

Ontario Health Teams: Stakeholder Webinar
April 5, 2019 at 2PM
English Transcript

Moderator: David Jensen

[00:00:03;17] Welcome to the stakeholder webcast on the government's plan to oversee the development of Ontario Health Teams across the province. I'm David Jensen, with the Communications and Marketing Division here at the Ministry.

[00:00:14;25] On Wednesday, the Ministry released the guidance document that is now available to health care providers and organizations, on the process involved in becoming an Ontario Health Team. Here today to provide you with further information on this process, we have Helen Angus, the Deputy Minister of Health and Long-Term Care, Melanie Fraser, the Associate Deputy Minister of Health Services, Allison Costello, a Director with the Hospitals and Emergency Services Division, and Greg Hein, Assistant Deputy Minister of the Digital Health Secretariat.

[00:00:46;13] During the next 90 minutes, we will have opening remarks, followed by a webinar presentation, and then closing with a Q&A session. For those of you who are interested, you can start sending in your questions now, but to start things off we'll open with opening remarks from the Deputy.

DM Helen Angus:

[00:01:02;03] Thanks a lot, David. Good afternoon, bonjour. Thank you for joining this webinar about Ontario Health Teams.

[00:01:08;02] As David said, I'm Helen Angus and I am the Deputy Minister of Health and Long-Term Care, and I am here with many colleagues from the ministry. There's also a few in the room who have been supporting this work over the past many months.

[00:01:21;03] I hope that some of you actually had a chance to join us earlier this week with the Minister on Wednesday at the Telephone Town Hall, and we are so glad that so many of you are here today. I know we had a number of questions coming out of that Town Hall, and hope we have a chance to answer them both today and the days ahead.

[00:01:38;19] Today's webinar will provide you the opportunity to hear more about the important role that Ontario Health Teams will play in the transformation of our health care system.

We will be providing detail on who should participate - the answer is everyone, how to get involved, as well as resources that are available to help you get started.

[00:02:00;06] We're going to hold ample time for questions and answers towards the end of the webinar. So, this is the first in a series of technical webinars the ministry will be hosting with providers who are interested in becoming Ontario Health Teams. More information about dates and times will be posted on the Ontario Health Team webpage.

[00:02:19;11] I am excited about the vision for Ontario Health Teams. It's about teams of providers working together to provide better, faster, more connected care for patients. It's a pretty compelling vision, and I think it's something we can all get on board with.

[00:02:33;29] We know from other jurisdictions, that this model can work. And we know that there are already many innovative practices in place throughout the province that support innovative delivery models and improved coordination of care.

The Ontario Health Team model is intended really to build on this innovation and extend the benefits of more integrated and accessible care across the entire province.

[00:02:55;12] I will encourage all interested groups of providers and organizations to participate in the assessment process to become an Ontario Health Team. We have received lots of interest in the model, but I want to be very clear at this time, no teams have been selected. That will only happen after we look at the assessments.

[00:03:14;02] We want providers to self-organize and determine how to best come forward to serve your local population and how to work towards a full and coordinated continuum of care for those patients.

[00:03:25;10] We know that not all providers will be at the same level of readiness to partner in this model, but we encourage you to start those conversations now. And we really want this to be all about partnership. It's not about certain sectors the lead or taking over. It really is about partners coming to the table as equal partners, with a joint commitment to improving patient outcomes and experience.

[00:03:51;14] We know that this is the kind of transformation that will take time; it will require ongoing support from us, as well as other partners in the system, and we're all going to learn from the first few teams that will implement the model. And we recognize that the ministry will have to play its part in removing barriers to enable Ontario Health Teams to truly achieve their potential.

[00:04:13;16] So I thank you in advance for your time and your interest. I look forward to connecting with you on many more occasions about this topic. We're all pretty passionate here, as I know you are as well.

[00:04:24;08] And on that note, it gives me great pleasure to turn things over to Melanie Fraser and our other panelists. I look forward to the Question and Answer session. So, take it away, Mel.

Melanie Fraser:

[00:04:34;04] Alright. Thank you Deputy for the introduction and for starting us off.

As Helen mentioned, my name is Mel Fraser and I am the Associate Deputy Minister here for Health Services, and I am so pleased to be here with the team and all of you today who are on the webinar.

[00:04:48;19] As Helen mentioned, this is really the first of many opportunities for both engagement as well as shared learning and question and answers. We will be continuing to post materials on our connected care webpage, so that's a really important place to go if you're looking for information. So we do encourage you to check back in there.

[00:05:10;08] On Wednesday this week, many of you like us, heard from Minister Elliott about this government's vision for the public health system and the critical role that Ontario Health Teams will play in transforming care for patients. So, today's session then is really about zeroing in on some of the important details about how we start this process - what the model and what the readiness assessment process is.

[00:05:35;21] So, before we dive deep into that, just a couple of housekeeping items, please note that this webinar will be recorded and it will be made available on the website that I mentioned, for those who couldn't make it today. There will also be a number of additional materials and best practice tools available on that websites. The slides that you're viewing on line right now, will also be posted to the website in both French and English.

[00:06:02;26] We will try to address as many questions as possible today but if there are those we don't get to, and I think there's already over 60 or 80 questions in the queue, so please feel free to direct them to the OntarioHealthTeams@ontario.ca. Again, that's a portal that you can find on that same webpage, for asking us questions.

[00:06:24;17] I guess the most important thing that we want to emphasize is that we did publish some guidance materials early this week. They were posted on that website and they will really become the primary reference source of information about how to become an Ontario Health Team, and I really encourage you, if you haven't had the opportunity yet, to read through those and give those a close look.

[00:06:48;22] So if you want to move ahead to slide four, I think we're going to jump right in, and talk a little bit about Ontario Health Teams. So, as Helen mentioned, this is a new model of care delivery where groups of providers and organizations come together to work as a team with patients in their communities. [00:07:08;12] These teams will be held clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined population.

[00:07:19;16] And we've had lots of questions about does this mean that providers have to be in the same location, the same building? It doesn't. So, even if providers aren't in the same organization or physical location they'll still be working together as a team, along with patients and communities, to achieve common goals related to the Quadruple Aim. [00:07:39;17] And I think most people are familiar with Quadruple Aim, but it really is about
 Better health outcomes
 Better experience for patients, and providers
 And better value for the system.

[00:07:49;25] So the overall goal then, is for the system to provide more integrated and connected care that works for patients, for families, their caregivers, and for communities across Ontario.

[00:08:01;20] So, looking ahead to Slide 5, in terms of the long-term vision for Ontario Health Teams, we talk about the health teams at maturity, so at maturity we want all Ontarians to have the opportunity to access care from an Ontario Health Team in their community.

[00:08:21;07] So each team will:

- Be asked to provide a full and coordinated continuum of care for an attributed population within a geographic region. So you can imagine that's primary care, that's hospital care,

that's home care, and as we mature, that could extend to be mental health services and supports, and other community supports.

- [00:08:42;02] We'll also want our health teams to offer patients that need it, 24/7 access to care coordination and system navigation services, to help them work towards seamlessly transitioning patients through their own healthcare journeys as they move from different health care settings.
- [00:09:01;12] Each team will be measured, report data on, and improve performance across a standardized framework aligned with that of Quadruple Aim. So again, focused on outcomes, experience, and value.
- [00:09:14;02] We'll ask our health teams to operate under a single point of accountability, and
- They'll receive an integrated funding envelope dedicated to the population that they serve.
- [00:09:23;23] Finally, will be an opportunity to reinvest savings into front line care and quality improvement.
- And we really do hope that these health teams will help leapfrog our digital improvements and take a 21st century approach to health care - which means improving access to patients' health information and virtual care through digital tools.

[00:09:48;19] So, I guess the emphasis is that this is a journey. We want to promote continuous movement to achieve this model across the entire province.

[00:09:58;11] We are very, very excited about having this opportunity to start this journey with you and my colleague, Allison Costello, is going to walk us through these core components of the model shortly, but I would just like to encourage all groups to organize their thinking, partnerships and planning based on their patient and communities' needs. [00:10:19;11] Helen indicated that this isn't about one sector taking over others locally, and we really mean that. This is truly a partnership of health service providers, coming together on their own organically, and rebuilding the care that the deliver, so that it's focused together around the patient.

[00:10:38;27] So with that, I will turn it over to Allison to take us through all the fine strokes.

Allison Costello:

[00:10:43;28] Terrific. We wanted to use the rest of the time in the webinar to provide an overview of the model components that are set out in the guidance documents. So certainly Mel and Helen have indicated that the guidance information has been released on Wednesday. We encourage all groups to really pore over that document. [00:11:03;05] Lots of thinking has gone into that. What will follow is a summary of all of the points that are set out in that guidance document. But the real meat of it, any additional questions you might have, you might find the answers to within the guidance document.

[00:11:16;00] So we have a picture of the guidance document there on the slide, and the listing of the model components. And essentially, across each model component, the guidance document sets out the expectations for provider groups to demonstrate minimum readiness criteria. [00:11:33;01] The expectations that we would have for them at year 1, after delivery, and what the expectation is at maturity, across each domain. So the slides that follow kind of follow within that format.

[00:11:46;03] The very first model component that we've indicated here really is about patient care and experience. The model really is built upon organizing care around the patient - where

they need it, when they need it, and how they would like to access that. [00:12:01;08] So, we've set out that at maturity, patients will have access to care when and where they need it, and have multiple options for how they access that, so that it really does talk about that digital aspect of that, that Greg will walk into in more detail.

[00:12:13;09] Um, we really think that by working together, providers will have the opportunity to support improved transitions, improved coordination, and improved communication. So we've set that out as sort of maturity aspirational goals there for patients having seamless care along each step of the journey - knowing where they're going, knowing what to expect, and what to do if things do go wrong. [00:12:37;13] Also being really involved in the communication across their care teams, that they're part of a team that is receiving information about their care, and they know where to go to and who to ask about anything related to their care.

[00:12:52;17] On the bottom of that slide we've set out the readiness criteria, the expectations that we would want providers to demonstrate through their self-assessment, and the minimum criteria that we think people should demonstrate for being ready to implement the model now. [00:13:08;19] So, we've set these out for this model component as the plans are in place to improve access, transitions and care, a number of integration measures, patient self-management and health literacy. We really think that those are important aspects of improved patient care, and a plan to improve access to digital health information.

[00:13:27;27] Existing capacity to coordinate care, so where they have had the ability before to coordinate better care across sector groups.

And a commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care. So, Mel certainly spoke to that navigation service that we are setting as a service delivery expectation, that we want to be able to have as a promise to the patients that they would receive through the Ontario Health Team Model.

[00:13:54;07] So, at the end of Year 1, we would expect that care has been redesigned for the patients that are supported. There's been improvement on access, transition, coordination, and integration.

[00:14:03;15] We would expect that there are zero cold handoffs for those patients that are being supported through an Ontario Health Team. They're caught, they're supported across those transitions. And the service is in place to support that 24/7 access that we would want to see improvements in, and tools in place for self-management, health literacy, and public information about what the team provides so that there is a lot of clarity about what the public should expect from their Ontario Health Team, and they can really identify with what services they've benefitted from receiving from it.

[00:14:37;17] We also expect to have improved service offerings for virtual care as well, and digital access to health information.

[00:14:47;01] The next model component is patient partnership and community engagement, and on this one specifically, we did want to flag that the Deputy and Mel both referred to upcoming webinars that we will have in the coming weeks. We plan to have patient partnership, and community engagement webinars, because we do think that it's an important aspect to talk a bit more about as groups are getting together to build their self-assessment.

[00:15:13;23] So, what we have set out here at maturity, teams will have uphold the principles of patient partnership, community engagement, and system co-design. That the team will be driven, and built really, around the needs of the patients and their communities. And they will meaningfully partner with all of those groups and have a robust patient partnership model and community engagement strategy in place.

[00:15:36;10] What that means for demonstrating at readiness, right now at readiness they set out is a demonstrated history of meaningful patient, family, and caregiver engagement. So, we know there's a number of different sectors and providers that have really strong examples of having really embedded patient, family, and caregiver engagement, and partnership in place, and really what the opportunity is here for, groups getting together to form an Ontario Health Team is bringing those kind of best successes and spreading them across the partnership that they would develop, that is cross-sectoral in nature.

[00:16:12;05] Um, that they would plan in place to include patients, families, and/or caregivers in their governance structure. We do see that as an expectation at maturity, so we really want to see that people are thinking about how to build that into their model.

[00:16:25;10] A commitment to develop an integrated patient engagement framework, and patient relations processes. So again, this idea refers to while patient relations processes are required, and in place in some sectors, what would the mechanism be for the Ontario Health Team that is cross-coordinated continuum of care, how would they support patient relations processes across all of the providers that are involved in Ontario Health Team.

[00:16:50;02] We would want to see that patients, families, and caregivers have been involved in the design and planning of the application. We would also want to see where it's relevant and possible for support from First Nations communities on reserve where applicable.

And adherence to the requirements of the French Language Services Act, in serving Ontario's French language communities.

[00:17:07;21] So, I'll point out of this, these particular ones, on Page 6 of the guidance document, there's additional information about how we see that, those engagements being really encouraged and our expectations for that improvement, we would want to see in patient population groups that have special needs.

[00:17:31;00] Year 1 expectations that we would have. Ontario Health Team has a Declaration of Values in place, that is aligned in principle with the Patient Declaration of Values for Ontario. So, this document was released in March by the Ministers PFAC and is available online.

[00:17:44;27] We really--we see it as an opportunity for Ontario Health Teams that are building to develop their own, so that we really do see the promise of this document being spread across providers that are delivering care.

[00:18:00;19] We would want to have patients and caregiver(s) as part of the governance structure and patient leadership where appropriate.

[00:18:09;18] Well-defined patient engagement in place, developed in partnership with patients, families, and caregivers. As well, having community engagement plan in place to

inform the ongoing outreach that providers would have with their communities as they develop their out-year planning.

[00:18:27;04] The next model component is a defined patient population. This is really about teams being responsible for the health outcomes of a population within a geographic area that is defined based on how patients typically access their care.

[00:18:40;18] There's been a lot of questions about the size of the population that we are picturing here, and we want to be really clear that we do not have a number on this. There have been numbers suggested that sort of relate to what an average might be expected, but what we really are encouraging within the guidance document is that the population is sufficient to optimize the clinical and financial outcomes of the mode. [00:19:04;11] So essentially that means you know, the different model components that we will get into in future webinars, we'll sort of set out that there's a certain size and volume of patients that need to be supported by an Ontario Health Team for the overall model components to work, as related to financial model and other aspects. [00:19:23;11] So, we've not put a number on that, but we do know that we want to see a large enough size that the model can sort of, at maturity, achieve the success of the overall framework.

[00:19:34;19] Regardless of size, the care is delivered according to the needs of the patients and the communities that are identified. So, we would expect that patients, or that groups identify in the readiness process, that they have a target population for Year 1, and plans on how to expand that population. And that there really is about having a sustained relationship in place with the patients that they are serving.

[00:20:01;11] At Year 1, we would expect that they've met their target they had set for themselves, and they have a plan in place for expanding that population.

[00:20:09;10] We've included as a note on this slide, that in order to hold Ontario Health Teams clinically and fiscally accountable for the total costs and health outcomes for their population, each team will have an attributed population that is--that they're responsible for, and on which outcomes and costs will be calculated. [00:20:26;10] This is essentially we will have more information to come on this, but essentially in order for us to provide the sites with information on data and costing information, we will be providing them with information about an attributed population that they are serving. So, there'll be more to come on that one in particular. I'm sure there will be lots of questions on that.

[00:20:47;14] In-Scope Services, this is quite a long list of services that we do--we do see and essentially what you can get at is, this is to the exclusion of very few things that we do see Ontario Health Teams being a full and coordinated continuum of care. [00:21:04;06] And they're based--it's developed based on the needs of the population that is being served. So we have, at maturity set-out that essentially we want everything being served. At maturity, we really do have a vision that the full population is being supported by Ontario Health Teams.

[00:21:16;19] But we know that really, at the beginning we know we will be starting with partners that have existing relationships, that understand maybe where their patient groups need a continuum of care being better supported, so that in the readiness criteria we are setting out that it would be at least three sectors. [00:21:36;26] We really do see hospital, home care, community care, and primary care being essential components of an initial start, but we do not want to put you know, bookend that. We really do want it to be quite inclusive - a really big tent,

as was said at the Town Hall the other day - so that it is really a full and comprehensive continuum of care for the patients being supported.

[00:21:58;22] But that, whoever is kind of at the table at the beginning, there is a plan for a broader spread so that the full continuum can eventually be reached.

[00:22:08;23] So at Year 1, we would want to see that they've delivered the services that had been intended, and there's a plan to expand that. And where primary care had been maybe, we do see that as an essential component of the model but if there is a little bit of primary care, we would want to see really that there is, that the plan is to expand that, and that primary care connections have been made to support that expansion.

[00:22:35;14] Next Slide, Leadership, Accountability, and Governance. So another question that has come up quite a bit, and was discussed quite a bit at the Town Hall on Wednesday, is about governance, and we want to be really clear that we have not predetermined any particular model of governance that would be--that Ontario Health Teams would need to conform to.

[00:22:55;18] We really want the groups to be free to determine the model that works best for them, their patients, and their communities. That the model that's chosen must be conducive to coordinated care delivery for patients and support achievement of performance targets, to achieve the accountability objectives.

[00:23:12;18] We really do mean that. There are a number of different examples of how governance has been--different governance models have been successful in achieving integrated care in Ontario. So, we are encouraged by all of those having had demonstrated success and we think that there's an opportunity to really understand from some of those sites that have achieved integrated care through a number of different mechanisms really, that they can achieve better care in a number of different governance models.

[00:23:42;00] We've included here that teams are expected to demonstrate strong financial management and controllership to appropriately oversee the integrated funding envelope. At scale, at maturity, this really is a complex funding arrangement that is inclusive of a full population cost, so we would really want to make sure that across all of the partner groups there's appropriate financial management in place.

[00:24:06;00] And we are also acknowledging that governance arrangements may evolve over time, there could be a plan in place to set it up, and a broader vision to see how these might change over time as they develop new ways of working together.

[00:24:20;04] So we would expect for readiness criteria that team members are identified and that there is some evidence groups having worked together to provide better integrated care.

[00:24:32;17] There's a plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s).

[00:24:39;19] There's a commitment to the vision of Ontario Health Team vision, which is really kind of set out in the guidance document. There's a commitment to developing a strategic plan for the team, and to reflecting a central brand. So, this is really about for the public, how will they understand what's available to them that we, as a ministry would want to sort of have in place so we are ensured that everyone's adhering to the same model of delivery and promise?

[00:25:07;09] There's a plan in place to work together, and if it's appropriate, through formal agreements between team members.

[00:25:14;07] At Year 1, there would be agreements with Ministry and the OHT, and there may be agreements in place across the OHT members.

We want to really emphasize that each provider's and organization's existing funding or service accountability agreement or service contract will remain in place over a transitionary and that the obligations that they have through their SAA would continue and must continue to be met. There will be a transition over time for the funding approach that we'll speak about in the coming slides, but also across the service accountability agreements.

[00:25:47;22] There's been some great work in areas of the province to develop an integrated approach to service accountability agreements, but as we are right now, the current accountabilities are in place, and continue to be. I think what we'll look at is where we can remove any barriers if there's any duplication in having a combined energy of service accountabilities in place. [00:26:07;27] So we would commit to sort of looking at that across the teams, but that we would want to really make clear that the service accountability agreements remain.

[00:26:18;01] There'd be a strategic plan in place for the Ontario Health Team and a central brand. And the physician and clinical engagement plan would be implemented.

[00:26:30;09] Performance Measurement, Quality Improvement, and Continuous Learning. So, at maturity we expect that Ontario Health Teams will provide high quality care using the best available evidence to produce the best possible outcomes for their patients.

[00:26:45;10] We would have a standard reporting framework that would be based on the Quadruple Aim, as Mel sort of set out, and there is a vision that performance will be publicly reported. So, everyone is being measured on a standardized approach for their service delivery, and there's a comparability across the sties that are in place because everything is publicly reported.

[00:27:09;28] Ontario Health Teams will use data to plan and mobilize resources for their patients and communities,

[00:27:15;06] For the readiness criteria, we would want to demonstrate an understanding of baseline performance based on the integrators that will be shared eventually. And a history of quality and performance improvement.

[00:27:26;00] They would have identified opportunities for reducing inappropriate variation and implementing clinical standards, and they would commit to collecting data, pursuing joint quality improvement, and engaging in continuous learning.

[00:27:37;22] At Year 1, we would expect to have an integrated QIP in place for the coming fiscal year. And there'd be progress made on the indicators that are collected, as well as progress made on clinical implementation of best practices.

[00:27:51;23] We also are wanting to have sites agree to participate in a central learning collaborative to support mentorship across groups that may be emerging to become an Ontario Health Team.

[00:28:04;00] We have included in the guidance document the Quadruple Aim Framework but we have not set out the indicators - over time we will - but we do think that the indicators that Ontario Health Team really will deliver on do relate to that integration of care. ALC and readmissions we see as being included, but we also know that to reflect patient experience, there is a need to develop additional indicators related to patient-reported outcome and experience measures, so we do see that. [00:28:31;17] We don't want to concern anybody about the commitment to collect additional data, but it does sort of relate to where there is a gap currently in data, and that does relate to what patients are experiencing through their care journeys.

[00:28:43;29] Funding and Incentive Approach. At maturity, Ontario Health Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient population.

[00:28:57;06] The future state will have a blended funding model, which will feature risk-adjusted population-based funding, as well as elements of activity-based funding, for example bundled care for specific conditions. Select low volume, high cost procedures would continue to be overseen and funded provincially. This is a pretty important point that has come up a number of times as well. Page 8 of the guidance document sets out how we see specialized services being captured, and we really do mean those low-volume, high-cost procedures that are currently provincially overseen and funded provincially. [00:29:33;22] We see those continuing to be like that because there are so few of them and they could, the cost of them can be catastrophic to a local health team that would be implementing care. So, we will be doing more work to sort of understand across the difference sectors how to build this model, this funding model approach with input from the sector, and how we will specifically approach the specialty care aspect of that as well.

[00:30:06;26] So, for the readiness criteria for this component, we have required that all partners have a demonstrated track record of responsible financial management. And confirmed a commitment to work towards an integrated funding envelope and a commitment to identify a single fund holder.

[00:30:24;15] A commitment to reinvest their savings to improve patient care. Demonstrated understanding of the costs of their population and associated cost drivers.

[00:30:33;08] At Year 1, this is another thing we would definitely want to emphasize is the continued allocation of individual funding envelopes for organizations, calculated using current methods in the near term. So, funding would still be allocated to the providers based on how we do that right now, and over time, we would transition to the model that was set out above. [00:30:56;13] There will be a transition period that we will definitely have information available and coming webinars to speak more about, but you know there's been a lot of questions about if I'm not an Ontario Health Team now, how does my funding change, and if there's an Ontario Health Team down the road, how does their funding change? [00:31:17;04] So, we really want to make clear that right off the bat, it is about the same funding approach, but that we'll be able to provide additional information to Ontario Health Teams about the costs of their attributed populations so that they can understand those cost drivers and understand how to improve care delivery to drive them down.

[00:31:35;24] They've demonstrated a better understanding of integrated funding envelope and analysis of financial data. And we would expect that at the end of Year 1, they would have the opportunity, they would be able to identify a single fund holder across the Ontario Health Team.

Next model is Greg's.

Greg Hein:

[00:31:54;18] Great, thanks Allison. So, if you look at high-performing integrated health systems, you quickly realize that there are three digital health competencies that are really crucial to success. One of them is for patients to be able to have choices in how they access their health services, digitally. [00:32:15;02] And there are a couple of different dimensions to this. One is simply easy online access to the data itself, and there are a number of ways this can happen through patient portals, but also through mobile applications that are geared to particular chronic conditions, for example.

[00:32:32;13] Another really important one is virtual care. Most integrated health systems that are successful have extensive use of virtual care, much more than we have right now in Ontario.

[00:32:45;26] There's also a really important patient experience and patient convenience dimension to it, and lots of people, when surveyed, are underlining the need for things like online booking.

[00:32:56;19] The wrapper for all of that patient choice is something that Julie Drury and her Patient and Family Advisory Council has underlined, and that is, it's more than just the transactional flow of data, it is really empowering patients to be full participants in the health care system.

[00:33:15;29] The second one is a competency that we've been working on, a capability that we've been working on for some time, and that is giving providers the ability to communicate across the continuum of care. There are lots of great solutions that exist in Ontario, but there's room for improvement. And through the Ontario Health Team model, we want to figure out how best to enhance some of those assets.

[00:33:40;17] The third one is really important because it's not enough just to digitize data and store it, and share it, you actually have to squeeze value out of it through the three items that are noted there. One is clinical standardization. Experts underline the need for clinical standardization. [00:33:59;23] It's not all top-down Provincial, and it's certainly driven by clinicians themselves, but if data isn't in a form that's easily shared and sufficiently standardized to do so, the overall effect will be diminished.

[00:34:16;11] The next is that we have an expectation of advanced analytics, both at point of service and with the province playing a role.

The last just picks up the crosswalk to performance and metrics that Allison was talking about, that digital health solutions themselves play a really important role in collecting that data.

[00:34:36;09] I'd also underline though, that it's not just adding new requirements, that the Ministry is committed to taking a look at all the reporting requirements that exist for hospitals and other HSPs, and figuring out how to whittle that down, and there's lot of leadership being demonstrated right now by the OHA and Health Quality Ontario in doing that.

[00:35:02;19] So, at maturity, you can imagine that free flow of information across the continuum of care, across providers caring for patients, and that patients and caregivers are consuming it based on their choice of frequency as well. And that the data is being maximized for quality outcomes.

[00:35:23;10] When it comes to readiness criteria, it really boils down to wanting to know the experience of the collection of providers in an OHT. What's your experience with digital health? What are the successes? What are some of the challenges you've been facing? And we're really here to help you identify those gaps and close the gaps, and that's something that we're really excited about.

[00:35:48;02] And then, from a process perspective, we'd really like to have a single point of contact for digital health identified, so that's something you can think about when you're doing your application.

[00:35:58;02] Year 1 expectations, it's really figuring out the flow of a Harmonized Information Management plan and how it's being operationalized. Another would be that you've got enhanced adoption of digital health solutions so that those gaps we've identified, together with you, have been addressed.

[00:36:21;14] And the last is squeezing, as I said, more value out of the data through advanced analytics and population health. Back to you.

Allison Costello:

[00:36:30;01] Terrific. So, who should participate? I think (unclear), everyone. I think that essentially that's what this slide says, we really do want to encourage all groups to get together to look through the document, look across the table with each other, and understand how they feel that they each demonstrate, and demonstrate together, all of the readiness components that we've just walked through, and that are in the guidance document. [00:36:57;18] We really want it to be self-organized, you know driven by how you work together and how you work to support patients' improved care. We appreciate that across, within one table and across different tables across a region, not all providers would be at the same level of readiness to implement the model. But we really do think it's important to get everybody at the table to start, to sort of understand at what point in time the others could be included, and how they could be supported to advance their maturity and readiness by watching and learning from other sites that are implementing.

[00:37:33;25] We'll go through the timelines in the coming slide, but we do really want to emphasize that there--the door's not opening and closing in the next six weeks and that's it; there will be additional opportunities in the readiness assessment process. The door is kind of opened as it is right now with the guidance document being available, so that people can understand what the model is, and look to that, and then we would continue to take in interested sties. [00:38:01;25] And we want to emphasize again, as we've said before, no teams have been selected. A lot of people have indicated interest and we know conversations and meetings had started even before the guidance document had been released, so we're exited about that energy, but we really did want to emphasize that we are looking through this process to identify who the initial sites will be for implementation.

[00:38:26;26] On the slide that follows, we've identified a suite of supports that the Ministry and other system partners are gearing up to deliver to support Ontario Health Teams to achieve their success and to advance maturity along, as a process that we'll walk through as well. So,

we've indicated that we are looking to legislative, regulatory policy and other barriers that might impede local integration to support better patient care. [00:38:54;18] So we will want to look to those sites that are implementing in the initial stages to understand what barriers that we might not have already heard about. We know--we know some that are, and we're actively looking at those that are widely known, but I think that we'll find out as we get closer to implementation, what additional things we could help to support by removing barriers.

[00:39:17;27] We want to support access to tools, templates, and services that will support the teams to achieve their goals, and the data that they will need to understand how their population works, essentially how their patient population accesses care, what their current performance looks like, how their costing information looks. So there's a lot of work going on int that right now to gear up to provide that information.

[00:39:45;10] We want to encourage and support teams to share information across those that are implementing models, so really to build a community practice to support a shared learning, but also we do think that there are some areas that there may need to be additional support for enhanced capacity and competency. [00:40:06;14] So we've identified governance, integrated governance specifically, as something that we can look to in the work that we'll do with the Ministers PFAC on patient engagement and also community engagement. [00:40:17;14] So, there'll be some important information related to what we would expect to see of a common visual brand that will have more information to come on that, and change management supports to get there as well. And a lot of what Greg has referred to, and really on the digital health supports that we want to understand what gaps might exist, and help to fill those gaps across the program.

[00:40:38;00] So, that's an overview of the suite of supports that we will be building for Ontario Health Teams that are identified, that will be an ongoing support for their maturation.

[00:40:50;10] The next section sort of gets into how to get there. So, what we've done in releasing the guidance document and identifying the timelines for the initial self-assessment is really kicked off the whole process. So, this process is meant to on-board interested groups through our readiness assessment process to determine who is currently, or with some assistance, demonstrates the key readiness criteria that we've identified for implementation, and identified groups that might not be ready yet, that could be supported along kind of a ladder of implementation. [00:41:24;18] So, we've got set out on this slide that the various steps of a self-assessment process, and a readiness assessment process, that will have multiple stages of--towards implementation of the Ontario Health Team model and eventual designation that relates to Bill 74, if passed, that there would be the opportunity for the Minister to designate Ontario Health Teams. So that is kind of the full maturity model of Ontario Health Teams that we'll have more information about what that means, what needs to be demonstrated by the teams to be designated.

[00:42:02;29] On the next slide, we'll just sort of go into what the self-assessment process looks to. So this is about the teams. This is the stage we're at right now, so this is where we're spending a little bit of time to show this is about teams familiarizing themselves with the model, and how they feel that they demonstrate their readiness against it.

[00:42:20;11] We would review those self-assessments and the timelines for when they're due, are in the slides that follow, and invite groups to complete a full application, and then invite subsequent groups to complete a site visit, with the aim of naming Ontario Health Team candidates by the fall of this year. [00:42:41;24] But what we're showing on the slide in this

visual is that through all of the various stages of application, and this initial one that has been launched this week, we want to support all the sites that are putting up their hand and indicating that they're wanting to get ready for the model. [00:42:59;15] So we really do see, no matter how ready you are, we want to support your progression along this model that we've indicated here. So, we've come up with these terms of in discovery, in development, the OHT candidate - which really means that we've kind of identified at the end of this readiness process, who is implementing the model, and the eventual designation is the full delivery of the model.

[00:43:24;09] We do want to support kind of everyone that lands in those columns, to achieve maturation along the progression there. We will work with a number of different groups, including patients, clinicians, and other system experts, to support the review of the applications, and the site visits as well.

[00:43:42;19] So, we'll have more information about the full application, all of the processes that follow after this, in the coming weeks. This is sort of the overview of the overall model.

[00:43:55;10] The timeline, the first call is this week with six weeks to complete the self-assessment. And then an invitation to fulfill applications set out in June. Evaluation of those and site visits over the summer, with a first cohort named in the fall.

[00:44:13;08] We are really wanting to make clear that this is just an initial window for the confirmation of sites by the fall, but that we really want to make clear that this is an ongoing intake and we do anticipate that we will launch an initial suite of dates in the fall for a subsequent go-through of this whole process. [00:44:36;10] But we really do encourage everyone to participate now. Start looking at the information and getting together with your partners.

[00:44:47;07] Resources to get started, we've included on here a list and I won't read through them, but essentially on the website that is listed there, there is a number of different documents that will help providers to understand more about the model, some key readings, the document itself, jurisdictional information, the link to the patient declaration of values, and a number of different other documents that will help to understand kind of the context for change that we're in. [00:45:14;01] And we will have a series of webinars that information will be available on those in the coming weeks, as well this webcast will be posted there.

[00:45:26;26] Key contacts. The email address that Mel had indicated, and additionally the Connected Care link that gets you kind of on the webmail, or the web server.

[00:45:40;12] So, what we have in the coming slides, and I'll ask for help across the table, is essentially those questions that we've been receiving most frequently to date. We've thought it would be good to just sort of get these out through the discussion right now, as we anticipate that this is a lot of what the sites have been interested in understanding. [00:46:03;04] And I'll say that any Q&A that we are receiving through the Ontario Health Teams website, we will be ongoing updating a public Q&A so that any information we're being shared, or we are sharing with interested sites, is being shared across all sites as well.

[00:46:25;01] So there--we had talked about this earlier in the slide deck as well, is the required population site size for the participant site in the model? No. You know, essentially we really want to let the communities develop what is appropriate for them, but that we do see that at maturity, the population size will be sufficient to really allow for the model to work. [00:46:50;11]

And that regardless of the size, the care will be delivered according to the needs of the patients and communities served.

[00:46:56;15] How many sites will be selected through the first round of assessments? This has not been predetermined. We--a number of people might have heard different numbers, but we have not predetermined that. It really will depend on how--what we see coming through in the applications, and how ready it is deemed that everybody is. So, we have not predetermined that number at all.

[00:47:19;26] The plan for spread and scale for Ontario Health Teams, we've tried to make really clear that this is not a pilot project, this is about eventual full coverage of the Ontario Health Team models. We will repeat this process until full coverage is achieved, and learn from the early implementation from the sites about how to best scale and spread the model.

[00:47:44;08] So, we've designed the process so that all providers can begin on the path towards becoming an Ontario Health Team, regardless of how ready they initially identify themselves.

[00:47:54;23] Will providers and organizations receive supports to participate in the process? We've identified that we do not think that the readiness assessment requires new funding to conduct. We've gone through some of the site supports, or the suite of supports that we feel will be developed to support the Ontario Health Teams through implementation and maturation along the model, but we will also make available through the website, and additional webinars, broad information that will support providers in implementing, or conducting their self-assessment.

[00:48:30;12] How can home care service provider organizations participate in Ontario Health Teams? What we've set out here is, really we do think that it's important to flag, and this question could be substituted for any particular sector. We really think it's important for sites to be really inclusive when they pull together local groups that are--that they work with or, that they may in the future collaborate with, to achieve improvements in patient care. [00:48:59;19] Want it to be as inclusive a table as possible, so we really do think that home care and along with any other sector, is really important to include as many partners as possible in that initial work, so that we can--so that a full continuum of care can be delivered.

[00:49:18;07] Will home care clients experience any service disruptions? We anticipate being very thoughtful about a transition plan for care coordination that is being overseen by the LHINs right now. So, we really do see that as an important aspect of establishing Ontario Health Teams, and it will be really a priority for us, and for us in working with the Ontario Health Teams that are establishing themselves to ensure that there is no disruption to patient care.

[00:49:48;23] Will physicians have the opportunity to participate in Ontario Health Teams, and will physician compensation change? We want to make really clear, and I think we've set it out in the guidance document in a lot of detail, that we really do see physician participation as an essential component of the model. Lessons from other jurisdictions suggest that strong physician engagement and leadership is key to the successful implementation of integrated, better coordinated care. [00:50:17;26] We really do see, and we've had some really positive conversations to date with ONA and others, and we know that there's a number of interested primary care groups that locally are identifying interest in participating, so we're really encouraged by that and hope that will continue. [00:50:35;21] But we want to make clear that the success of the OHT can be built on existing physician remuneration models and changes to

physician compensation are subject to negotiation with the OMA under the binding arbitration framework.

[00:50:49;07] Finally, how should organizations that deliver care across the province participate in Ontario Health Teams, and can an organization be part of more than one Ontario Health Team? So, this had been a question at the Town Hall the other day for groups that have kind of a provincial role as well as a local role. And I think our advice that we've set out here is really that locally, partners should be making best efforts to get to their local tables and we've identified that here. [00:51:18;16] So we think that getting to those tables to understand how they can participate in self-assessments should be doing that. We do see that it's likely that there will be providers that are members of more than one OHT, and we will sort of understand what the provincial--how that provincial role of those types of organizations can be supported across eventual spread when there are more OHTs in place.

[00:51:52;01] And now we're over to David for questions from the panel.

David Jensen:

[00:51:55;13] Thank you, Allison and Greg for a very informative presentation. We're going to dive in now to the questions that have been coming in. The first one up is when is maturity expected? Is the goal for every Ontario to be linked primarily to one Ontario Health Team?

Helen Angus:

[00:52:11;16] That's a really good question. I think, you know I think you can see that we imagine that individual Ontario Health Teams will mature themselves over time and include more partners. And I would say yes, the intention is that would have full coverage of the province with Ontario Health Teams and that every person in Ontario gets the benefit of more coordinated, seamless care that Ontario Health Teams can provide. [00:52:38;13] I don't know if there's anything you want to add to that, but I think that's the destination. It means it will take a while, but we are I think excited about the level of interest, and the fact that you know, there's lots of providers and communities that are on the road already.

David Jensen:

[00:52:56;18] Okay, our next question, how do you envision this working in northwestern Ontario, i.e. many areas don't have broadband internet, many First Nations communities, and its' a very large land mass.

Helen Angus:

[00:53:09;15] Certainly aware of that. I don't know whether you want to talk about that, but the customization to local context is a really important feature of the model, and I think we're pretty aware of that. We had some questions about it the other day.

Greg Hein

[00:53:24;05] I would just add that both northwest and northeast Ontario are leaders in things like virtual care, and one thing that we didn't talk about is the working with our colleagues at Ministry of Government and Consumer Services, on IT infrastructure. And those sorts of questions and gaps can be dealt with through those sorts of discussions, so we're alive to that issue.

Helen Angus:

[00:53:51;21] I actually think there's some smaller communities where this is going to work actually in some ways, more easily than in some of our larger centres where we know that the hospital and the long-term care, and the home care providers, are much more connected already.

WO

Or they are the same provider.

Helen Angus:

[00:54:09;07] Or the same provider with multiple accountability agreements. So you know, how could we actually work more flexible--flexibly with organizations that already exist?

David Jensen:

[00:54:18;13] Okay. There is mention of a funding envelope. Will organizations within the teams keep their current funding allotments or will the money be decided on by the lead of the team?

Helen Angus:

[00:54:29;20] So I think Allison, you talked about that.

Allison Costello:

Yeah.

Helen Angus:

And maybe you want to just go back over that.

Allison Costello:

Yeah, and we're really excited to talk more about the approach that will be developed for the funding envelope, but essentially right off the bat, people will still experience--they will receive their funding in the same way they're receiving it now, so through their service accountability agreement and through the allocation and payment tracking system that currently exists.

[00:54:52;28] So, it wouldn't be that the single fund holder that we've identified suddenly has control over the books for all of the partners involved, but over time, there would be mechanisms put in place so that a single fund holder is deploying funding across the provider groups, but in a way that's sort of understood across the partner groups.

[00:55:14;06] So, what's really--we want to make clear is that the funding will continue to be flowing as it currently is, but that there'll be additional information that providers will have access to, to understand better the costs of the patients that they're serving, so they can understand how to better serve them, and how to change care delivery. [00:55:33;22] But it wouldn't be that all of a sudden they've lost control and autonomy over their own allocation.

Melanie Fraser:

[00:55:39;05] And I would just add to that, I think that's where the governance becomes really important in that these partners are coming together and deciding on the governance model that suits their context. And really, this is about having trusted partnerships and so as those partnerships, and as that governance matures, our funding mechanisms will mature as well, to support the use of those funds centered around patient care, as opposed to centered around sector-based care.

David Jensen:

[00:56:10;09] Okay, our next question, will the Ontario Health Team replace the family health teams currently operating within the province?

Helen Angus:
No.

Allison Costello:
No.

Helen Angus:
[00:56:19;19] They just have the word team in them, both, but actually family health teams, I think, are an important building block for better integrated care given the access to inter-professional care that they allow for patients. So, I see that family health teams are--can become part of Ontario Health Teams and I think Allison you talked a little bit about the compensation models staying the same. But, I think they have, you know, a lot to offer Ontario Health Teams.

David Jensen:
[00:56:50;07] Is mental health supportive housing expected to be included in health teams?

Helen Angus:
[00:56:57;04] Absolutely! I think we're pretty excited about the possibility, and I think on the slide you showed Allison, as well that you know, we were looking at the health service providers, but you also saw on the list housing providers, and community support providers, and other providers of health and social services, who you know, can collaborate together to actually meet the needs of a defined population. [00:57:24;09] You know, they might not be part of the funding envelope initially, but they certainly will be part of the planning and the, you know the more flexible delivery around human services. I don't know if you want to add much more to that, but I think it's part of the plan.

Allison Costello:
[00:57:36;24] No, I think it's really important and we're working really closely with our colleagues in the community, mental health, and French language services division, to really ensure that through the development and implementation of the mental health strategy, the opportunities for improved standardization and better coordinated care delivery are kind of seen through what the Ontario Health Team potential is. [00:58:02;16] And I think for those sectors that are sort of not typically, not traditional health sectors we see it as a real opportunity for potential. And over time we would kind of figure out how to address the funding approaches, but where those partnerships you know, it would be really encouraging to see those types of partnerships being at the table right off the bat, so the non-traditional kind of supports are being considered.

David Jensen:
[00:58:31;17] Okay, our next question, can there be any health teams that have a specialized focus of a particular population at maturity, such as dementia care, or frail seniors?

Helen Angus:
[00:58:41;22] Yeah, we've thought about that, and obviously you know, we've seen some initial proposals that have tried to bring together all the service providers related to a particular population. I would say it's generally a geographic population. You'd have to really kind of show

us how it would work for a specialized group of patients, and how you would want to make sure that their regular care was actually included.

[00:59:11;04] So, I think it's an idea that we're exploring, but I don't see us creating new kinds of silos within the system, and I think that's the concern is we want to make sure that this really meets the objective of integrated care, and that we're looking at the needs of whole people, as opposed to trying to kind of isolate more narrowly a set of service providers.

[00:59:36;20] There's lots of specialty service providers in the province. Their important work will continue, and we see them as important resources for the Ontario Health Teams. And I think as you mentioned earlier, we're really talking about they would be funded kind of separately from Ontario Health Teams because of their, either across Ontario provincial role, or they have a very important regional role.

Allison Costello:

[01:00:00;24] I think you know, where there have been really great advances in dementia care, or other clinical pathways that have been developed and implemented, it's a great learning and an opportunity for partnerships that have developed, that could eventually take that learning and expand it to a broader population coverage, and not just one condition, but we do see the model being approaching the full population's needs. [01:00:28;07] So what could be kind of gained and spread based on a strong implementation of an evidence-based model for care for things like dementia are fantastic, and I think that it's really about spreading that and seeing what can be adapted for a boarder population.

David Jensen:

[01:00:46;27] Okay, we have someone asking, will I have the option as a patient, to choose the Ontario Health Team that I want to belong to?

Helen Angus:

[01:00:54;05] You will always have your choice of provider. That's an important part of the model, and you know whether people who want to get their care closer to work than their home, or you know, have an attachment to a particular provider, and are connected into their network, I think you know, patient choice is a preeminent value that we have here.

David Jensen:

[01:01:21;01] Okay, next up, will there be any standards or programs to drive or assist digital interoperability between service providers engaged in an Ontario Health Team?

Greg Hein

[01:01:31;14] Absolutely. That's one of the most exciting parts of this new model that the government wants to, for the first time, pass something that will be in effect, a health information exchange policy that will set the rules of the game for how information is shared across different assets both e-health Ontario's assets, point of service ones including hospital information systems, EMRs, runs the gamut, and that will be absolutely integral to supporting OHTs and health care provision more generally.

David Jensen:

[01:02:11;05] Okay. How do you see existing LHIN care coordinators with vast experience in these transitions, fitting in your current model?

Helen Angus:

[01:02:21;25] So, I think they--absolutely, the premise of that question is absolutely right, that there is a huge understanding, knowledge, and connection to patients that care coordinators have. And so, you know how can we take best advantage of their valuable skills I think is a question we will be asking individual Ontario Health Teams.

[01:02:43;21] I think there's some--you know, there have been some interesting ideas that have been brought forward by stakeholders about having more care coordination embedded in the clinical environment and in primary care specifically. I think that you know, has great interest and promise, but we'll be interested to see how the Ontario Health Teams imagined you know, the important function of care coordination occurring.

[01:03:08;21] I can see care coordination actually being part of many of the providers who are part of the Ontario Health Teams, so we will what the plans coming forward, but it's a required function obviously, and the requirement to have 24-7 capability really I think speaks to the need to have care coordination available to the patients who are part of Ontario Health Teams.

David Jensen:

[01:03:35;05] Okay, next up, if you're a private practicing chiropractor, or other provider, but work collaboratively with physicians, interprofessional primary care teams, hospitals, et cetera, are you eligible to be part of an Ontario Health Team, or do you have to be a publicly-funded health care provider?

Helen Angus:

[01:03:54;15] I think--go ahead.

Melanie Fraser:

I was going to say no, you're absolutely welcome to join. I think what we are looking for, and what we've talked about, is really quite a permissive environment where our focus is on patient experience and patient outcomes, and providing connected care around patients. [01:04:11;26] So, if there are providers that--and professionals that can come together as a team to provide those services, and serve a population of people, that's exactly what we want. So, whether it's chiropractic services, I think the list was huge - we had labs, we had emergency health services, mental health services. It's really about that continuum of care being built around patient needs and community needs locally.

David Jensen:

[01:04:45;12] Okay. How is pediatrics going to be part of an Ontario Health Team?

Helen Angus:

[01:04:51;23] So, I think children are part of the population of interest, so obviously you know in many Ontario Health Teams you know, children will be, I guess, an important consideration about how they organize around the specific needs of children

[01:05:08;16] I would say that you know, that is probably one area where we've seen some work up of some ideas about how to improve care for children, particularly where we have a specialty hospital, a children's treatment centre, and a home care program that are already provided by one organization. [01:05:29;11] And so you know, there's a real opportunity there I think to actually make a difference, particularly for children who have complex needs and you know, we just--every time we have a meeting at the Ministry with our LHIN partners, we often have a patient story, and this week it was about a patient who had a medically-complex child,

extremely complex, and it was sort of heartbreaking and challenging, and realizing that it would be a wonderful thing if Ontario Health Teams could actually be a bit more flexible around the needs of families and children like that. [01:06:09;22] And if we could actually really make a difference in those lives. So, we took it as a challenge to redouble our efforts in that area, and really do some good work.

Allison Costello:

[01:06:20;29] And it was a classic example of--it wasn't a resource issue or a capacity issue in the system, it was really about policy barriers, and other barriers, you know rules that are siloed, getting in the way of really looking at the patient as a whole person, and centering care around them. So we're hoping again, and I think we mentioned this in the slide deck, that this will be an opportunity for the health teams to identify to us what the opportunity is there to remove some of those barriers that may be just simple changes to rules or sort of a lighter touch in terms of policies, that actually produce better outcomes for patients quite easily.

David Jensen:

[01:07:08;06] Okay, next up, how will the existing market share based home care contracts be transitioned into this new way of doing business?

Helen Angus:

[01:07:16;08] Yeah, so we probably have a lot of work ahead of us. Yeah, I think you know, that's a conversation I think we need to have in terms of doing some of the finetuning around implementation. You know, it's something that we would want to work with a sector on, including the Premier's Council, actually, to give us some advice on if this is the destination, what are all the things we need to line up in order to do that? [01:07:41;13] So, I don't have a brilliant answer, but I do have a kind of promise to start working on that in a very sensible way because we really want to make sure, I think to one of the questions, one of the Q&A's that we want to make sure that we're doing this in a way that only enhances services, and doesn't actually cause any disruption. [01:08:02;19] So that the important relationship between patients and their current care team is, you know, a thing that we value and want to make sure that that's managed through any transition.

David Jensen:

[01:08:18;01] Next question is, how will long-term care be able to partner with other organizations given the prescriptive and prohibitive requirements -- of the Long-Term Care Homes Act?

Helen Angus:

[01:08:33;06] So, I think that's another opportunity for interesting ways to think about can we have kind of somewhat lower or more flexible rules for long-term care providers? We're obviously not going to take our eye off of making sure that we have high-quality care provided in homes. [01:08:52;28] But there are examples where long-term care homes provide additional specialty care. As, probably some of you may know, I spent some time leading the Ontario Real Network inside Cancer Care Ontario, and some long-term care homes provide some I guess, it's mostly peritoneal, but dialysis services. [01:09:16;15] You know, can we work with our long-term care homes to continue to offer some specialty care capabilities that would be helpful to an Ontario Health Team? So that's just one example, but I think you know, they're an important part of the fabric of any community support, and we're obviously in the process of building more, and I think it would be--I think it's an interesting area of exploration. [01:09:39;28] And I also see long-term care not only as a building, but it's also a service, and I think there's lots of

interesting ideas within the long-term care sector that I hope Ontario Health Teams are able to harness.

David Jensen:

[01:09:52;25] When will the standards and requirements for digital health solutions be available to review, and what is the best way for digital health innovators to engage with Ontario Health Teams to address their needs?

Greg Hein

[01:10:04;07] That's a great question, and I'm glad to see the focus on standards that will allow for the better sharing of information.

We're getting close to finishing a complete draft of the digital health information exchange policy I was referring to. So, and in fact it takes advice that we've garnered over the last couple years from different IT vendor associations and innovation associations. [01:10:38;21] So, we're eager to share it with the field. I would say probably over the next couple months, maybe as soon as the next month, given the sense of urgency.

[01:10:52;20] I know, I don't think I'm speaking out of turn, that there are some big stakeholder partners like the Ontario Medical Association that are really interested and supportive of that policy, too. So, we're eager to share it, it's real, and it's got to be one of the foundations of what we do.

David Jensen:

[01:11:12;02] Okay, will the provision of medical supplies, rental of equipment, and infusion medication be part of the Ontario Health Team, or will they continued to be provided under certain LHIN contracts?

Helen Angus:

[01:11:26;00] That's an interesting question. I kind of had always imagined that that would be you know, we actually have a pretty good delivery system. We also have other work underway around procurement. And I would think that you know, we can have a conversation about what the best way to do that is, but again, I go back to the point about making sure that people still get excellent care and support in the home. [01:11:49;07] And you know, it would be I think ill-advised to disrupt, you know, current supply chains that work unless there was you know, clearly a whole better idea about how do that.

[01:12:01;07] And, we want to make sure that people get you know, good-quality care at home, and we know so much of home care is wound care and requires supplies, and so I think that we want to make use of existing channels to the extent possible.

David Jensen:

[01:12:16;12] Will each agency that is a part of an Ontario Health Team still have their own M-SAA and the targets associated with the M-SAA, and will they continue to report quarterly on these targets?

(overlapping - unclear)

Allison Costello:

[01:12:30;25] Yes, so I think we do want to understand what the track would be over time to develop an integrated approach, so that there are not multiple reporting mechanisms that would

feel burdensome, but because Ontario Health Teams will be starting in different places and it is starting as kind of a big bang in every region, the service accountability framework that is in place right now will continue, but that we would support--look to those groups that are getting off the ground to understand how we can reduce the burden, and really advance the approach for an integrated service accountability agreement.

[01:13:09;12] There had been interest in developing integrated service accountability agreements before Ontario Health Teams were on our radar, so I do think that there is, you know, whatever we do learn through the implementation of the initial Ontario Health Teams, we'll probably be able to spread some of that learning in earlier ways if it's possible.
[01:13:27;19] But, over time that will be in place, but as we're implementing these initial Ontario Health Teams, the current SAAs will be in place. With all of the obligations that they include.

David Jensen:

[01:13:43;29] How will organizations that submit their readiness assessments be evaluated, specifically as it relates to their adherence to the French Language Services Act?

Allison Costello:

[01:13:54;17] You know, when we talk about adherence to the French Language Services Act, we do--that isn't a particular--the question that we've indicated within this self-assessment framework is the commitment to follow it. So we do expect that it is a legislative requirement.

[01:14:10;18] So, that one is expected that teams are demonstrating that commitment, but we will review the self-assessments and across-matrix ministry team and over at each subsequent step we will have additional advisors participating in the review, including members of the Minister's PFAC and sector leaders. [01:14:41;01] What we also want to do through the self-assessment process and review of that application is really get some kind of local intelligence about what we're seeing on the page. So, I do think that we will be doing some--we will read it, but I think we'll also do a little bit of a check-in on anything, and loop back and follow up with any local--with the LHINs and others to understand how these teams are working together.

[01:15:06;09] So, we will have a standardized approach for viewing those, and the French Language Services is an expectation. Tim, I don't know if you wanted to join us?

Tim:

[01:15:19;02] I just wanted to add that the French Language Health Services Advisory Council and the French Language Health Planning entities are intended to be a continuing part of the structure of support for adherence to, and respect for the French Language Services Act. So there's a range of expertise about French language services in the system now that will be deployed and a lot of good regional knowledge about how to best forward respect for the French Language Services Act and improving access to services for francophones that will be part of the discussion within Ontario Health Teams.

Helen Angus:

Thanks, Tim.

David Jensen:

[01:16:00;09] Can you describe the process that you would use to review EOI's if there are multiple EOI's from one region?

Allison Costello:

[01:16:07;23] Yeah, we've been describing this as matchmaking where we do think if we do see some provider groups in a local area that have come forward individually and maybe are a little bit too close down the street that we would, we will do I think, follow up to understand how those groups could get together and form a broader--a broader application. [01:16:29;08] But also you know, as we sort of identify that there could be some teams that are not at the same level of readiness across even in one table, so if they even got together to understand what they might achieve together and if that would be over time that they would achieve that, so we do think that we will be doing--we will allow ourselves that time to do that follow-up and understand what the broader opportunity is for more comprehensive coverage and inclusion of provider groups, or at least the inclusion of them in the conversation, so that the broader expansion is being thought through while people are implementing.

David Jensen:

[01:17:07;22] Next question, you mentioned that providers are not expected to be in the same physical location to be in the team. What are the expectations regarding teams using the same electronic medical record within a team?

Helen Angus:

[01:17:19;09] I mean clearly, it's an advantage, right?

Greg Hein

I mean if you go back to the international comparison, the high-performing systems, if they're corporations, have a single platform. We clearly don't have that in Ontario, so our challenge will be how do we take the various point of service systems, like multiple EMRs and multiple HISs, provincial assets, ways to share information like e-consult, Health Report Manager, how do we take those and make OHTs the gravitational pull for them? [01:17:54;14] How do we wrap programs around those disparate assets so that we can find ways to share information?

[01:18:02;06] I can--I'll underline that there's no top-down, cookie cutter approach. Some parts of the province are thinking about a new hospital information systems as the basis for greater sharing, and opening those up. Other parts of the province have a lot of providers on their EMRs, and are contemplating using those to share data more extensively. [01:18:27;08] That's part of the planning process that we want to engage prospective OHTs on. To do it in a creative way and to look for innovative solutions, while tapping into some of the existing assets.

David Jensen:

[01:18:39;12] Okay, we have someone asking, if I am a provider in a smaller community that can't provide a full continuum of care, should I reach out beyond my existing catchment?

Helen Angus:

[01:18:49;15] I think so, yeah. I think again, there probably are other resources as a small provider in a community, that you--that your patients or the people that you serve, get access from this--or get access to, or want to access services in the larger communities. So I think you know, it's a conversation that you should be part of and see you know, how you could make it work in your context.

David Jensen:

[01:19:18;29] There are many requirements within the readiness assessment that potential teams are to assess themselves against. Do any of the requirements have a higher priority or will receive higher weighting in the ministry's assessment of applications?

Allison Costello:

[01:19:34;04] We've talked--like when we were developing the approach for this, and developing what we thought were the minimum requirements, we talked about setting a high bar, or a medium bar, or a low bar, and we definitely landed on a high bar and we definitely acknowledge that this--this is not an easy undertaking, this really is about shifting and transforming the way care is delivered. [01:19:56;03] And we--for that reason, we acknowledged that there will not be a full--you know, every provider that comes to the door will be ready to implement the model, so we fully acknowledge that. There are some groups that might be more ready than others, and we've set the bar high for you know, because we do think that it is important to, across all the domains which will be measured equally, to really make sure that we're advancing all of those important aspects. [01:20:23;07] It's not about you know, just the digital, or just the funding approach, it really is the full--the full continuum, or the full model components that really is what the Ontario Health Team promise is. So, we acknowledge that it's--that it is about identifying how ready you feel you are based on those minimum specifications - that's what the self-assessment is about. It's about looking at that list, and we will have a subsequent webinar that will walk through the actual template and explain how to use it, explain how to use that kind of toggle list at the bottom of it to say I've looked at all of the requirements, I feel like I've got these - not I, we feel like we've got these - and this is where I would place myself along the continuum of readiness.

[01:21:10;25] And if partners are not able to say that they are fully ready, that's okay, they're in the system, like they're in that kind of step-wise approach that we showed that says we are putting our hand up, we are interested in participating, we know that this is the broader vision moving forward, and we want to have access to the supports that you're talking about.

[01:21:30;27] We want to understand what the learning opportunity is from those sites that are implementing. So we don't want anyone to be scared away from how high the bar has been set because we do anticipate you know, you will look at it and score yourself based on where you think you are, and we acknowledge that. [01:21:49;28] There's no point in saying you're more ready when you don't feel it. So for sure, we definitely acknowledge that that is the approach for setting a high bar, and really supporting everybody to get to that high bar.

Melanie Fraser:

[01:22:02;13] Yeah, I think that's a really good point. Like, there is no pass or fail here, right. It's just measuring as you grow and I think, to your point Allison, you know there is no point on scoring yourself higher than you are. It's actually better to say we're here and we really need the supports from the ministry or other sector partners to get our measure up to that level of the bar and that's where we want to jump in and provide you with those supports. [01:22:29;14] So, it really is--everyone should feel--there are no winners and losers. Everyone's a winner, you're just sort of at a--getting closer to getting to the finish line.

David Jensen:

[01:22:40;02] Okay, we're down to our second-last question, will patients be required to access all of their care through the Ontario Health Team?

Helen Angus:

[01:22:50;04] No. Again, it goes back to patients will have a choice of providers across--you know, whether in their primary care provider or other providers, and I think you know, that's a fundamental I think belief that that's a tenet of the work that we do. And so, we'll figure out what that means in terms of the money behind the scenes, but it really is you know, we will make sure that patients are allowed that choice and that continues to be a feature of the health care system.

David Jensen:

[01:23:22;13] Okay, and our final question, could we, or should we build off partnerships or discussions started off through sub-regions or health links?

Helen Angus:

[01:23:33;22] Yes! That makes me--that is a question that makes me happy. Some people know that I did a lot of work on health links and I think those are great foundations, right, because the relationships that were established in the case of health links around the most complex patients, or you know, looking at sub-LHINs and the work that was done there, I think all of these things have helped us get ready to really do something like Ontario Health Teams, and to make sure that this becomes kind of a standard of care for the province of Ontario.

[01:24:07;22] And I know we're going to do it in a step-wise way, but I think we're convinced of the rightness of the destination, and we're doing this you know, on the back of work that has been done across the province over the period of many years, and in fact you know, some of the stakeholders have come and talked to us saying we've been getting ready for this for a decade or two, so we're happy to be providing that opportunity and to maybe give it a little bit more formality, perhaps, than what had been contemplated before. [01:24:40;08] And to really make the promise of integrated, coordinated, and connected care, a real one.

David Jensen:

[01:24:47;19] Okay, great. I just wanted to say, for those of you who still have questions, you can email them into ontariohealthteams@ontario.ca. And now I'm going to turn it over to Melanie Fraser for the closing remarks.

Melanie Fraser:

Actually, I think it would be nice if the Deputy was able to join us here, I'm going to give her the final word today.

Helen Angus:

[01:25:07;12] Well it takes a team.

Melanie Fraser:

It does take a team.

Helen Angus:

It does take a team. So really wanted to remind everybody to access the guidance materials online, and feel free to direct any questions to the team, now that you've seen us, on the Ontario Health Team inbox. We'll have more opportunities for questions and answers during our next webinar, which will take place on April 16, and that one will focus on the self-assessment form itself.

[01:25:33;28] But, we know that there will be many formal and informal opportunities for us to talk and learn going forward.

[01:25:44;03] Obviously I want to thank the Minister of Health for her leadership, and for those of you who saw her passion and interest earlier this week. But my job is really to thank the ministry team who have been working tirelessly to bring this to life for many months.

[01:26:00;05] So you can tell that Allison has great command of the material; she is the lead director for Ontario Health Teams, as well as the team behind her: Jackie Houston, Neil

McMullin, Stephanie Soo, Jenny Malone, and many others across the ministry, and that's why we have more than us here actually, in the room.

[01:26:22;24] And I guess I get to take a second just to thank Melissa Farrell for her contribution and leadership. As some of you know, Melissa is leaving us to take on a terrific responsibility at St. Joseph's Hospital in Hamilton. So, your contributions here at the Ministry of Health and Long-Term Care are really important, and you've left a legacy of change and improvement that I think any public servant would be proud of at the end of the year--of the career, and you've done it mid-career, so good on you.

[01:26:59;17] Thank you to all all of our partners and stakeholders who have been giving us advice and helping to shape this along the way. Special call out to the work of the Premier's Council, who have been you know, exceptional advisors to us. But, and the many, many tables that they've established, so we've definitely benefitted from that, as we will going forward.

[01:27:23;01] So, thank you all of you for joining us today, for your enthusiasm and interest in helping build Ontario Health Teams, and for the great work you do, and I hope you can sense our own excitement and desire to work closely with you in the coming weeks, months, and years. So, thanks again, and we'll be talking to you very soon.

(off camera)

(end)