



Ontario Health Teams

Introduction and Overview

Ministry of Health and Long-Term Care
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Speakers:

- Deputy Minister Helen Angus
- Melanie Fraser (Associate Deputy Ministry, Health Services)
- Greg Hein (Assistant Deputy Minister, Digital Health Secretariat)
- Allison Costello (Lead Director, Ontario Health Teams)

Note:

- This is the first in a series of technical webinars the ministry will be hosting with providers interested in becoming Ontario Health Teams. Dates and times will be posted on the OHT webpage.
- The next webinar will be scheduled shortly and communicated through the Connected Care Updates Newsletter.



Introduction and Overview

What are Ontario Health Teams?

- Ontario Health Teams are a new model of integrated care delivery that will enable patients, families, communities, providers and system leaders to work together, innovate, and build on what is best in Ontario's health care system.
- Through this model, groups of health care providers will 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.
- As a team, they will work to achieve common goals related to improved health outcomes, patient and provider experience, and value.
- The goal is to provide better, more integrated care across the province. We call this new model of care - **Ontario Health Teams (OHTs)**.

Ontario Health Teams are groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population.

A Vision for Ontario Health Teams

At maturity, every Ontarian will have access to an Ontario Health Team that will:



Provide a full and coordinated continuum of care for an attributed population within a geographic region



Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey



Be measured, report on and improve performance across a standardized framework linked to the 'Quadruple Aim': better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value



Operate within a single, clear accountability framework



Be funded through an integrated funding envelope



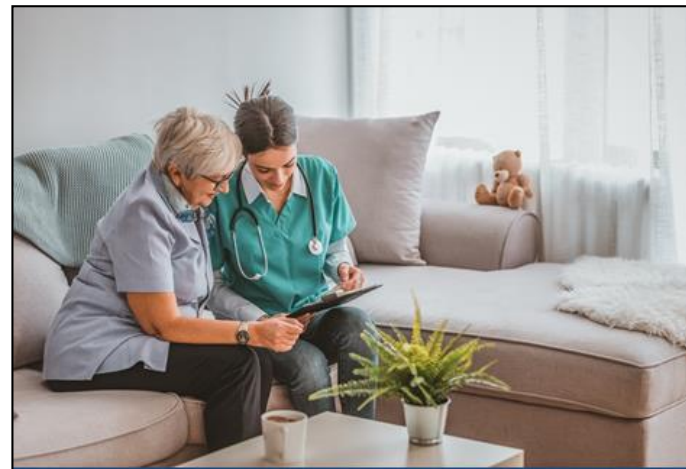
Reinvest into front line care



Improve access to secure digital tools, including online health records and virtual care options for patients – a 21st century approach to health care

Ontario Health Teams Guidance Document

- The **Ontario Health Teams: Guidance for Health Care Providers and Organizations** sets out the process for providers to become Ontario Health Teams.
- There are multiple components to the Ontario Health Team model:
 1. Patient Care & Experience
 2. Patient Partnership & Community Engagement
 3. Defined Patient Population
 4. In-Scope Services
 5. Leadership, Accountability, & Governance
 6. Performance Measurement, Quality Improvement, & Continuous Learning
 7. Funding and Incentive Structure
 8. Digital Health
- The guidance document specifies each of these components in detail, including:
 - **Minimum readiness criteria** that groups must demonstrate over the course of the readiness assessment process in order to be considered for Ontario Health Team Candidate selection
 - Expectations for Ontario Health Team Candidates at the end of their **first year** of operations
 - Expectations for an Ontario Health Team at **maturity**



Ontario Health Teams: Guidance for Health Care Providers and Organizations



1. Patient Care & Experience

At Maturity:

- **Access** – Patients will access care when and where they need it. They will have many ways to access their care, including digital choices.
- **Coordination & Transitions** – Patients' care will be seamless, and each step in their care journeys will be planned. Patients will know who they can go to when they need help navigating their care or when things go wrong.
- **Communication & Information** – Patients will be able to access their health records digitally. They will be provided information about their condition and know how to be active partners in managing their own health and health conditions. Patients will know what services are available to them from their Ontario Health Team and how to access services outside of their Team.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information.• Existing capacity to coordinate care.• Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.	<ul style="list-style-type: none">• Care has been redesigned.• Access, transitions and coordination, and integration have improved.• Zero cold handoffs.• 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the Team's services are in place.• Expanded virtual care offerings and availability of digital access to health information.

2. Patient Partnership and Community Engagement

At Maturity:

- Teams will uphold the principles of patient partnership, community engagement, and system co-design.
- Teams will be driven by the needs of patients and communities.
- They will meaningfully partner with patients, families, caregivers, and communities, based on a robust patient partnership model and community engagement strategy.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Demonstrated history of meaningful patient, family, and caregiver engagement.• Plan in place to include patient(s), families, and/or caregiver(s) in governance structure(s) and put in place patient leadership• Commitment to develop an integrated patient engagement framework, and patient relations process.• Indication of whether patients, families, and caregivers have been involved in the design and planning of the application and support from First Nations communities on reserve where applicable.• Adherence to the requirements of the French Language Services Act, as applicable, in serving Ontario's French language communities.	<ul style="list-style-type: none">• The Ontario Health Team has a Patient Declaration of Values in place, aligned in principle with the Patient Declaration of Values for Ontario.• Patient(s), families, and/or caregiver(s) are members of governance structure(s) and patient leadership is established.• Well-defined patient engagement, consultation, and partnership strategy/framework and patient relations process are in place, developed in partnership with patients, families, and caregivers.• Community engagement plan is in place to inform continued implementation and out-year planning.

3. Defined Patient Population

At Maturity:

- Teams will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care.
- The size of each Ontario Health Team’s population will be sufficient to fully optimize clinical and financial outcomes and will account for unique regional variations and the needs across rural, urban, and northern communities.
- Regardless of size, care delivery will be tailored according to the needs of the patients and communities served.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Identified population and geography at maturity and target population for year 1.• Process in place for building sustained care relationships with patients.• High-volume service delivery target for year 1.	<ul style="list-style-type: none">• Patient access and service delivery target met.• Sustained care relationship with targeted patients is developed and reported.• Plan in place for expanding target population.

Note:



In order to hold Ontario Health Teams clinically and fiscally accountable for the total costs and health outcomes of their population, each Team will have an “attributed population” – the population that the Ontario Health Team is responsible for and on which outcomes and costs will be calculated.

Attribution methods are in development.

4. In-Scope Services

At Maturity:

- Teams will offer a full and coordinated continuum of services to achieve target outcomes, including but not limited to:
 - Primary care (including inter-professional primary care and physicians)
 - Secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services))
 - Home care
 - Community support services
 - Mental health and addictions
 - Health promotion and disease prevention
 - Rehabilitation and complex care
 - Palliative care (e.g., hospice)
 - Residential care and short-term transitional care (e.g., in supportive housing, long-term care homes, retirement homes)
 - Long-term care home placement
 - Emergency health services
 - Laboratory and diagnostic services
 - Midwifery services
 - Other social and community services and other services, as needed by the population.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care).• Plan in place to phase in full continuum of care.	<ul style="list-style-type: none">• Plan in place for expanding range and volume of services provided.• Primary care coverage for a significant proportion of the population.

5. Leadership, Accountability, & Governance

At Maturity:

- Providers that form Ontario Health Teams will be free to determine the governance model that works best for them, their patients, and their communities. Any governance model chosen must be conducive to coordinated care delivery for patients, support achievement of performance targets, and enable the achievement of accountability objectives.
- Teams will also be expected to demonstrate strong financial management and controllership to appropriately oversee its integrated funding envelope.
- Governance arrangements may evolve, transitional governance structures could be in place as teams adapt to new ways of working together.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none"> • Team members are identified and some can demonstrate a history of working together to provide integrated care. • Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). • Commitment to the Ontario Health Team vision and goals, developing a strategic plan for team, reflecting a central brand. • Plan in place to work together, where applicable through formal agreements between team members. 	<ul style="list-style-type: none"> • Agreements with Ministry and between Ontario Health Team members (where applicable) in place. • Each provider's/organization's existing funding or service accountability agreement or service contract will remain in place, and reporting and other obligations set out in those agreements must continue to be met. • Strategic plan for the Ontario Health Team and central brand in place. • Physician and clinical engagement plan implemented.

6. Performance Measurement, Quality Improvement, & Continuous Learning

At Maturity:

- Ontario Health Teams will provide high quality care that is informed by the best available evidence and clinical standards, with an ongoing focus on the best possible outcomes through continuous quality improvement at all levels.
- A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Ontario Health Teams are providing integrated care, and performance will be reported.
- Each Ontario Health Team will need the ability to analyze data to plan and mobilize resources for its patient population and community.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement.• Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence.• Commitment to collect data, pursue joint quality improvement activities, engage in continuous learning, and champion integrated care.	<ul style="list-style-type: none">• Integrated Quality Improvement Plan in place for the following fiscal year.• Progress made to reduce variation and implement clinical standards or best available evidence.• Complete and accurate reporting on required indicators.• Participation in central learning collaborative.

7. Funding and Incentive Structure

At Maturity:

- Ontario Health Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.
- Budgets will be set according to a blended funding model, which will feature risk-adjusted population-based funding, as well as elements of activity-based funding (i.e., bundled care) for specific episodic conditions. Select low volume, high cost procedures would continue to be overseen and funded provincially.
- As we work toward maturity, teams that exceed performance and cost targets will be eligible for shared savings incentives to use towards front line care. Teams will be able to risk and gain-share among members.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• All partners have demonstrated a track record of responsible financial management.• Confirmed commitment to work towards an integrated funding envelope and identify a single fund holder.• Confirmed commitment to reinvest savings to improve patient care.• Demonstrated understanding of the costs of their population and associated cost drivers.	<ul style="list-style-type: none">• Continued allocation of individual funding envelopes for organizations, calculated using current methods in the near term.• A better understanding of an integrated funding envelope and analysis of financial data.• A single identified fund holder by end of Year 1 in anticipation that an integrated funding envelope will be allocated in future years.

8. Digital Health

- Based on our research of Integrated Delivery Systems in other jurisdictions (e.g. Accountable Care Organizations in the United States; similar efforts in the UK and Europe), three key themes related to digital health capabilities have been identified.
- The key digital capabilities for OHTs are interdependent and work together:
 1. **Ability for patients to have digital choices** such as virtual care, online appointment booking and digital access to patient health records, that improve utilization by empowering patients to better manage their health and create alternatives to in-person care.
 2. **Ability for frontline providers to communicate and share information**, including shared patient records among all care providers within an OHT, complemented with the tools needed to enable real-time, team-based care.
 3. **Ability for the OHT to manage itself and improve performance**
 - **Clinical standardization** including common clinician workflows and pathways that are embedded within digital systems to drive quality improvement at scale.
 - **Advanced analytics** and strong information management practices to enable population health management and ongoing quality improvement.
 - **Reporting and measurement** to the ministry, agency and other parties as required.

8. Digital Health continued

At Maturity:

- Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.
- These tools will also significantly improve the operations of health service providers and organizations, enabling improved workflows and reducing common day-to-day challenges that result in provider frustration and burnout.

Readiness Criteria	Year 1 Expectations
<ul style="list-style-type: none">• Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators.• Single point of contact for digital health activities.• Digital health gaps identified and plans in place to address gaps and share information.	<ul style="list-style-type: none">• Harmonized Information Management plan in place.• Increased adoption of digital health tools.• Plans in place to streamline and integrate point of service systems and use data to support patient care and population health management.



Who Should Participate

Who Should Participate in the Ontario Health Team Model?

- **All** interested groups of providers and organizations are invited and encouraged to participate in the assessment process to become an Ontario Health Team.
- Local providers are encouraged to self-organize and determine how to best come together to serve their local population and how to work to provide a full and coordinated continuum of care for patients.
- Although not all local providers may be at the same level of readiness to partner in this model, early and ongoing conversations across the spectrum of care are still encouraged.
 - Interested providers can come forward with a plan to expand partnerships over time.
- There will be additional opportunities to participate in the readiness assessment process.

Note: While many providers have expressed interest in participating, at this time no teams have been selected.

Suite of Supports

A suite of supports will be provided to Ontario Health Teams.

ENABLERS:

- **Addressing legislative, regulatory and policy or other barriers** that may impede the provision of innovative, efficient, integrated care for early adopters to succeed and to enable full implementation of the model at scale.
- **Providing access to optional provincial templates, tools, and services;** tools for patient, family, and caregiver engagement and partnership; tools for provider and patient identification; and tools for digitally and securely sharing information.
- **Access to the OHT's performance measurement data** as well as population and financial analytics (e.g., data on costing, health service utilization, referral patterns).
- **Support to grow and share best practices** including governance (board) training, and focused learning on implementing integration, and patient engagement tools.
- **Communications support including** common visual branding resources, common key messages, stakeholder and public communication materials.
- **Change management support** to transition into the Ontario Health Team model of care.
- **Digital health supports** including clear policies and standards for digital services, priority access to provincial digital services, a team to work with early adopters to co-design their digital health and information management practices.



How to Get Involved

The Path to Becoming an Ontario Health Team

To onboard interested groups of providers and organizations, a readiness assessment process is being launched to:

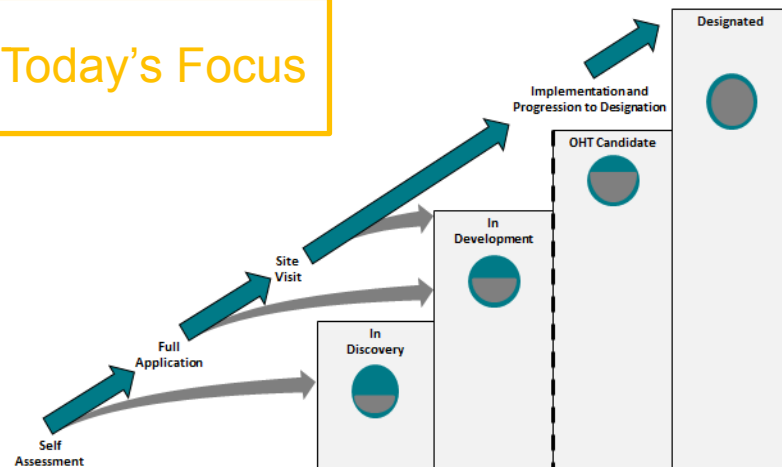
- Determine which groups currently (or with some assistance) meet the key readiness criteria to begin implementation of the OHT model, and
- Identify groups who are not yet ready to begin implementation but who can be actively supported to work towards readiness (i.e., those who are 'In Development' or 'In Discovery').

The path to becoming a designated OHT consists of four steps:

1. **Self-Assessing Readiness:** Interested groups of providers and organizations assess their readiness and begin working to meet key readiness criteria for implementation.

Today's Focus

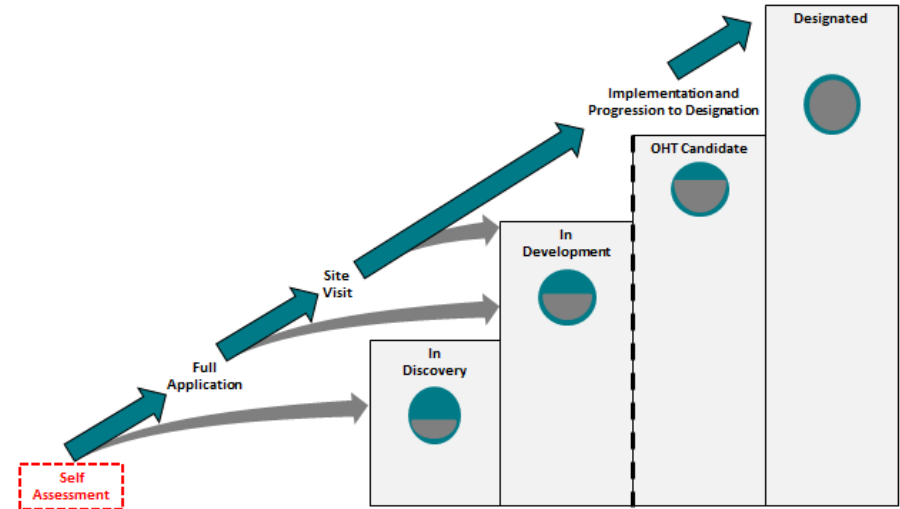
2. **Validating Provider Readiness:** Based on Self-Assessments, groups of providers are identified as being In Discovery or In Development stages of readiness.
3. **Becoming an OHT Candidate:** Groups of providers that demonstrate through an invitational, full application that they meet key readiness criteria are selected to begin implementation of the OHT model.
4. **Becoming a Designated OHT:** OHT Candidates that are ready to receive an integrated funding envelope and operate under a single accountability agreement can be designated*.



Readiness Assessment Process: Self-Assessment

Self-Assessment Overview:

- This stage allows teams to familiarize themselves with the model and required components, and work through together how they would meet the minimum criteria.
- Self-Assessment submissions will be reviewed and those deemed to be in the beginning stage of readiness will receive access to supports to continue working towards further readiness. These teams will be considered as 'In Discovery'.
- Those teams that demonstrate a higher degree of readiness to become OHTs (i.e., 'In Development') will be invited to prepare and submit a Full Application.



Readiness Assessment Team:

- Expert advisors as appropriate (e.g. clinical, sector, and research experts)
- Ministry representatives (including primary care, home care, hospitals, mental health, digital health, and others)

Readiness Assessment: An Ongoing Process

MILESTONE	TIMELINE
First call for Self-Assessments	April 3, 2019 – May 15, 2019 (6 weeks)
Invitation to submit Full Applications	June 3, 2019 – July 12, 2019 (6 weeks)
Evaluation of Full Applications and site visits	July 15, 2019 – August 16, 2019 (5 weeks)
Selection of first cohort of OHTs	Fall 2019
Next call for Self-Assessments	Fall 2019

Note:



Providers or groups of providers who are not ready to participate in the first call for Self-Assessments will have further opportunities to participate

All providers and organizations who participate in the assessment process will have access to supports that will help improve readiness and eventual implementation



Resources to Get Started

Online Resources to Get Started

Ontario Health Team Resources

The following resources may help you on your journey to becoming an Ontario Health Team :

- **Guidance Document for Health Care Providers and Organizations:** Designed to guide groups of health care providers and organizations in becoming Ontario Health Teams.
- **A Jurisdictional Scan:** Presents findings on integrated care systems around the world that integrate care across the full continuum of care.
- **Essential Reading List:** A short list of articles on lessons learned from integrated care implementations around the world.

Learn More About Connected Care

- **Building a Connected Public Health Care System for the Patient:** Ontario Health and Ontario Health Team backgrounder.
- **Patient Declaration of Values for Ontario:** a list of principles and values that will guide the culture of Ontario Health Teams.
- **Hallway Health Care: A System Under Strain:** a report that provides an overview of key challenges contributing to hallway healthcare and opportunities for integrated care.

Webinars and other information

- In addition to online resources, a series of educational webinars to support providers interested in becoming OHTs will be held.
- Webinar recordings, slides and continuously updated Qs and As will be available online for future reference.

To access these resources please visit:

<http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx>

Key Contact Information

Questions related to Ontario Health Teams and its application process:

Allison Costello, Lead Director, Ontario Health Teams
ontariohealthteams@ontario.ca

Additionally, ministry staff contacts for OHT inquiries during the assessment and implementation process are being identified.

Questions related to Ontario's plan to build a connected public health care system:

connectedcare@ontario.ca

A photograph of several hands of different skin tones stacked together in a circle, symbolizing teamwork and support. The image is overlaid with a semi-transparent blue filter. A dark blue horizontal bar is positioned at the bottom of the image, containing the text 'Questions and Answers' in white.

Questions and Answers

Questions and Answers

Is there a required population size to participate in the OHT model?

- **No.** The number of patients attributed to each Ontario Health Team will vary, depending upon the number of Ontarians living within the local community, the number and type of local providers that participate in the Ontario Health Team model, and local access and referral patterns.
- At maturity, the size of each Ontario Health Team's population will be sufficient to fully optimize clinical and financial outcomes and will account for unique regional variations and the needs across our rural, urban, and northern communities.
- Regardless of size, care delivery will be tailored according to the needs of the patients and communities served.

How many OHTs will be selected through the first round of assessment?

- **This has not been pre-determined.** It will depend on how many teams come forward and their level of readiness.
- Ontario Health Team Candidates will be selected based on the extent to which they are able to meet the readiness criteria set out in the Guidance Document.

Questions and Answers

What is the plan for scale and spread of this model?

- **Ontario Health Teams are not a pilot project.** At maturity, every Ontarian will have the opportunity to access care from an Ontario Health Team.
- The assessment process will be repeated until full provincial coverage is achieved. Rapid learning approaches will be used to apply lessons learned from earlier adopters to ongoing implementation and model refinement.
- The assessment process is designed so that all providers and organizations can begin the path towards becoming an Ontario Health Team, regardless of their initial state of readiness.

Will interested providers and organizations receive supports (e.g., project management funding) to support their participation in the readiness assessment process?

- The readiness assessment does not require new funding to conduct.
- Resources to support participation in the readiness assessment process are available online at <http://health.gov.on.ca/en/pro/programs/connectedcare/oh/default.aspx>
- Additional webinars will also be held.

Questions and Answers

How can home care service provider organizations (SPOs) participate in OHTs?

- At maturity, OHTs will include **all** sectors across the continuum of care, including home and community care. As teams conduct their readiness assessments, home and community care providers that they currently collaborate with or may collaborate with in the future should participate in an effort to be as inclusive of the full continuum of care as possible.

Will home care clients experience service disruptions?

- OHTs will be expected to build comprehensive transition plans to manage patient transitions, patient access, and care pathways and to avoid any disruption to patient care.
- The current home and community care services will continue to be delivered and will continue to support post-acute, long-stay, medically complex, and palliative and end-of-life patients.
- The legislative, regulatory and policy framework remains in place while the government engages in ongoing consideration of how to foster innovative approaches to integrated care within the OHT model.
- The ministry will also work with OHTs and LHINs that continue to deliver home and community care on provincial considerations regarding health human resources and continuity of business processes.

Questions and Answers

Will physicians have the opportunity to participate in Ontario Health Teams? Will physician compensation change?

- Lessons from other jurisdictions suggest that strong physician engagement and leadership – particularly among primary care providers – is key to successful implementation of integrated, better connected care.
- Successful Ontario Health Teams can be built on existing physician remuneration models.
- Changes to physician compensation are subject to negotiation with the Ontario Medical Association under the binding arbitration framework.

How should organizations that deliver care across the province participate in Ontario Health Teams? Can an organization be part of more than one Ontario Health Team?

- Organizations that deliver care in many different communities have the opportunity to participate in readiness assessments in those communities. These organizations can reach out to other local providers to begin discussions and should determine which communities they wish to focus on during the first call for self-assessments, recognizing that there will be future opportunities.
- As Ontario Health Teams scale and spread across the province, organizations that deliver care across different communities may have relationships with or be part of more than one Ontario Health Team.

Next Webinar

- The next webinar on April 16th, 12-1pm will continue to focus on the self-assessment process and supports.
- Over the coming weeks, additional webinars will be held on the following topics:
 - Patient partnership
 - Community engagement
- Future webinars will be held on topics such as:
 - Funding and incentives
 - Governance
 - Performance measurement
 - Digital health and information management.
- Webinar registration links will be shared through the Connected Care newsletter. Please email connectedcare@ontario.ca to sign up.



Thank you