Chatham - Kent OHT
ONTARIO HEALTH TEAM

Achieving the best health and well-being together

The Chatham-Kent Ontario Health Team: Application Review

www.ckoht.ca

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Achieving the best health and well-being together:

What is an Ontario Health Team?

Ontario's Case for Change

The Premier's Council on Improving Healthcare and Ending Hallway Medicine has highlighted key areas in which Ontario's healthcare system is under pressure, and exhibiting clear symptoms of strain:

Different healthcare Needs

There are more patients with complex needs and an increase in chronic issues that require careful and coordinated management, like an aging population living longer with high rates of dementia. Fair access to healthcare across the province continues to be a concern.

Stress on Caregivers and Providers

Healthcare providers, family members, and friends are feeling the strain of a system that isn't making caregiving easy. This leads to high levels of stress and places a heavy burden on caregivers to act as advocates for timely and high-quality healthcare services.

The Patient Experience

Patients are receiving care in unconventional spaces such as hallways and waiting too long to receive their care in a system that is increasingly difficult to access; as a result, our hospitals are crowded.

Immediate and Long-Term Capacity Pressures

Ontario does not have an adequate or appropriate mix of services and beds throughout its healthcare system.

Responsibility and Accountability in the System

Ontario's healthcare system is large. Responsibility for coordinating high-quality healthcare is spread across many organizations.

There is a fundamental lack of clarity about which service provider should be providing what services to patients and how to work together effectively. Ontario could be getting better value for the money it currently spends on the healthcare system.

Source: *Hallway healthcare: A System Under Strain*, First Interim Report of the Premier's Council on Improving Healthcare and Ending Hallway Medicine, January 2019

Key Components/Benefits: Ontario Health Teams

Overall, the People's Health Care Act is aimed at improving holistic health outcomes for Ontario's population, by addressing challenges in the structure of the system and its incentives. Key components of the OHTs include:

- **Defined target population**
- **Integrated patient care and experience**
- **Shared governance and accountability**
- **Unified performance measurements**
- **Coordinated continuum of care**
- **Meaningful patient and community engagement**
- **Shared funding envelope**
- **A ' digital first' approach**

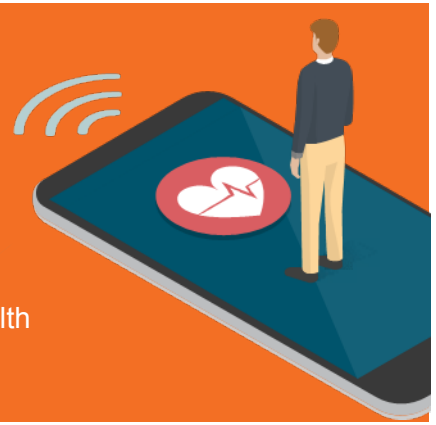
Key benefits to the system are expected to include:

Costs of Care

- ✓ Integrated systems will **deliver care closer to home** – not in expensive Emergency Departments.
- ✓ Ontario Health Teams will be **clinically and fiscally** - accountable for the health of their population.

Access to Care

- ✓ A key success factor for the transformation will be **ending "hallway medicine"** in Ontario.
- ✓ Teams will include hospitals, family doctors, social services, and **sometimes unexpected partners**.
- ✓ Partners will work together to innovate and design a more **patient-centred** system.
- ✓ Enhanced **digital services** will make managing health and wellness more convenient.



What does Effective Partnership look like in emerging OHTs?

Inclusive Partnerships

All sectors of care are invited to participate in the OHT strategic planning sessions. This includes social services and non-traditional partners.

Trust Amongst Partners

Trust, mutual respect, and clear lines of accountability allow the partners to come to decisions as a system and moves forward against a tight timeline.

No Organizational Egos

When designing the future system of care, partners are able to put aside the short-term interests of their organization, and recognize the value that others bring to the table.

Transparency in Communication

Decision making is transparent, and communication is frequent, especially at the leadership level of the OHT.

True Collaboration Amongst Partners

All the partners have a voice in the co-design of the system. Cross-sectoral teams work together to define what the future of healthcare looks like.

Patient-Centred Planning

Patients (i.e. patients/clients, families, and caregivers) are deeply involved in system design, and have a voice at the leadership level of the OHT.

Improving Mildred's health and well-being

- 73 years old from Bothwell
- Lives with one of her adult children & their family
- End stage renal disease; receiving hemodialysis for 2 years at CKHA; also diabetes, COPD
- Travels to Chatham for dialysis 3x per week; social activity
- Uses Emergency Department when ill rather than family physician; frequently admitted due to not following medication and dietary requirements
- Refuses home care; family is getting burnt out
- Care team would like Mildred to access programs at Seniors Centre in Bothwell

Let's see how the CKOHT can help achieve the best health and well-being for Mildred…

Achieving the best health and well-being together:

The Journey So Far

CKOHT Steering Committee and Work Streams

- Population, Performance & Quality
- Home and Community Care Services
- Integrated Care Design
- Diversity & Equity
- Digital & Virtual Access
- Governance and Leadership

Membership includes leadership and staff from each partner agency, as well as nearly two dozen patient advisors

Steering Committee

Co-Chairs:
Lori Marshall, CKHA
Dr. Jim Wheeler
Judy Gragtmans, PA

CKOHT Agency Partners – Phase 1

Thamesview Family Health Team

Chatham-Kent Family Health Team

Tilbury District Family Health Team

Chatham-Kent Community Health Centres

Centres de santé communautaire de Chatham-Kent

Chatham-Kent Health Alliance

March of Dimes Canada / La Marche des dix sous du Canada

Société Alzheimer Society Chatham-Kent

TransForm Shared Service Organization

Municipality of Chatham-Kent — Cultivating Growth, Shore to Shore

Erie St. Clair Behavioural Supports Ontario

Erie St. Clair LHIN

westover Treatment Centre

Canadian Mental Health Association Lambton Kent

Association canadienne pour la santé mentale Filiale de Lambton Kent

Chatham-Kent Hospice

St. Andrew's Residence — Active Living • Professional Care

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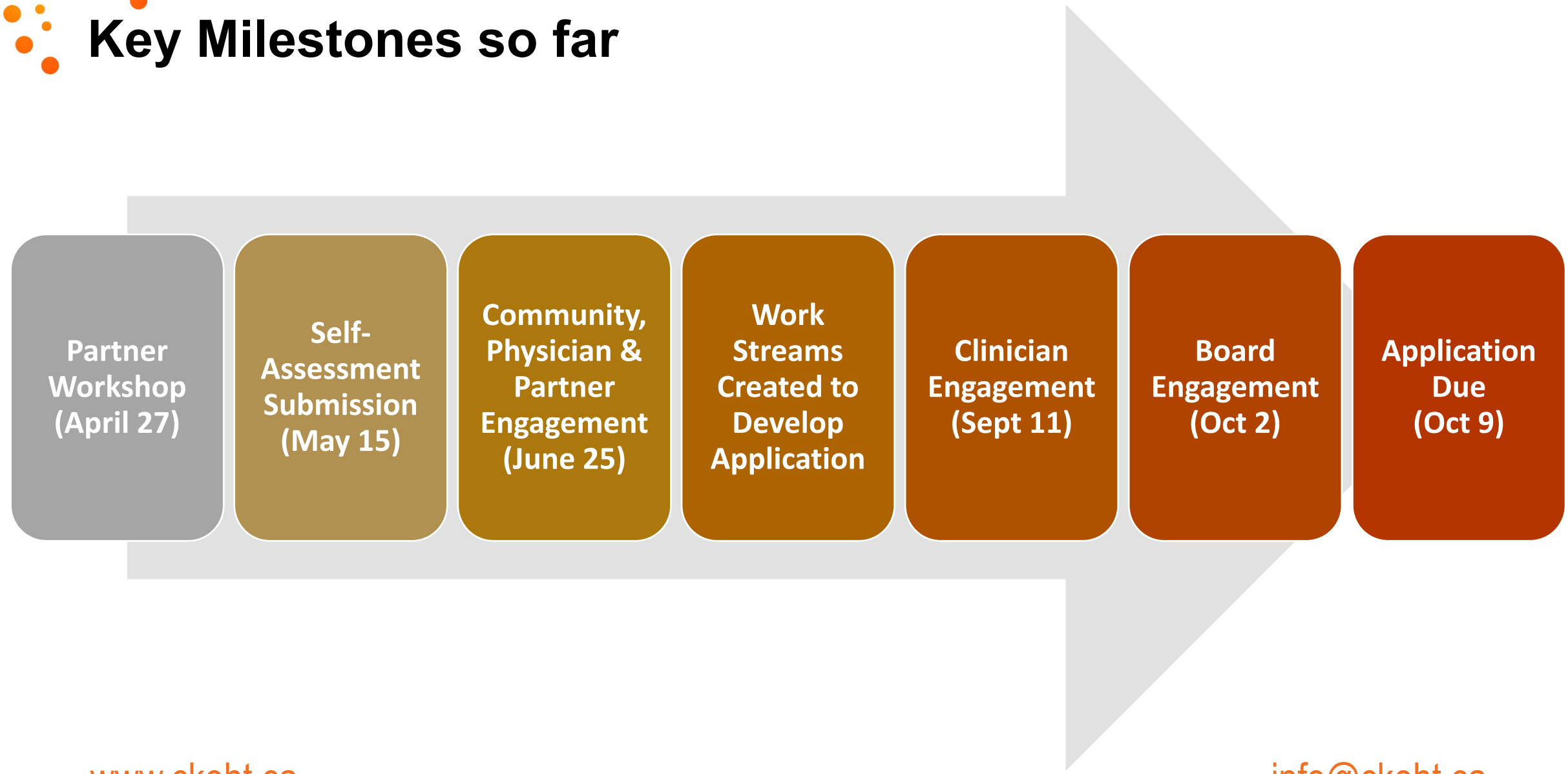
Key Milestones so far



About Our Population

At maturity, the CKOHT will serve the

105,241

residents of Chatham-Kent, Walpole Island, and surrounding areas

This follows the patient **vs** geography

82,944

patients currently enrolled

of all costs are attributed to **chronic conditions**

Top costs based on Health Profile Groups include Dementia, Palliative and Skin Ulcers

Establishing the Year One Population

Avoidable Hospitalization

Risk

Health Care Expenditures

Adults **(55+)** with at least **one** of the following criteria:

- HEART FAILURE OR ANGINA
- COPD
- DEMENTIA
- DIABETES

and/or are complex (using Health Links definition)

Year One Population
approximately
11,000 patients
enrolled

Achieving the best health and well-being together:

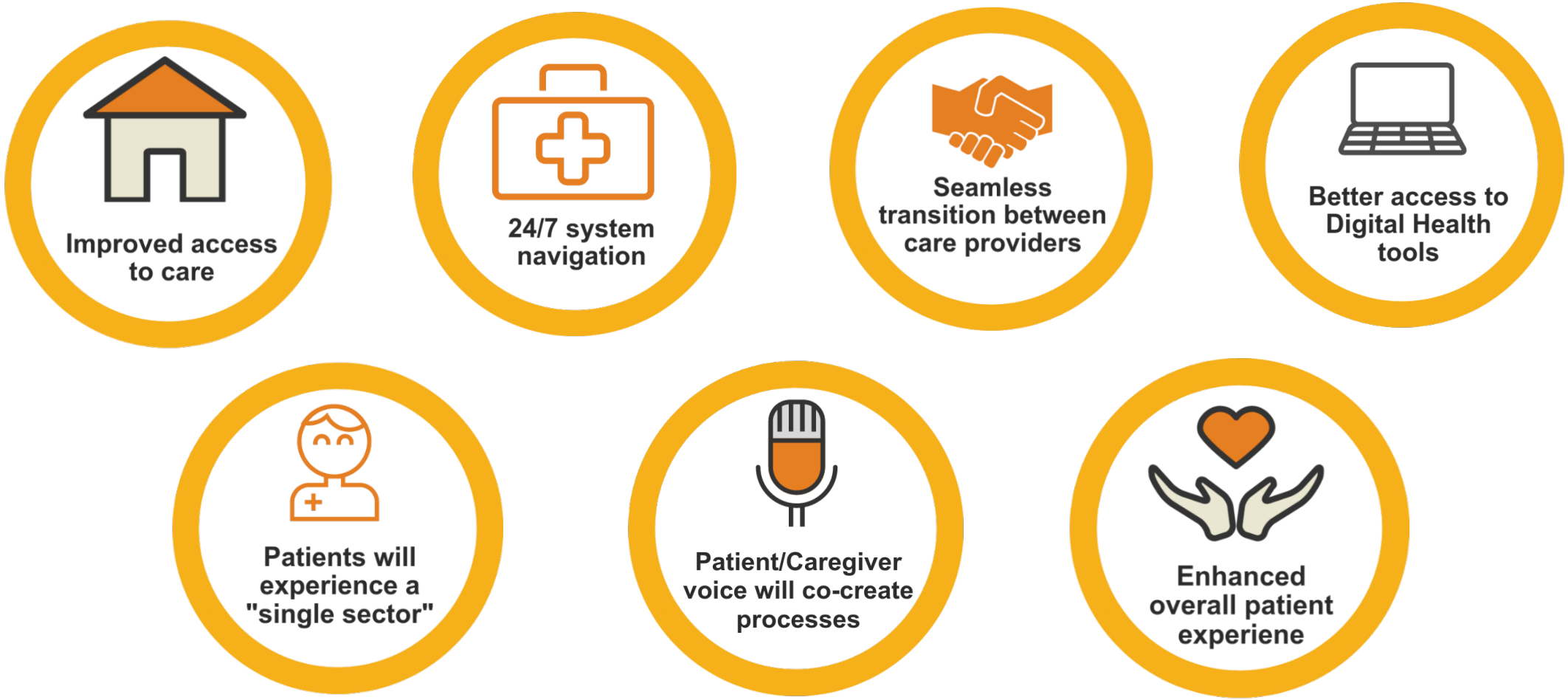
Patient Care

Building Blocks through Partner Collaboration

"This is a journey… a road less travelled… but begun… together with trusted companions who really want to ensure the patient journey for the target population in year one and beyond is as seamless as possible."

- Judy Gragtmans, Patient Advisor (Co-chair)

Overarching Patient Care Goals



Building Blocks through Partner Collaboration

- Process mapping to improve transitions between care
- Education so all team members are aware of full scope of all health professionals within CKOHT
- Build on success of Health Links by all CKOHT partners sharing in the accountability of care coordination
- Scale current pilot projects across CKOHT:
  - Example: Chatham-Kent FHT and a community rehab clinic are collaborating on musculoskeletal care leading to decreased opioid prescriptions, decreased falls, etc.
- CKOHT in high-state of readiness to leverage existing digital health tools to share patient information securely across providers in Year 1
  - 64% of partners currently use ClinicalConnect to view electronic health records; plans underway to provide access to the remaining partners

Key Initiatives through Partner Collaboration

Leverage existing resources and build expanded 24/7 support models at maturity

- Leverage partners currently providing 24/7 on-call support including Westover, CMHA, March of Dimes and Alzheimer's Society
  - Enabling direct access to home and community care service providers will coordinate services for urgent matters from 8am-8pm and mitigate accessing acute care or Emergency Department
  - At maturity, 24/7 care coordination for patients requiring intensive case management support
  - Intent to pool/realign primary care resources to expand access on weekends
- All partners will use and promote eriestclairhealthline.ca – a digital health and community information network – as well as 211
  - Both play pivotal role in 24/7 system navigation

Key Initiatives through Partner Collaboration

Use digital health tools to support patient services and enhance patient access to care and information

- Access to digital platforms for all CKOHT agencies (e.g. CHRIS)
- Standardized screener, assessment and digital platform for intake to home and community care services
- Use Ontario Telemedicine Network to connect, for example, Francophone or Indigenous patients with Francophone or Indigenous providers virtually; opportunity to explore eVisit primary care solutions
- Explore expanding CoHealth smartphone application across CKOHT; currently used at CKHA
- Plan for patient portal solution which could include tools like MyChart – patients create and manage their own personal health information

Key Initiatives through Partner Collaboration

Support self-management and self-directed care

- In Year 1, combine resources, expand and centralize intake for self-management programs including:
  - Master Your Health – group sessions to help patients self-manage chronic disease or chronic pain through Family Health Teams and Community Health Centres
  - First Link® – connecting dementia patients with health services and information through Alzheimer's Society
  - Other support groups, diabetes education centres, etc.

Key Initiatives through Partner Collaboration

A system navigator/care coordinator will be single point of contact to help patients navigate between sectors

- Assigned at patient's entry to health system
- System navigators to complete transition visits with chronic/complex patients prior to discharge = smooth transition to community, long-term care
- Home and community care waitlist accessible to all partners to help better manage waitlists and reduce wait times
- Patients will have access to In-Office Care Coordination:
  - Assists with system navigation during extended evening hours and weekends
  - Will evolve at maturity into collaborative triaging system to help patients determine most appropriate place/time to receive care

Key Initiatives through Partner Collaboration

Grow and expand Clinical Care Coordinator models

- Clinical Care Coordinator model has reduced Emergency Department visits for most vulnerable patients by 20%
- These positions are registered nurses who provide care coordination and hands-on nursing, supporting:
  - Primary Care (e.g. Family Health Teams, Community Health Centres)
  - eRehab programs in hospital
  - Behavioural Supports Ontario (e.g. dementia patients)

Current home and community care resource integration:

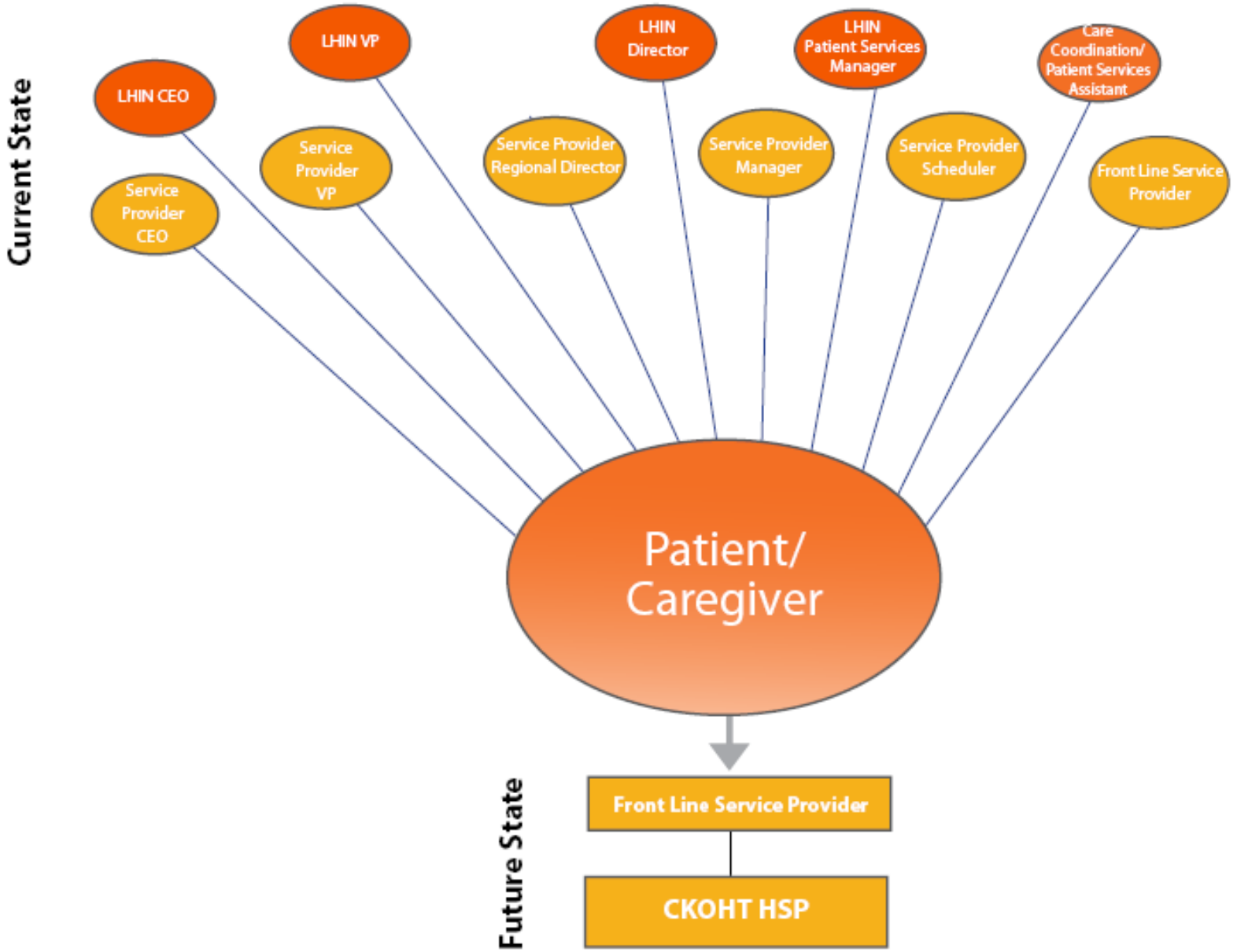
- Clinical Care Coordinators working in primary care settings
- Hospital Care Coordinators doing Integrated Discharge Planning at CKHA
- Intake Care Coordinators co-located with Lambton Elderly Outreach navigator
- Community Care Coordinators aligned with primary care practitioner caseloads

Key Initiatives through Partner Collaboration

Innovative service delivery supporting patient care and system flow

- Leverage eShift platform to develop virtual hospital ward for elderly patients considered Alternate Level of Care:
  - Reduced length of stay in hospital
  - Increased capacity and flow within hospital
  - Patients less likely to return to emergency department or be readmitted
- eRehab, integrated hospital discharge, family managed care
- Intensive Hospital to Home an example of collaboration with hospital and community supports; lowest Alternate Level of Care stats in the province
- Fully automated medical supply chain management through TransForm expanded to Health Service Providers
  - $1.3M in savings from home and community care project

Home and Community Care – Patient Vision



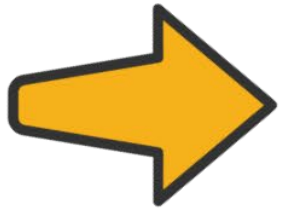
Achieving the best health and well-being together:

Health Equity

Diversity across the CKOHT Catchment Area

Sub-Groups of Year 1 Population

- Caregivers with complexities
- Rainbow Community
- Low German
- Mental Health and Addictions
- Vulnerable/marginalized/socio-economically challenged
- HIV-positive individuals
- Temporary foreign workers
- Newcomers/Immigrants (especially Syrian Refugees)
- Homeless population
- Cognitive challenges/Intellectual disabilities
- Isolated individuals (living alone/geographically)



Tailored approaches due to **linguistic** and **access barriers** as well as **unique cultural** and **religious beliefs** and/or practices

Applying a Health Equity Lens to Patient Care

Develop strategies and implementation goals for Year 1 and maturity

- Apply the principles of “Active Offer”
- Strategize for cultural and linguistic sensitivity/safety training
- Offer services and/or access to certified professional interpreters
- Hire diverse multilingual staff representative of diverse populations served
- Use personalized, anti-oppressive, inclusive approaches to scale and spread adoption of Social Prescribing, Model of Health and Wellbeing and Health Equity framework within the CKOHT
- Primary care to collect equity and population-based socio-demographic data to inform planning and for stratification to further address health disparities

Meeting the Unique Needs of Indigenous Communities

- Uphold the London District Chief's Council Declaration
- Enact directions for forthcoming Indigenous health policy by the Indigenous Secretariat
- Embed the Indigenous cultural structural model into service delivery, use newly created Indigenous care resources
- Strategy in Year 1 for Indigenous Cultural Safety Training
- Meaningful dialogue about Indigenous-specific health inequities and oppression
- Supports for Indigenous-governed health centres and/or Indigenous health leaders to direct the planning and implementation of Indigenous health services
- Develop plans for transferring control of services provided to Indigenous clients back to Indigenous people/communities, without offloading burden of cost

Meeting the Unique Needs of Francophone Communities

- Create an “active offer” strategy
- Comprehensive French Language Services Plan will include:
  - Referral pathways for Francophone patients
  - Processes to identify a patient’s preferred language
  - Adapting and/or building health information systems accordingly
  - Identification of existing bilingual human resources and volunteers
  - Recruitment preference for bilingual human resources/volunteers
  - Partnerships with French language colleges/universities to host bilingual trainees
  - Opportunities for staff to learn French language
  - Use of over-the-phone professional interpretation services as required
  - Marketing of available resources (e.g. Community of Practice for bilingual professionals)

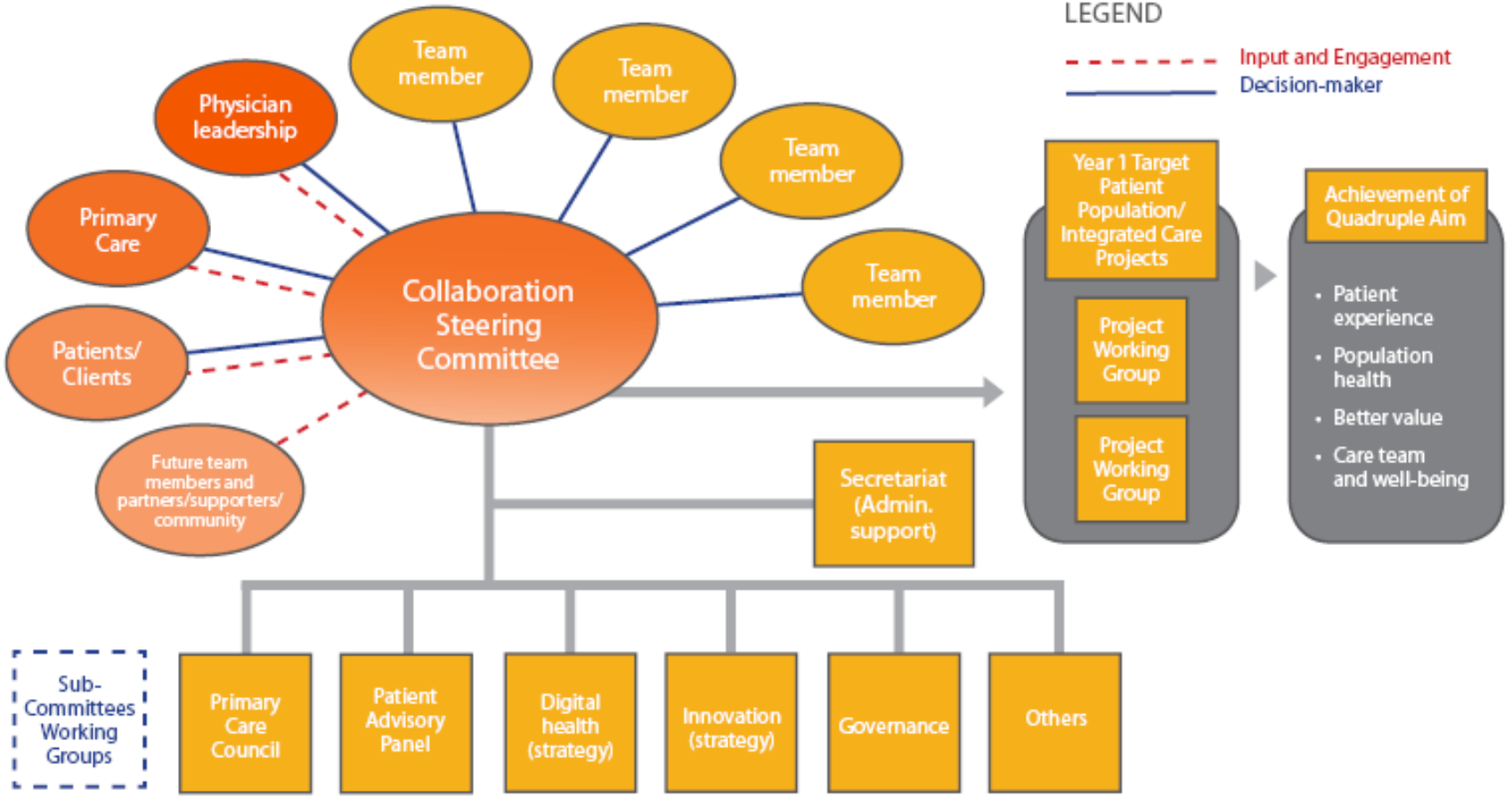
Achieving the best health and well-being together:

Collaborating for Success

Current Collaboration amongst CKOHT Partners

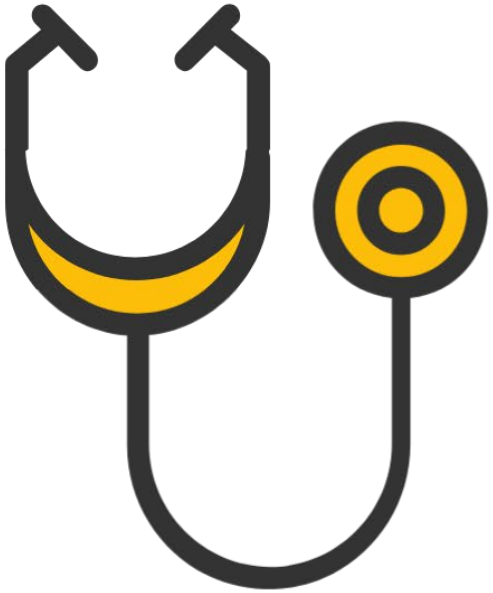
- **83% of patients enrolled in primary care via a partner organization**
- Some examples of CKOHT partners working together on patient services:
  - **IDEAS** (Quality Improvement training)
  - **Health Links** (coordinated care planning for most complex patients)
  - **Community Paramedicine** (support for frequent EMS users to find community services)
  - **Cross-Provider funding** (e.g. Access Open Minds for mental health and addictions)
  - **Intensive Hospital to Home** (Bundled Care w/hospital and home and community care)
  - **Population Health** (Drug awareness/harm reduction programs, dental care)
  - **Behavioural Support Ontario** (supporting dementia patients w/responsive behaviours)
- Commitment to work with regional partners and neighbouring OHTs to support patient flow patterns
- Proposed regional approach to support patients seeking specialist care outside of their natural OHT without compromising or complicating the roles or funding of various OHTs within the southwest region

YEAR 1 GOVERNANCE MODEL



- Transitional Leadership of Steering Committee provided by Phase 1 partners
- Board Chair Council of partner agencies ensures alignment and communication
- Agreement developed by Dec. 31, 2019 to support creation of Collaboration Steering Committee

Primary Care Role in Governance Structure



Primary Care Council to be formed with mandate to provide advice directly to the Steering Committee

The chair of the **Primary Care Council** will be appointed to the Steering Committee to **act as a liaison** and **ensure the voice** of primary care providers is represented in the steering committee

The majority of patients enter the health care system through primary care and so primary care leadership is crucial in the CKOHT achieving success.

Physicians and Nurse Practitioners will be instrumental in ongoing design and planning, so flexible meeting times and virtual attendance will be considered.

Patient, Family & Caregiver Role in Governance Structure

Development of a **CKOHT Patient/Client, Family and Caregiver Advisory Panel**

Two members to sit on the **Collaboration Steering Committee** to act as liaisons between the steering committee and the advisory panel

"As a patient, we have been involved from the beginning."
- Kathy Borthwick, Patient Advisor

Management and Contribution to Support CKOHT

- Responsibility and costs associated with operating the CKOHT will be fairly shared by all partner agencies
- Shared secretariat (administrative support) and coordination functions have been contributed by partners to date (decision support, administration, project management, communications, etc.)
- Assessment of partner resources that can be deployed to further support CKOHT objectives will be conducted for Year 1

Collaborating with Partner Agency Boards

Partner boards are ***not*** handing over governance accountability to the Chatham-Kent Ontario Health Team

The CKOHT is:	The CKOHT is *not*:
• A collaboration between health care partners • Focused on the expertise and professionals within partner agencies to support improved programs and services for patients • Working at a strategic level to co-design an improved local health care system • Committed to working with existing partner agency boards to set and approve system goals	• Taking the place of agencies or agency boards • Making/implementing decisions that directly affect a partner agency without consulting that agency's board • Adding barriers to an agency's ability to provide patient care or manage its operations • Setting unrealistic expectations for partner agencies/boards/staff

Future Collaboration between CKOHT Partners

"In order to provide care that is fully and actively coordinated across OHT partners, we need to fundamentally shift the way we think to realign care across organizational lines to encompass the patient's journey. This requires building on our common vision, principles and trusting relationships."

- Working groups for key priority areas such as system navigation, effective transitions and care coordination
- Develop care protocols and pathways
- Process mapping exercises to determine how best to integrate care for Year 1 Population
- Identify process to reduce duplication and reallocate resources to address gaps
- Develop information protocols to share patient data and coordinated care plans

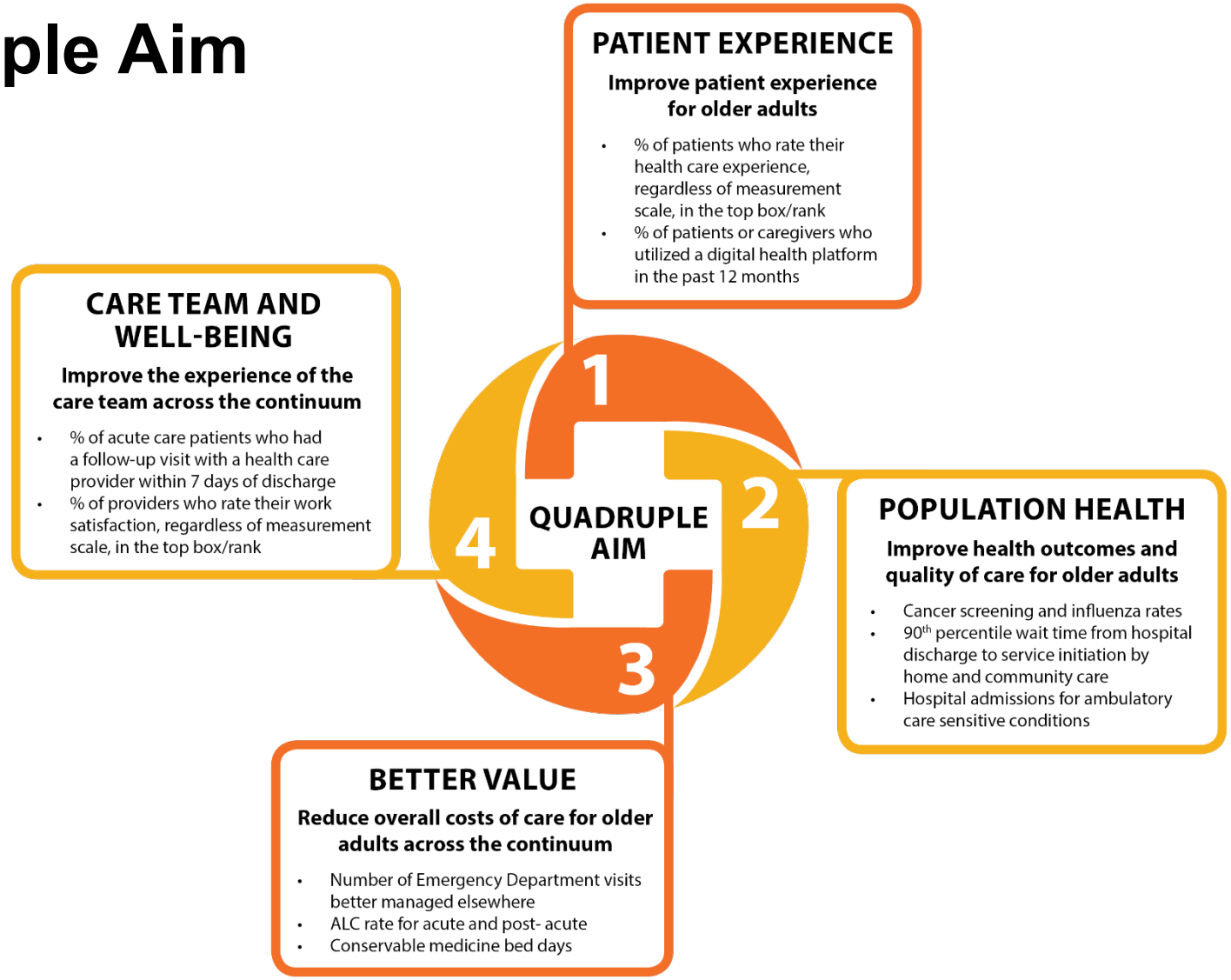
Right individuals receive the right level of support at the right time

Achieving the best health and well-being together:

Measuring our Success

Achieving the Quadruple Aim

- As a team, deliver full continuum of care to the full attributed population
- Shared leadership
- Inclusion of patient and clinician voice in decision making



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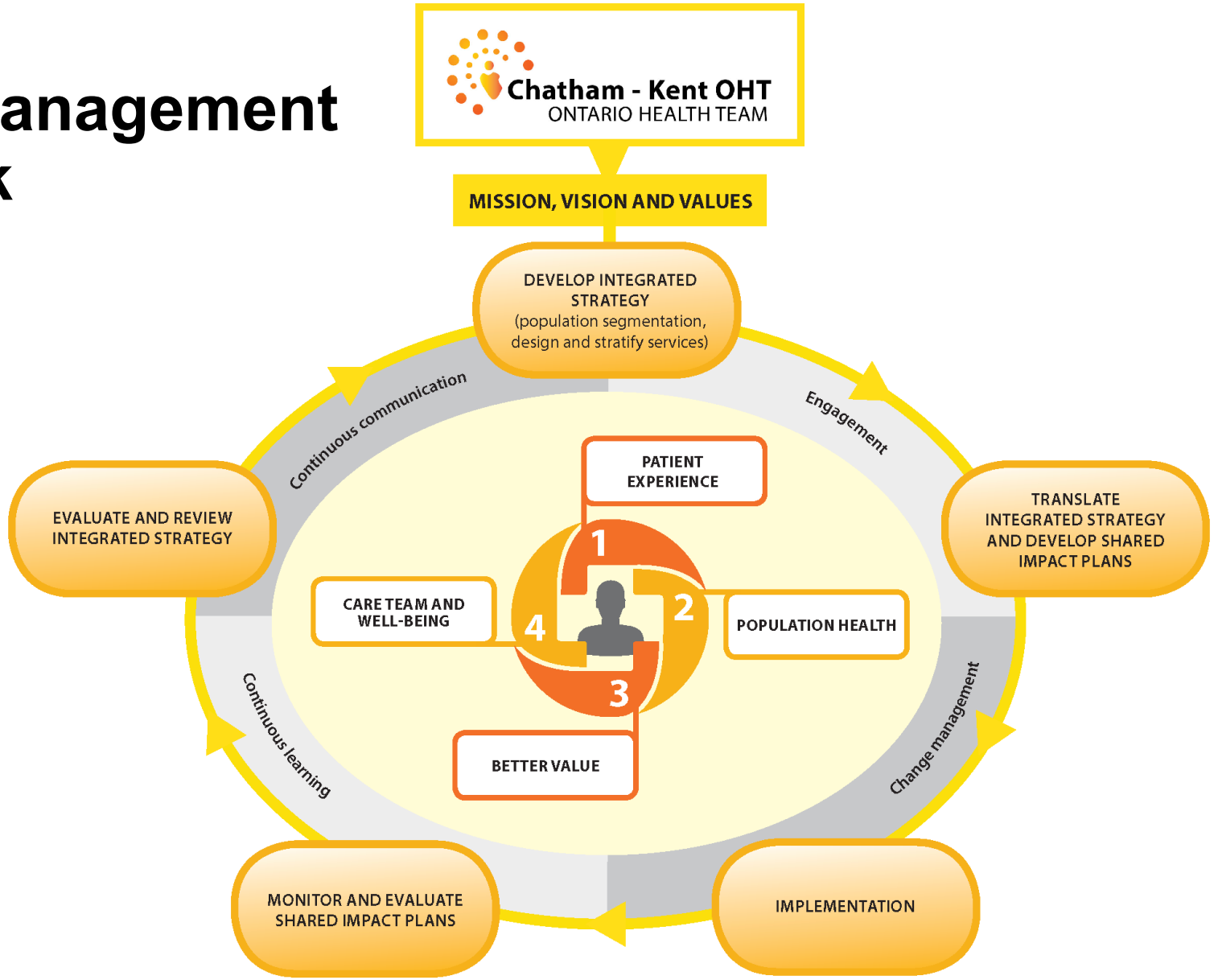
Strategy Management Framework



Setting & Achieving Common Goals, Values & Practices

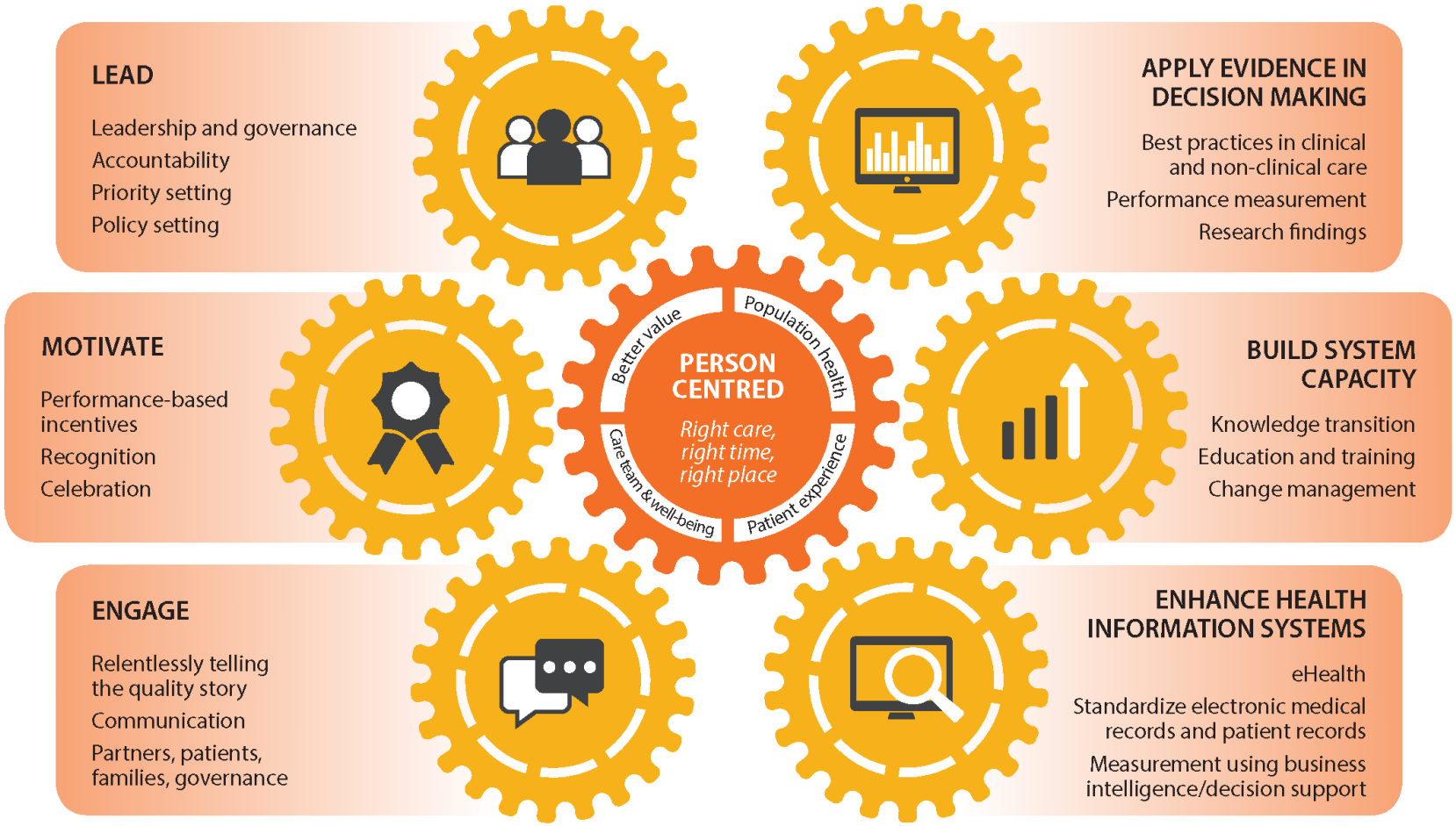
- Guiding Principles and Values of CKOHT developed by the Steering Committee
- Decision making guided by **Patient Declaration of Values**:
  - Respect and Dignity
  - Empathy and Compassion
  - Accountability
  - Transparency
  - Equity and Engagement
- Partners have shared commitments and principles of care including:
  - Focus on the whole person
  - Applying social determinants of health lens
  - Shared leadership
  - Further evolution of primary care

Continuous Learning and Improvement

Approach to quality/performance improvement and continuous learning includes:

- Leveraging existing resource capacity and formalizing ongoing process
- Assessing strategies during implementation phase:
  - centralized pool of resources/back office support
  - agreed upon standard approaches and tools
  - evidence-based practice learning forums
  - common indicators for members to measure against
- Using proven models of data analytics (e.g. population health, health care utilization) to understand value – to achieve goal of reinvesting in front-line care
- Disclosing of governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation and mitigating strategies

Quality Enabling Improvement Framework



Model adapted from South West LHIN

Have we helped improve Mildred's health and well-being?

Collaboration between care team means fewer touch points, better information sharing, smoother transitions and improved access to care

- Mildred finally visits Family Physician, who is part of a Family Health Team and recommends home and community care supports
- While skeptical, on physician's advice, agrees to meet with on-site Clinical Care Coordinator about home care and Health Links supports due to her chronic/complex conditions; services put in place
- Transportation arranged through CareLink for dialysis; also to attend Seniors Centre for social time; providing family some much needed respite
- Mildred and family are now users of ErieStClairHealthline.ca to search for services and upcoming events
- Enhanced supports means fewer trips to ED and reduced hospital admissions

Achieving the best health and well-being together:

Launching the CKOHT

Implementation and Risk Analysis

- Project management methodologies applied to support ongoing project work, risk analysis, contingency and mitigation planning

- 30, 60, 90, 180-day plans and milestones developed according to goals for each work stream to support delivering Year 1 goals

Risks and Potential Barriers to Implementation

Identified risks include:

- Patient privacy and security concerns with further digitized health system
- Funding structures for primary care and other clinicians when moving to 24/7 access model
- Lack of primary care clinicians for attributed population with a significant number of unattached patients

Potential barriers include:

- Significant legal and human resources advice needed to navigate labour relations impacts and PLSTR legislation
- Human resources duplication exists
- Partner corporate policies may not support CKOHT vision

Change Management

Bringing diverse agencies together under the CKOHT requires support through the change process – with a focus on *people*

- Leverage existing expertise among partners and established relationships:
  - Several CKOHT members are certified in ProSci Change Management using ADKAR approach
- Activities include communication, relationship building, increasing awareness and knowledge, identifying champions, etc.
- CKOHT has interim governance structure – fundamental to good change management
- Strong foundation already in place with confirmed vision, brand and communication strategy and strategic management framework

Improved Information Sharing between Partners

- Evolve access to existing resources in Year 1 including:
  - Clinical Connect
  - Electronic Medical Records (EMR)
  - Digital Health Drug Repository (DHDR)
  - Health Report Manager with eNotification and Provincial Resources
- Existing regional data sharing agreements (DSA) outline each partner's obligations to safeguard patient information (e.g. PHIPA)
- Identify early opportunities to improve care coordination and documentation between transitions to avoid "double documentation" and missing/incomplete information errors

CKOHT partners in high state of readiness to expand current usage of digital health tools

Virtual Care Tools (n=12)	Current State % Complete
OTN	57%
eConsult	7%
eReferral (OCEAN)	28%
eSHIFT	21%
CoHealth	7%
Provider-Patient Messaging	7%
Online Scheduling	7%

Ongoing Engagement with Patients, Partners, Community

Engagement sessions have occured or are scheduled

A comprehensive Communications Plan (including engagement) is key in acheiving Year 1 goals and objective

Engagements have been inclusive, with sessions targeting:

- Francophone and Indigenous communities
- Chatham-Kent Local Immigration Partnerships
- Physicians/Nurse Practitioners
- Patients
- Rural Leaders
- Seniors
- System Partners

Deadline for Full Application Submission

What's next?

Deadline October 9, 2019

1 Full application

A selection of groups will be invited to submit a full application.

- ✓ Full Applications will be reviewed and evaluated and those that demonstrate a higher degree of readiness for implementation will be invited to participate in an In-Person Visit.

Fall 2019

2 In-person visit

Based on ministry review, a selection of sites will undergo an in person visit.

- ✓ During this visit, providers will be expected to present a comprehensive current state assessment of their system and a vision for the future of patient care in the near and longer-terms. Further details will be provided to groups selected for an in-person visit.

Fall 2019

3 OHT Announcement

The initial OHTs selected to officially launch will be announced.

- ✓ Based on ministry review and evaluation of the full application and site visit, applicant groups will be selected to officially launch an OHT.

Start of Year 1 = ???

Achieving the best health and well-being together:

Thank you