Ontario Health Teams
Self-Assessment Process

Ministry of Health and Long-Term Care
April 16, 2019
Recall: Implementation of the Ontario Health Teams Model

• The government is transforming the public health care system to improve patient experience and strengthen local services.

• Ontario Health Teams (OHTs) are being introduced to provide a new way of organizing and delivering services in local communities.

• 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.

• On April 3rd, 2019 the Ministry launched an open call for Self-Assessments for interested groups of providers and organizations to assess their readiness and begin working to meet key readiness criteria for implementation.

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<th>MILESTONE</th>
<th>TIMELINE</th>
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<tbody>
<tr>
<td>Open call for Self-Assessments</td>
<td>April 3, 2019 – May 15, 2019 (6 weeks)</td>
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<tr>
<td>Invitation to submit Full Applications</td>
<td>June 3, 2019 – July 12, 2019 (6 weeks)</td>
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<tr>
<td>Evaluation of Full Applications and site visits</td>
<td>July 15, 2019 – August 16, 2019 (5 weeks)</td>
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<td>Selection of first cohort of OHTs</td>
<td>Early September 2019</td>
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<tr>
<td>Continuous Intake</td>
<td>Beginning May 2019</td>
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Note: Services for specialized conditions and procedures (e.g. transplant and neurosurgery) will continue to be delivered by existing specialized providers and will be provincially coordinated.

In some cases providers might offer care within an OHT, as well as provide provincially coordinated specialized services.
Recall: 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

This means providers should be...

- Seeking out partnerships and redesigning care in ways that best serve local communities in terms of health outcomes and patient experience
- Using available data and pooling local intelligence to understand population needs
- Thinking outside the box - identifying opportunities for doing things better and differently
Overview

01 Self-Assessment Overview
02 Part I: General Information & Commitments
03 Part II: Self-Assessment Scoring
04 Part III: Implementation Snapshot
05 Part IV: Sign Off
06 Resources to Get Started
07 Next Steps

Speakers:
- Allison Costello (Lead Director, Ontario Health Teams)
- Jackie Houston (Manager, Program Development Unit)
- Stephanie Soo (Team Lead, Program Development Unit)
- Jenny Moloney (Team Lead, Quality Performance & Evaluation Unit)
- Ben King, (Manager, Digital Health Secretariat)

Note:
- This is the second in a series of technical webinars the ministry will be hosting with providers interested in becoming Ontario Health Teams.
Self-Assessment Overview
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.

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*.

*If passed, Bill 74, *The People’s Health Care Act, 2019*, would allow the designation of integrated care delivery systems (Ontario Health Teams). See s.29 of the *Connecting Care Act, 2019* – Schedule 1 of Bill 74.
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)
Guidance for Completing the Self-Assessment

• Please refer to *Ontario Health Teams: Guidance for Health Care Providers and Organizations* document to complete this form.

• This form should be endorsed and signed-off by leadership from all participating providers/organizations. While Board approval is not required due to the short timeframes of the Self-Assessment, participants are expected to confirm the highest level of commitment possible.

• Answers to relevant questions should be clear and concise. Supporting documentation may be supplied.

• Submit the Self-Assessment form to OntarioHealthTeams@ontario.ca.

• Where appropriate, the Ministry of Health and Long-Term Care (the Ministry) may suggest that groups that submit separate Self-Assessments collaborate to re-submit a joint assessment.

• Please contact OntarioHealthTeams@ontario.ca for any inquiries regarding this Self-Assessment form.
Part I: General Information and Commitments
Part I: General Information and Commitments

Highlights

• Provide basic information about the members of your team

• Teams should seek to form partnerships that will support care redesign for better health outcomes and patient experience

• Confirm whether your team is open to collaborating with others (i.e., matchmaking)

• Confirm your team has read the guidance document in full
Part II: Self-Assessment Scoring
Model Component 1: Patient Care and Experience

• **At maturity**, Ontario Health Teams will offer patients, families and caregivers the highest quality care and best experience possible.

**Highlights**

• Teams should assess their ability to identify opportunities and propose a plan to improve
  
  ➢ **Access** to services provided by partners (e.g., wait times, availability of services)
  
  ➢ **Transitions** and coordination of care between care settings and providers (e.g., assessment of care needs, care planning, information sharing), and
  
  ➢ **Key measures of integration** (e.g., alternate level of care, avoidable emergency department visits, readmission rates, hallway bed use)
  
  ➢ **Digital access** for patients to their health information (e.g., patient portal for digital access to records from hospitals within the Ontario Health Team)
Model Component 2: Patient Partnership & Community Engagement

- At maturity, Ontario Health Teams will uphold the principles of patient partnership, community engagement, and system co-design.

**Highlights**

- Examples of high-quality patient engagement and partnership activities include:
  
  - Presence of a Patient and Family Advisory Council within each partner organization reporting to senior leadership (CEO or Board), inclusion of patient partners on key committees, etc.

- Successful patient leadership includes, but is not limited to, characteristics such as:
  
  - Making patients an integral part of strategic decision-making body (e.g. patients are included on an executive leadership team; patients are included on other strategic tables, including, but not limited to quality/safety/risk committees or councils)
  
  - Involving patient leaders at the outset of service/program/policy design

- Adherence to the requirements of the French Languages Services Act applies to team members who are designated under the Act

- Support for First Nations communities is required if a team’s proposed geography includes First Nations reserves
Model Component 3: Defined Patient Population

- **At maturity**, Ontario Health Teams will be responsible for meeting the health care needs of a population within a geographic area that is defined based on local factors and how patients typically access care.

**Highlights**

- The Ontario Health Team model is a total population health model – teams should be thinking about a maturity vision that includes an entire population, not just a specific condition or segment focus.
  - The Ministry will attribute or assign residents to an Ontario Health Team based on an understanding of existing patient flow and health care utilization patterns.

- At the same time, teams should think about who in their population they would focus on in their first year of operations.

- Teams should be forming locally, based on the way that patients access care and the partnerships that are best for patients. Geographical boundaries are not pre-determined. Proposed geographies may adjust over the course of the assessment process.

- Teams should consider whether they have a way of tracking who they serve.

- Teams should consider what proportion of their proposed year 1 population will actually receive redesigned care.

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Assess your team’s ability to meet the following requirements:  

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Yes</th>
<th>No</th>
<th>Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your team is able to identify the population it proposes to be accountable for at maturity</td>
<td>☐</td>
<td>☐</td>
<td>N/A</td>
</tr>
<tr>
<td>Your team is able to identify the target population it proposes to focus on in Year 1</td>
<td>☐</td>
<td>☐</td>
<td>N/A</td>
</tr>
<tr>
<td>Your team is able to define a geographic catchment that is based on existing patient access patterns</td>
<td>☐</td>
<td>☐</td>
<td>N/A</td>
</tr>
<tr>
<td>You know how you will track (e.g., register/roster/enrol) the patients who receive services from your team in Year 1</td>
<td>☐</td>
<td>☐</td>
<td>N/A</td>
</tr>
<tr>
<td>Of your Year 1 target population, you are confident that you will be able to deliver integrated care to a high proportion of this population and can set an achievable service delivery volume target accordingly</td>
<td>☐</td>
<td>☐</td>
<td>N/A</td>
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**Rationale (300 words maximum)**

Please provide a rationale for your self-assessment response. In addition, please include in your response:

- Who you would be accountable for at Maturity – describe the proposed population and geographic service area that your team would be responsible for at Maturity. Include any known data or estimates regarding the characteristics of this population, such as size and demographics, specific health care needs, health status (e.g., disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

- Who you would focus on in Year 1 – describe the proposed target population and geographic service area that your team would focus on in Year 1. Include any known data or estimates regarding the characteristics of this population and explain why you have elected to focus on this population first.

Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap and transitions between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 target populations and populations at maturity.
Model Component 4: In Scope Services

- **At maturity**, Ontario Health Teams will provide a **full and coordinated continuum of care** for all but the most highly-specialized conditions to achieve better patient and population health outcomes as needed by the population.

**Highlights**

- Teams should consider whether they are able to deliver at least three sectors of care at the service delivery capacity required by the proposed year 1 population
- Priority will be given to teams that can deliver at least three of hospital care, primary care, home care, and/or community care

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**Assess your team’s ability to meet the following requirements:**

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<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Your team is able to deliver coordinated services across at least three sectors of care and you have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., your team includes enough primary care physicians to care for all Year 1 patients)</td>
<td>☐️</td>
<td>☐️</td>
<td>☐️</td>
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<tr>
<td>You are able to propose a plan for phasing in the full continuum of care overtime, including explicit identification of further partners for inclusion</td>
<td>☐️</td>
<td>☐️</td>
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<tr>
<td>As part of that plan, you can specifically propose an approach for expanding your team’s primary care services to meet population need at maturity</td>
<td>☐️</td>
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<td>N/A</td>
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*In addition to your scoring rationale, please identify the services you propose to provide to your Year 1 population. For each checked service, you must have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., to check off primary care physicians, your team must include enough primary care physicians to care for your Year 1 population). Where relevant, provide additional detail about each service (e.g., which member of your team would provide the service).*

- primary care
- interprofessional primary care
- physicians
- secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services))
- home care and 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)
- emergency health services
- laboratory and diagnostic services
- midwifery services; and
- other social and community services and other services, as needed by the population (please provide more details below):
Model Component 5: Leadership, Accountability and Governance

- **At maturity**, Ontario Health Teams will be self-governed, operating under a shared vision and working towards common goals. Each Team will operate through a single clinical and fiscal accountability framework.

**Highlights**

- Teams should consider whether they’ve had success working together in the past to improve integrated care (examples include but are not limited to Health Links, Rural Health Hubs, Bundled Care, SPiN, etc.). Trusting relationships are key.
- There is no “right” governance model. Teams are expected to determine the governance model is the one that works best for the needs of patients.

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### Assess your team’s ability to meet the following requirements:

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<tbody>
<tr>
<td>You have identified your partners and at least some partners on your team are able to demonstrate a history of formally working with one another to advance integrated care</td>
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<tr>
<td>You are able to propose a plan for physician and clinical engagement and ensuring inclusion of physician and clinical leadership as part of the team’s leadership and/or governance structure(s)</td>
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<tr>
<td>Your team is committed to:</td>
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<tr>
<td>- The vision and goals of the Ontario Health Team model</td>
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<td></td>
<td>N/A</td>
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<tr>
<td>- Putting in place a strategic plan or direction for the team, consistent with the Ontario Health Team vision</td>
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<tr>
<td>- Reflecting a central brand</td>
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<td>N/A</td>
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<tr>
<td>- Working together towards a single clinical and fiscal accountability framework</td>
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<td>N/A</td>
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<tr>
<td>- Entering into formal agreements with one another</td>
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Model Component 6: Performance Measurement, Quality Improvement, and Continuous Learning

- At maturity, Ontario Health Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement.

Highlights

- Teams should assess their data collection practices and demonstrate an understanding of their performance on select key integration metrics. Indicators include:
  - 30-day inpatient readmission rate
  - Alternate level of care
  - Avoidable emergency department visits.

- Your team should demonstrate a history of meaningful quality and performance improvement. For example, you can show year-over-year performance improvement on organizational Quality Improvement Plans (QIPs) or accountability metrics.
Model Component 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.

**Highlights**

• Teams should have a track record of responsible financial management and demonstrate a commitment to work toward an integrated funding envelope.

• Examples of evidence that suggests poor or declining financial management include:

  - For hospitals - Balanced budget waivers due to deficit, operating pressures request history, cash advance request history, deteriorating working funds position, demonstrated difficulty in managing cross-provider funding as part of bundled care.

  - For primary care (physician and non-physician models) - Non-compliance with their current contract, service accountability agreement and applicable public service procurement practices

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<tr>
<th>Assess your team’s ability to meet the following requirements:</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Each partner in the team is able to demonstrate a strong track record of responsible financial management (this may include successful involvement in bundled care and management of cross-provider funding)</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Your team can demonstrate that it has a basic understanding of the costs and associated cost drivers for your Year 1 population and/or proposed population at maturity</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Your team is committed to:</td>
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<tr>
<td>Working towards an integrated funding envelope and identifying a single fund holder</td>
<td>❑</td>
<td>❑</td>
<td>N/A</td>
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<tr>
<td>Investing shared savings to improve care</td>
<td>❑</td>
<td>❑</td>
<td>N/A</td>
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Model Component 8: Digital Health

- At maturity, Ontario Health Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

**Highlights**

- Teams should be able to confirm their approach to provide patients with digital choices such as virtual care and timely digital access to their health records required to meet their year 1 expectations.

- Teams should be able to digitally record and have some capability to share information with one another.

- Your team should be able to present a comprehensive current state assessment and confirm an approach to reach maturity for digital health that is aligned with provincial services and standards.

- There should be a senior-level single point of contact identified who will represent the team and support all digital health activities.

### Assess your team’s ability to meet the following requirements:

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<th>Requirements</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Most partners in the team have existing digital health capabilities that are already being used for virtual care, record sharing and decision support</td>
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<tr>
<td>Your team is able to propose a comprehensive plan to improve information sharing and resolve any remaining digital health gaps, consistent with provincial guidance regarding standards and services</td>
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<tr>
<td>Your team can identify a senior-level single point of contact for digital health</td>
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Part III: Implementation Snapshot

Highlights

• Explain how your team will do things differently
• What will you do first?
• What are the key risks?

Please provide a high-level overview (maximum 500 words) of how you plan to implement the Ontario Health Team model and change care for your proposed Year 1 target population. Include in your response:

• Considering the Quadruple Aim, standard performance measurement indicators, and Year 1 Expectations for Early Adopters set out in the Ontario Health Teams Guidance for Health Care Providers and Organizations, what are your immediate implementation priorities?
• What would you anticipate as key risks to successfully meeting Year 1 Expectations and how would you address them?
Part IV: Sign Off
Part IV: Sign Off

Highlights

• The highest level of commitment possible is encouraged
• Every participating member of the team should sign the form
Next Webinar

- Future webinars may 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.
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:

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
Thank you