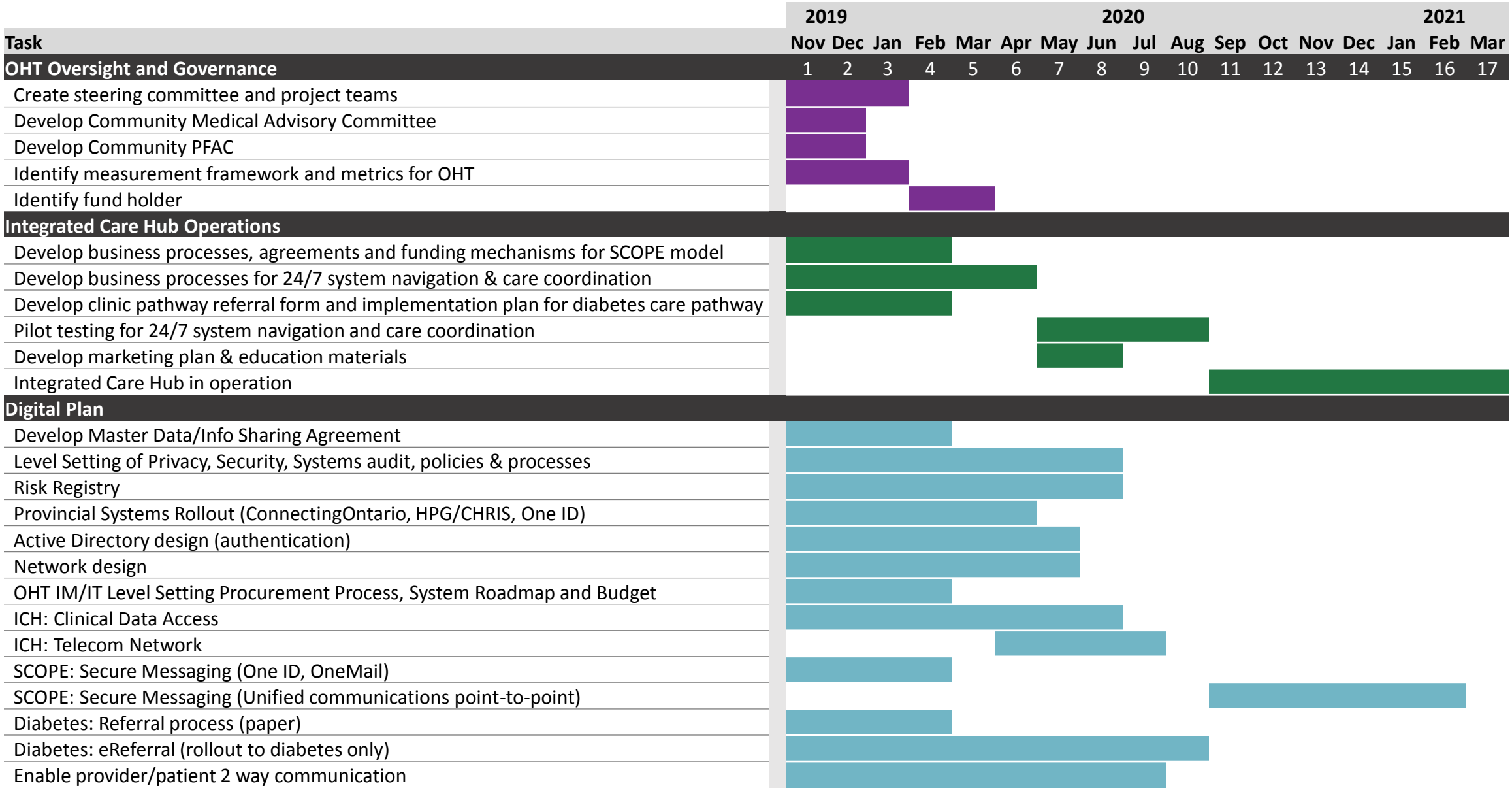
HOW WE WILL MAKE IT HAPPEN: DIGITAL ENABLERS



HOW WE WILL MAKE IT HAPPEN: DECISION-MAKING



HOW WE WILL MAKE IT HAPPEN: IMPLEMENTATION PLAN



WHAT WE NEED TO SUCCEED

- SCOPE Model
  - Specialists
  - eConsult
- Incentives for:
  - Physician leadership
  - OHT physician participation
  - After hours care
  - Virtual care

- Utilize existing space space for Integrated Care Hub
- Resources to support:
  - Change management
  - Communications
  - Project Management

- Improve efficiencies with adoption of provincial assets
- Funding for digital initiatives

- Privacy Legislation to enable data sharing
- Guidance for home care consistency
- Accountability agreements

WHAT SUCCESS LOOKS LIKE

Success to Date

- One team
- In-kind supports
- Location/staffing for Integrated Care Hub
- Anticipated funding

Anticipated Success

- Improvement in patient experience
- Improvement in provider experience
- Improved performance measures
- Increased financial efficiency

OUR TEAM

QUESTIONS?

Please join us for a tour of the

Integrated Care Hub (ICH)

24/7 Care Coordination

SCOPE

System Navigation

APPENDIX SLIDES

INDIGENOUS & FRANCOPHONE ENGAGEMENT

Indigenous

- ≈ 1% of population identifies as Indigenous or Métis (7,940)
- OHT partners work with Métis Nation of Ontario (Brampton) and Peel Aboriginal Network/Indigenous Friendship Centre

Francophone

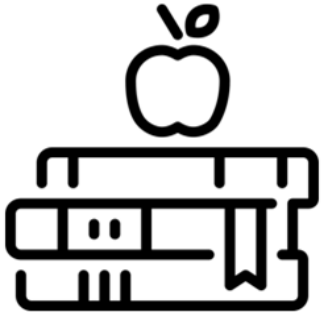
- ≈ 2% of population is francophone (12,095)
  - ≈ ½ born outside Canada
  - ≈ ½ visible minority
- FLS entity is Reflet Salvéo, who participated in our community engagement by distributing our survey to residents

The OHT is committed to using the Health Equity Impact Assessment tool in its design and implementation to identify and respond to unintended potential health effects of its plans. Epidemiological studies, health status profiles, and community narratives of Indigenous health all point to diabetes as a significant population health challenge.

PRIMARY CARE ENGAGEMENT

Our Approach

- Identified physician leaders
- Committee participation
- Physician leaders outreach
- Surveys



What we have learnt

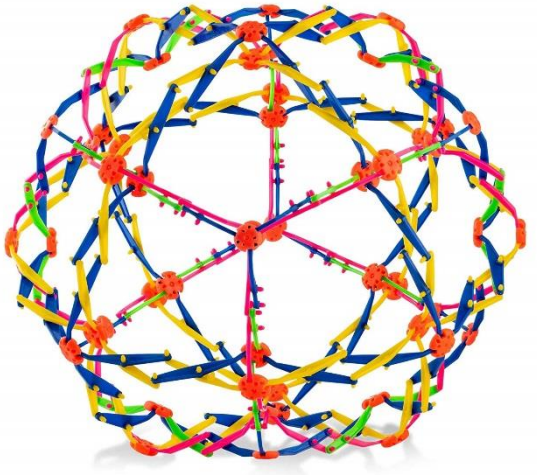
- Capacity
- Team-based
- Connectedness

What we will do in the future

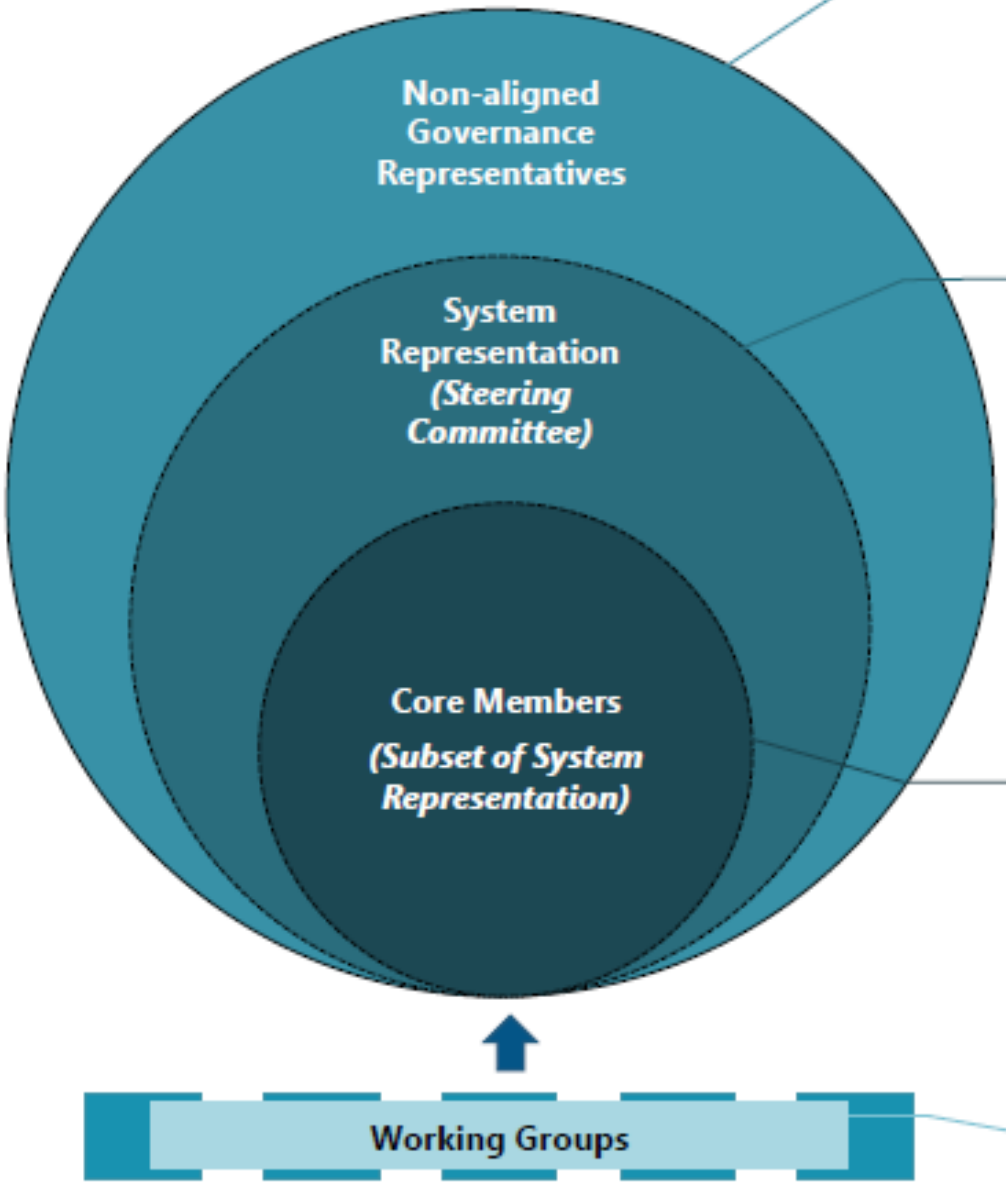
- Community Medical Advisory Committee
- Ongoing support for physician members
- Physician outreach
- Marketing plan for SCOPE

HOME AND COMMUNITY CARE MODERNIZATION

- Neighbourhood Networks of Care
- Streamline assessment practices and information sharing (data sharing standards)
- Develop ideal Care Coordination/Service Navigation approaches within population focus on all health and social needs and align all care coordinator functions to be consistent regardless of the CC's employer
- Outcome based pathways of care delivery
- Increase virtual care approaches into home and community care delivery
- Support more congregate care delivery and funding associated with these models of care
- Change Management approach to work as interprofessional community based care teams



DECISION-MAKING



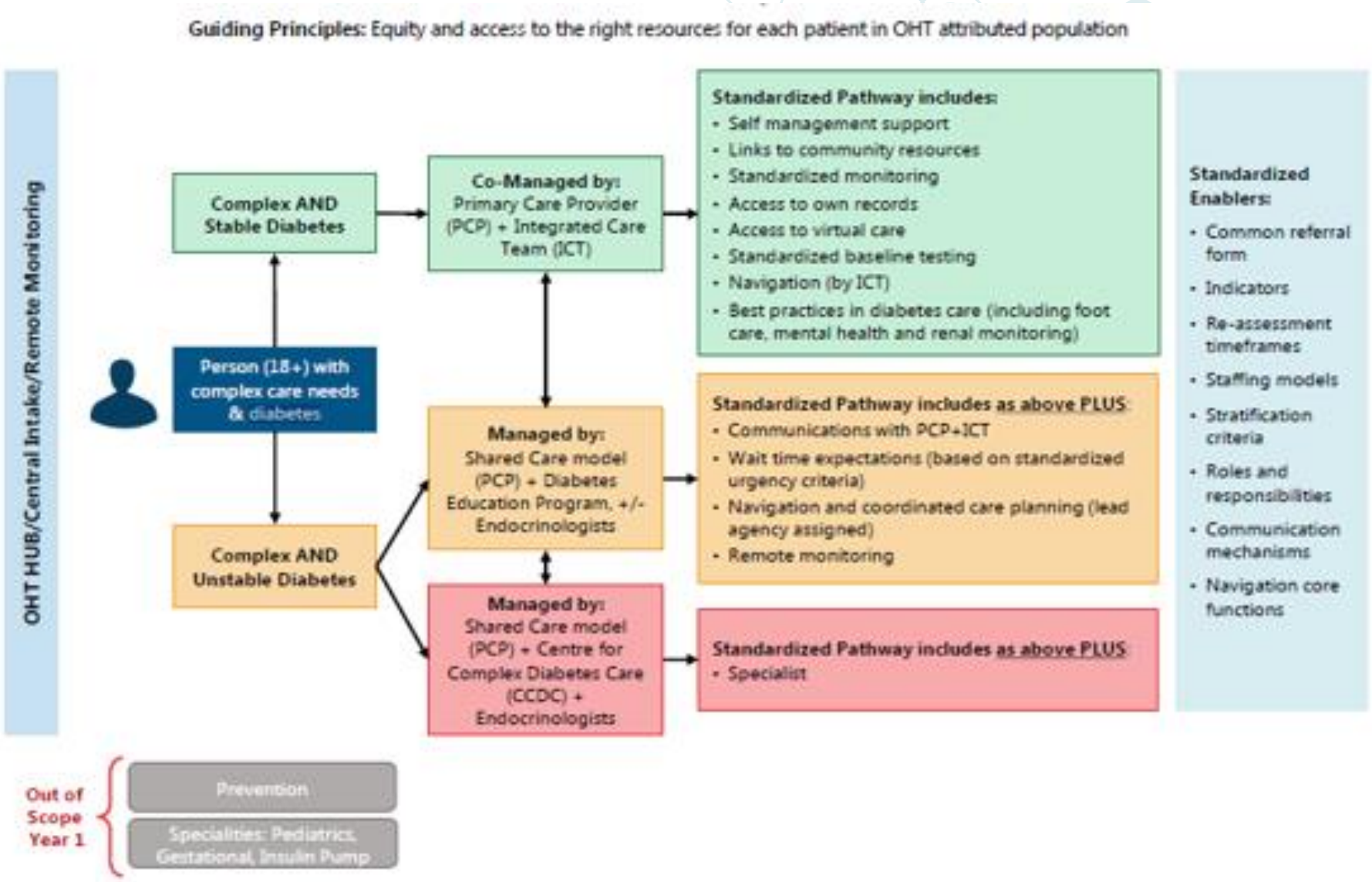
- Non-employees of any partner with strong healthcare governance experience
- Ex-Officio
- Purpose is to observe Interim OHT Oversight Collaborative and assist and contribute to the evolution and design of a longer-term governance model for the OHT

- System representatives – chosen by OHT members and affiliates, Senior Executives (SE) or Physicians (P) where indicated:
  - Patients and Family
  - Physicians from representative Community MAC
  - Primary Care (SE) or (P)
  - Long-Term Care
  - Community Support Services
  - Home and Community Care
  - Mental Health and Addictions
  - Acute Care
- Voting Members for governance, structural or strategic issues and for systems insights for Core Members groups

- Flexible Membership based on participation in shared budget and risk for Year One projects
- Responsible for operational oversight and decision making for Year One Project and other duties as agreed by Interim OHT Oversight Collaborative
- Responsible for decisions related to the allocation of shared resources for Year One and operational decisions, processes and policies for Year One

- Working groups created to focus on specific deliverables, guided by the Steering Committee

COMPLEX CARE PATHWAY



Developed by the OHT Care Management: Diabetes Working Group & Clinical Advisors and informed by Health Quality Ontario Quality Standards (Draft Transitions from Hospital to Home, COPD, and Diabetic Foot Ulcers)

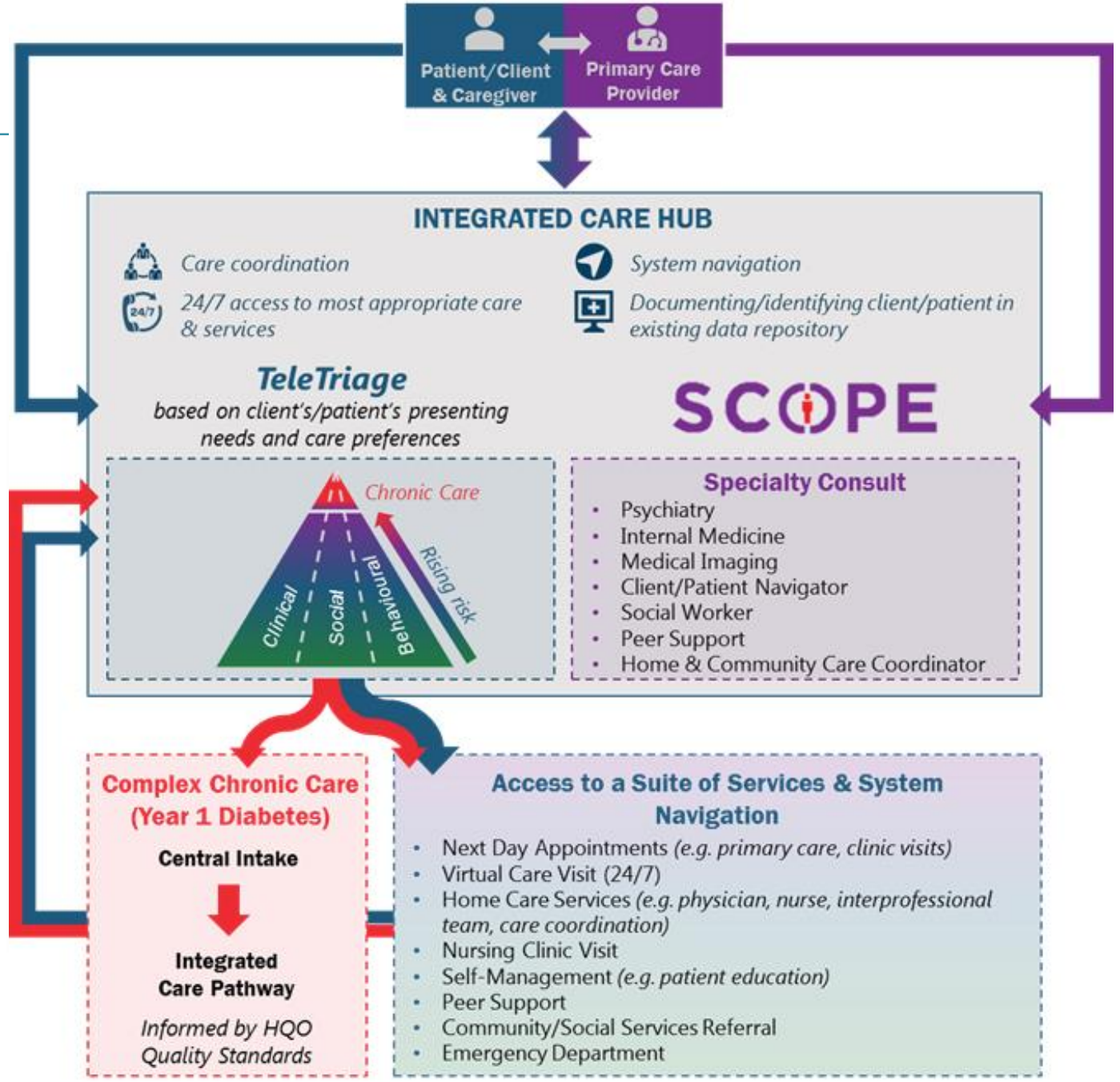
INDICATORS & MEASUREMENT

Year 1 Initiative	Anticipated Resulting Improvements in Patient Experience for Year 1 Target Population
Integrated Care Hub providing System Navigation and 24/7 Care Coordination	• Timely access to primary care • Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere) • 7-day physician follow-up post discharge
SCOPE Model	• Rate of hospitalization for ambulatory care sensitive conditions (ACSC) • 30-day readmission rate
Complex Care Pathway (Diabetes)	

INTEGRATED CARE HUB (DETAILED)

A key component of the Integrated Care Hub is the identification and stratification of patients according to *The Population Health Pyramid*

- Demonstrates that high-risk clients/patients are lower in volume, but higher in costs due to complex care needs
- The ICH will enable the OHT to identify people at each point of the pyramid, design appropriate interventions to manage and reduce risk, and positively impact the Quadruple Aim over time
- Targeted interventions can range from prevention and wellness services to more complex health and social services
- Identifying and stratifying the population by complexity will be critical to deliver efficient services



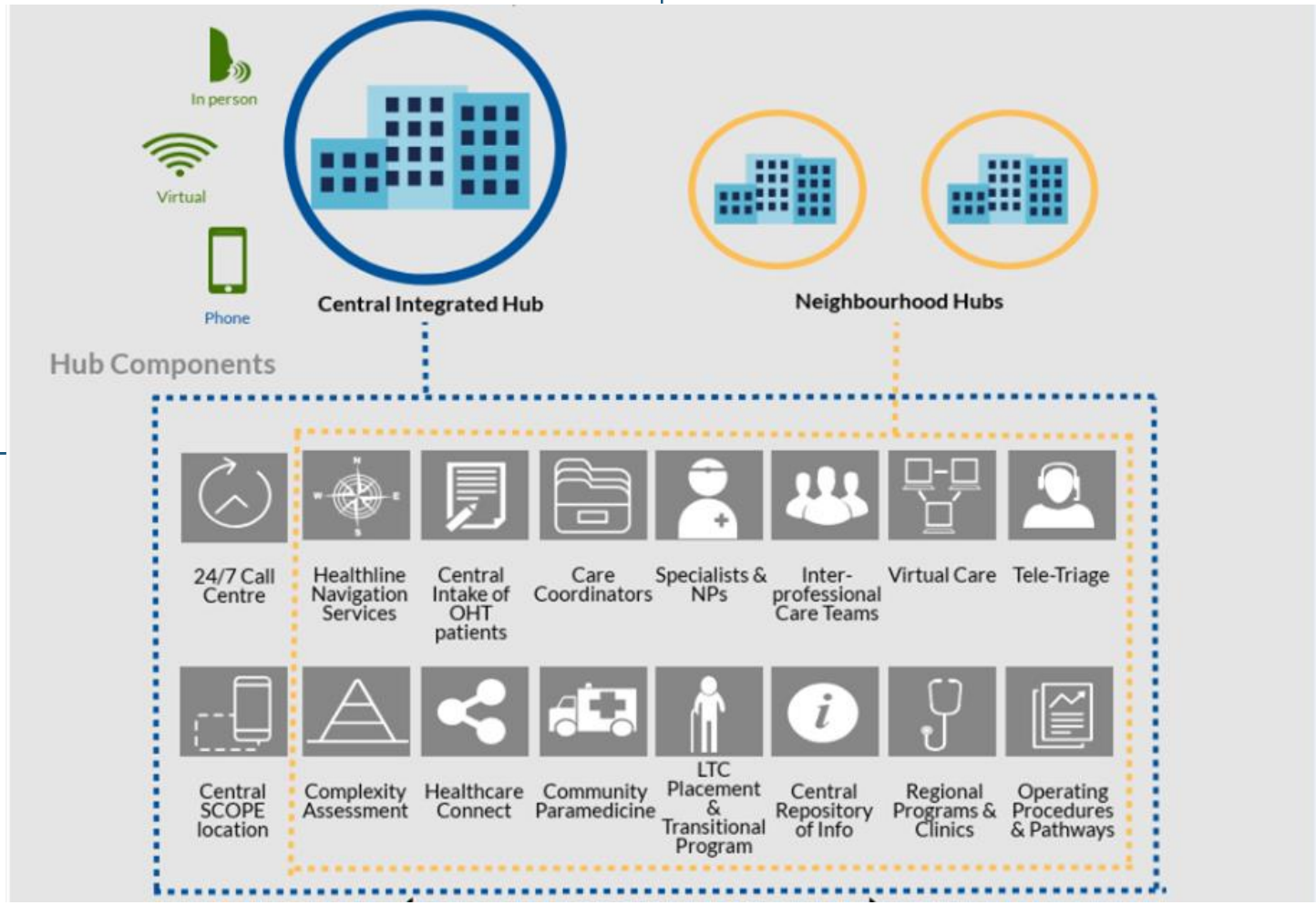
INTEGRATED CARE HUB AT MATURITY

Clients/ Patients/ Caregivers can access the hub by:

- Self/caregiver referral
- Primary care referral
- Community paramedicine
- Acute care transition

Primary Care Clinicians can access the hub for system navigation services, referral services, specialist consults for their patients.

Community service organizations can access the hub for system navigation services, referral services, etc. for their clients.



There are both physical and virtual elements to the hub (locations TBD). Many services can be accessed in person 24/7 call centre & SCOPE accessed virtually Neighbourhood hubs provide interprofessional supports for Primary Care Specific resources from Home & Community Care & partner organizations are brought together in the hub (e.g. navigation services, care coordination service)

CONSIDERATIONS FOR WHAT WE NEED TO SUCCEED

Our recommendations for provincial supports

Central Supports

1. Provincial funding and coordination of SCOPE model to support the multiple OHTs proposing implementing it—perhaps employing existing critical care pathways and partnerships.
2. Technological implementation team for SCOPE for each physician office.
3. A mechanism for OHT communication with decision-makers at the provincial level to make recommendations and seek assistance
4. Modernize funding approaches to increase fungibility, drive value and enable outcome-based approaches to care
5. Review regulations to allow all SPOs and CSS providers to serve as Health Information Custodians
6. Revise HCCA to include virtual care under the definition of home care.
7. Review primary care funding models to incent provision of preventative, integrated, and virtual care
8. Review per capita funding for all sectors across the province to target greater equity
9. Enabling of an interoperable IT structure for our partners to allow for data sharing and patient stuff

OHT Process

1. Clear explanation of the candidate phase—how long it lasts and expectations
2. Inclusion of OHT members in co-design of an accountability agreement
3. Explanation of what the requirements are for receiving a consolidated funding envelope

Funding

CHANGE MANAGEMENT

CHANGE PROCESS & TOOLS

Organizational Change Process

- Prepare for Change
- Manage the Change
- Reinforce the Change

Prosci

Individual Change Process

A D K A R

Awareness Desire Knowledge
Ability Reinforcement

Prosci

CHANGE MANAGEMENT LEVERS

- CHANGE PLANNING
- MEASUREMENT & RISK MITIGATION
- PARTNERSHIP & COLLABORATION
- STAKEHOLDER ENGAGEMENT & COMMUNICATION
- GOVERNANCE & ORGANIZATION DESIGN
- LEADERSHIP
- LEARNING & COACHING
- CULTURE

OUTCOMES

- ALIGNMENT
- AGILITY
- MINDSET
- TRUST

Four Implementation Phases of Integrated Care

1. Initiative and design phase
2. Experimental and execution phase
3. Expansion and monitoring phase
4. Consolidation and transformation phase

Organizational Change Process

- Prepare for Change
- Manage the Change
- Reinforce the Change

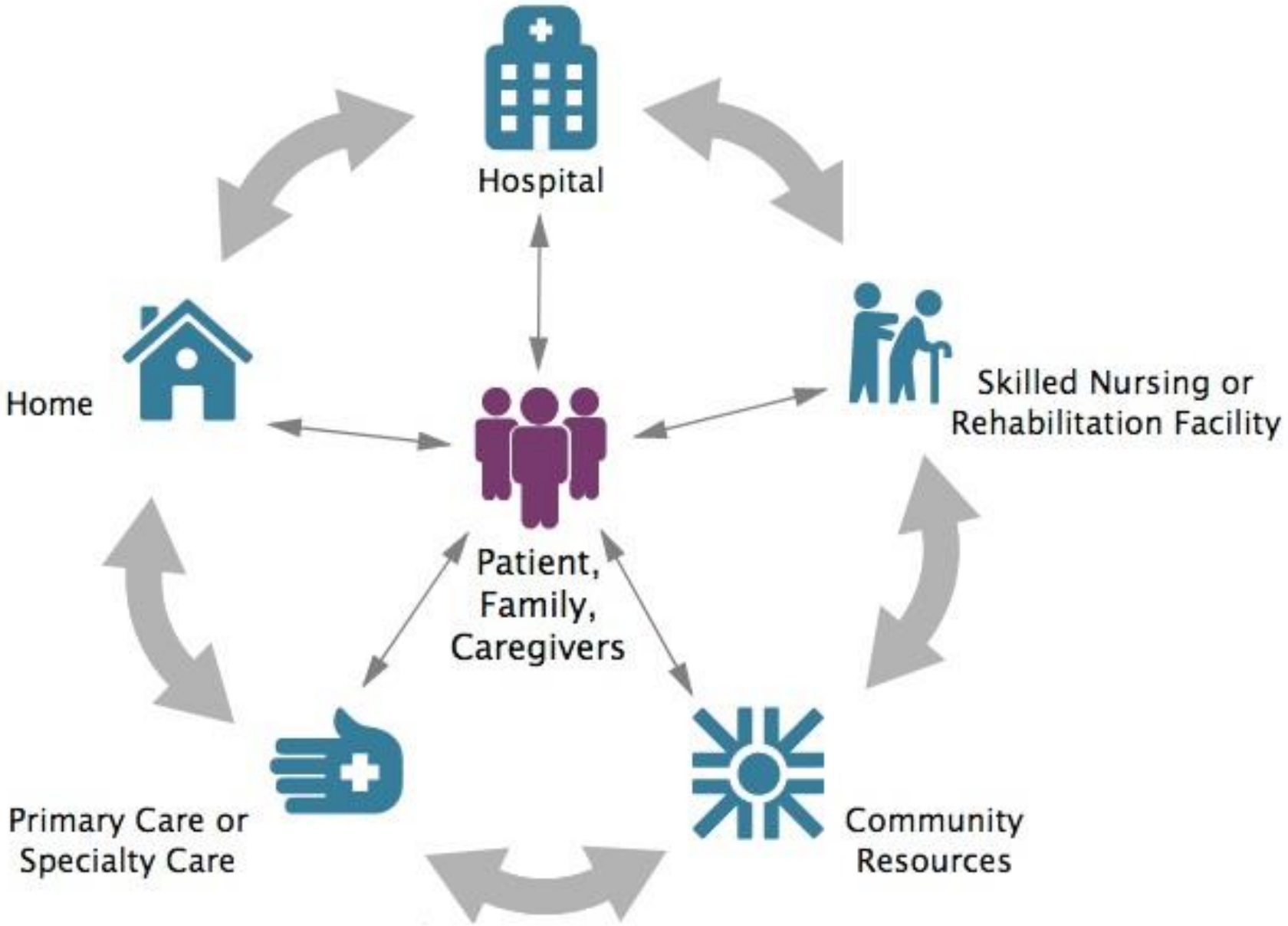
Individual Change Process

A D K A R

Awareness Desire Knowledge Ability Reinforcement

		Pre-Assessment to Full Application Submission Acceptance (March – October 2019 tbc)	
Change lever	**Change Management Objectives**	**1. Initiative & Design Phase – Prepare for Change**	
Partnership & Collaboration	• Build trust, alignment, and collaboration between all partners and stakeholders, including clients/patients, care delivery partners, front line clinicians, primary care physicians and leaders.	• Co-creation of self assessment and full application with partners • Identified Member and Affiliate partners	• Sharing resources and expertise across OHT working groups and partners to enable collective planning and design of the OHT
Stakeholder Engagement & Communication	• Involve stakeholders in the change in ways that establish meaningful influence and commitment. • Ensure change is guided from the partners and led by front line team members . • Continually reinforce a compelling change story that is understood and generates buy-in .	• Hosted OHT introduction meetings with all stakeholders • Physician engagement and information sessions were held • Regular 1:1 partner planning meetings to inform the OHT process • Expanded physician participation (care, specialist and nurse practitioner) • Board engagement sessions for submission sign-off • Physician engagement plan in progress	• Community-wide engagement event and survey • Organized OHT check-ins with planning committee and working groups • Identified an engagement and communication tool for consensus building during face to face meetings (Slido) • Enabled broader OHT communications for partners and boards • OHT branding and logo process in development
Governance & Organization Design	• Solidify and operationalize a collaborative structure that brings together organizations to deliver integrated care. • Co-design the organization to align strategy, structure, process, technology, people practices, and metrics and rewards to be agile and achieve integrated care goals.	• Created cross sectional partnership planning committee • Established working groups focused on: 1) care management, 2) governance and funding and 3) digital infrastructure and operations with meeting norms and rules of engagement • Reinforcement that decision making resides with OHT partners • Sign on process (MOU) for anchor partners and declaration of intent for physicians	• Designed Integrated Care Hub concept • Designed a patient stratification framework • Identified target Year 1 population and focus on diabetes • Identified geography
Leadership	• Develop active and visible leaders, who are adaptive and can sponsor change in ways that encourage engagement, inspire trust and enable collaboration throughout the whole system.	• Early stages of preparing leaders to lead change and different ways of working	• Involved partners and patient/family/community to lead the process
Learning & Coaching	• Develop new, sustainable skills and expertise to ensure individuals and teams are agile and able to perform in an integrated care environment.	• OHT-wide governance awareness and learning sessions	• OHT 101 education sessions
Culture	• Change the culture and embed a shared set of values and front line behaviours so that the client/patient feels they are dealing with one entity.	• Building a partnership collation to lead change beginning with shared power and membership on the planning committee, working groups, OHT partnership group	• Working in new ways to set the foundation for new behaviours and skills needed for partnership and collaboration

		Year 1 & Beyond		
		1. Design Phase - Prepare for Change	2. Experimental and Execution Phase – Manage Change	3. Expansion & Monitoring
Change lever	**Change Management Objectives**	**First 6 Months**	**Next 6 – 18 Months**	**18 Months & Beyond**
Partnership & Collaboration	• Build trust, alignment, and collaboration between all partners and stakeholders, including clients/patients, care delivery partners, front line clinicians, primary care physicians, and leaders.	• Implementation of rules of engagement and norms for working groups • Establish basic protocols and ground rules for collaboration • Establish MOU & Partnership Agreements • ICH Interprofessional Team Launch Sessions for Navigation & Care Coordination and Digital Access teams	• Team development and collaboration sessions for inter professional health care teams in the hub (within and across organizations) • Design partnership workshops with partners to elevate trust, relationships and processes to deliver on agreements • Partnership Transparency Workshops (member partners & stakeholders) to build trust, surface learnings and adapt	• Continue implementing partnership workshops and team development sessions • Care delivery partners seek new opportunities for collaboration with current or new partners
Stakeholder Engagement & Communication	• Involve stakeholders in the change in ways that establish meaningful influence and commitment. • Ensure change is guided from the partners and led by front line team members. • Continually reinforce a compelling change story that is understood and generates buy in.	• Begin and continue stakeholder mapping • Conduct stakeholder interviews and/or focus groups • Prepare Stakeholder Impact Assessment to identify the impacts to people, process, technology • Begin to build a compelling change story on the "WHY" of OHT & Integrated Care Hub (ICH) • Continue to leverage OHT outreach efforts by applicable provincial and local groups (e.g. OMA, OCFP) for primary care providers • Establish additional two-way communication vehicles including social media	• Develop Sponsorship Roadmap and activities for partners to lead the change • Develop key messages/talk points for partners on vision for change and benefits for patients and stakeholders • Identify areas of risk and develop mitigation plans • Establish ongoing 'Change Check-in' process and cadence with key stakeholders • Prepare ongoing engagement plan for key stakeholder groups; clients/patients, Board/leaders, partners, front line clinicians, primary care physicians, & community, Union	• Share success stories and learning to create excitement for expansion phase • Revise Stakeholder Mapping for expanded care partners • Integrated lessons learned from Year 1 population and revise stakeholder engagement and communications plans accordingly
Governance & Organization Design	• Solidify and operationalize a collaborative governance structure that brings together organizations to deliver integrated care. • Co-design the organization to align strategy, structure, process, technology, people practices, and metrics and rewards to be agile and achieve integrated care goals.	• Identify stakeholders included in the governance process (including patient and community) • Operational oversight - develop ways of working and structure • Finalize phase 1 organizational design of new integrated hub • Complete required workforce planning and other associated HR needs • Determine Job Design Implications for roles in the Integrated Care Hub (ICH) • Staff roles and the interdisciplinary teams required for the ICH	• Establish a shared decision-making framework and structure for how organizational leaders (e.g., senior management and boards) will make decisions. • Clarify a problem solving and dispute resolution process • Evaluate where there is duplication of efforts and opportunities for streamlined efforts • Co-create shared OHT vision, values and strategy with clients/patients & community, Board, partners, front line clinicians • Identification of which population each neighbourhood hub serves	• Future state process mapping on next iteration hub focus • Lessons learned and continuous improvement of process, technology, and people practices • Organizational structures shift to support the new integrated delivery processes, as required
Leadership	• Develop active and visible leaders, who are adaptive and can sponsor change in ways that encourage engagement, inspire trust and enable collaboration throughout the whole system.	• Identify operational oversight membership/leadership • Prepare leaders on leadership role to sponsor change • Identify current and emerging leaders from partner network for future OHT leadership roles (including primary care providers)	• Engage operational leadership on development of OHT vision, values & strategy to guide OHT development • Leadership briefings on lessons learned • Change Leadership Workshops	• Build Partner coaching capability • Develop OHT Leadership Development Plan and Leadership Competencies • Develop and implement an OHT Leadership Training Program
Learning & Coaching	• Develop new, sustainable skills and expertise to ensure individuals and teams are agile and able to perform in an integrated care environment.	• Determine knowledge and skills required for roles in the Integrated Care Hub (ICH)	• Facilitate Change Management Training for project teams and Change Champions • Conduct a learning and training inventory assessment to identify current resources available • Identify where cross training could be leveraged • Facilitate Change Leadership Training	• Ongoing coaching and support for key stakeholders • Resilience training for 24/7 environment • Develop role based training (eLearning, job aids, toolkits) • Implement learning and coaching approach and plan to support new knowledge and skills required • Develop mentoring and buddy programs
Culture	• Change the culture and embed a shared set of values and front line behaviours so that the client/patient feels they are dealing with one entity.	• Celebrate progress through key events and regular communications	• Develop Leader-led engagement plan • Process to co-create OHT shared values and behaviours • Begin to develop culture branding and artifacts • Identify Culture Champions	• Value discussion toolkit • Host leader-led Eegagement sessions • Embed values and behaviours in ICH processes and systems


Hospital
Home
Skilled Nursing or
Rehabilitation Facility
Patient,
Family,
Caregivers
Primary Care or
Specialty Care
Community
Resources