TELE-TOWN HALL: ONTARIO HEALTH TEAMS

Summary | *April 3rd, 2019*

The call began with remarks from Minister Elliott. She mostly reiterated previously-announced information and messaging, although there were some new details. Key points in her remarks:

- OHTs will be a new integrated model of care delivery where partners work as one coordinated team
- These teams will provide full range of services and streamline navigation
- Providers will have common goals – improving health outcomes, the patient and provider experience, and value
- Teams will be clinically and fiscally responsible for providing care to patients in a defined geography
- Teams will need to meaningfully engage with patients, families, caregivers and communities
- We expect that patients, families, caregivers, communities and providers will more actively shape how care is delivered
- Providers will be free to determine which governance model works best for them and how to provide care based on best practices and standards
- Teams will work together with a single funding stream
- They will also ensure patients have access to digital tools

Following is a detailed summary of the questions and answers that followed:

Q1. HELEN ANGUS, Deputy Minister of Health and Long-Term Care*: So guidance material is on the website today. Can you hit some highlights of the process?*

MELISSA FARRELL, Assistant Deputy Minister, Hospitals and Emergency Services: The process for assessment is outlined in the guidance material. The website address was sent with the invitation to today's session. There's also the readiness assessment self-assessment form for individuals to start the process. This will be a multi-phase approach. First is the self-assessment, where interested providers or groups complete the self-assessment form. It provides context around the 7 elements of an OHT. We are asking you to get together and complete the self-assessment – demonstrating your experience working in an integrated way, any existing agreements you have, and your understanding of the patient population you would serve.

We intend to have a continuous intake process, but we know some want to go now, so that's why we have put some dates for early adopters. So there is 6 weeks for that self-assessment. As these come in we will do some match-making where we may be missing some populations, or where a provider has been missed that's completed their own self-assessment. And then we will be doing a readiness assessment, which includes another 6 week process for the full application. Then we will conduct an in-person visit. And finally we will make available a list of either candidates to be OHTs or those designated as an OHT. The ultimate goal is to be designated as an OHT through the legislation.

Q2. ANGUS: *There are a lot more materials we'll provide to interested communities, from data to innovative models of care to organizational advice. Melissa, can you describe some of those materials and supports?*

FARRELL: The Minister has heard loud and clear that there are supports people need, including eliminating legislative, regulatory and policy barriers to collaboration. There will be regulatory and policy supports where needed. We will be providing teams with data and information that may not be readily-accessible today. We'll offer some project management support.

The level of supports the Ministry and Ontario Health would like to put out to the system are detailed in the guidance material. Another is governance material – many have asked what the model should be. It will be clear in the guidance materials this is really up to what works best for the providers. But we have a lot of experience in governance support around the province and can help with this.

Q3. 3SIXTY PUBLIC AFFAIRS*: Will there be changes to other aspects of the health care system? Specifically, pharmaceuticals and medical devices. Will there be any changes to procurement or funding to have this holistic approach to the patient experience?*

ANGUS: Not initially. It's expected that the ODB and ADP will remain largely as they are, as entitlement programs and managed by the Ministry. You know we're doing a lot of work on procurement so in future we could contemplate including them as part of blended payments, but not at this time. We wouldn't want different bundles of drugs and devices available in different OHTs.

Q4. HALDIMAND-NORFOLK: *We are a community agency and get some LHIN funding as well as revenue. My question is do we know – I know it will be one funding envelope, but is it the team itself that determines how funds are distributed? And on governance, how much input does the lead have on organizations considering becoming part of an OHT with larger stakeholders?*

ANGUS: We are looking for true partnerships. The idea that one organization gets the money and doles it out to others is not what we want. We want providers to come around the table and make decisions together.

FARRELL: Think of it as a partnership.

ANGUS: Not a paymaster.

ELLIOTT: I just wanted to confirm that we do see it as a partnership. Though I've met with groups that are well along the path of giving integrated care, for some other areas that may want to be teams and aren't as far along we will have resources and mentors. We have heard that it's about a relationship of trust. That means with patients, having that trust, and also having trust that all providers will do their parts in providing integrated patient care.

ANGUS: Community support services will be an important part of that care.

Q5a. SOUTHWEST LHIN: *If an OHT is built on partnership, do you expect an OHT to be under one building with one board?*

ANGUS: There are opportunities for different governance models. I can't imagine having the whole team in one building. But this is about making sure providers are working together. There are different ways to accomplish that. Sometimes in the past we've had mergers, but sometimes we've had things like integrated service agreements. Part of the challenge will be for the Ministry to be less siloed in our thinking and how we fund the system as well.

FARRELL: This question has come up for a long time. Integration can take many forms. The guidance materials say it should be up to providers who have built those trusting relationships to come forward. It could be amalgamation, joint venture, alliances, or contracts. Provider groups will not be all the same. There may be a very different approach in Toronto, Barrie, Guelph, or Kingston.

Q5b. SOUTHWEST LHIN: *I'm a care coordinator. We have a shortage of PSWs and community nurses in our LHIN and, I'm sure, across the province. How does this Bill address that?*

ANGUS: This Bill isn't a solution to the PSW challenge. We have other levers to help recruit and retain PSWs and it's something we're working on. You'll be hearing more from us.

ELLIOTT: Though it's not officially part of the plan, I've heard from groups already providing integrated care that their PSWs feel like they're part of the team to support the patient. While they may feel disconnected in other settings, here they are part of the team. No one person is more important than anyone else. So I'm hopeful this plan will help with retention, but we have other things to consider, and we are looking at health human resources.

Q6. EXTENDICARE: *My question is about centralization versus decentralization. We operate in 13 of 14 LHINs, both long-term care and home care. There are significant discrepancies across LHINs that make it a challenge. I worry – my question is what does this look like with 30 to 50 local health teams? And with respect to funding, will that policy be set centrally?*

ANGUS: You'll want to attend the call on Friday for more technical questions. I think there's an ability to be quite specific about outcomes and have standard funding models and IT systems while still being sensitive to local needs. We want to provide high quality, standardized care across the province – that's part of what's behind the creation of Ontario Health. Hopefully we can get some customization in OHTs but standard platforms for providing care. We're trying to strike that balance.

ELLIOTT: With respect to funding, that will have to do with size. Some teams will be smaller, so funding will depend on the size of the population being served.

Q7a. COMMUNICARE THERAPY: *We work with a lot of providers so may end up having something like 16 different self-assessments to consider in only 6 weeks. Could you explain how we might prioritize which group we approach to complete the self-assessment?*

FARRELL: Is your org in different regions?

Q7b. COMMUNICARE THERAPY: *It's not just about geography. I was thinking more about – we have a LHIN contract. I'm envisioning we might have a proposal with a pediatric hospital, or one or more FHTs. We could come forward with multiple self-assessments but I don't know if we'd have the time to do so.*

FARRELL: We can imagine organizations that are part of multiple OHTs. But when going through self-assessments you'll see the tent should be bigger rather than smaller. Just a couple of organizations working together on a self-assessment won't be successful. So you might be part of a few applications but I don't think it would be as many as you're thinking right now.

Q7c. COMMUNICARE THERAPY: *I understand that. I guess another way to ask would be – in the self-assessment, would it be appropriate to say we'd like to continue to work with multiple organizations but won't know that until we see how the OHTs evolve? Some of us want to continue with all our current relationships. We'll work with whomever. But it may not be obvious from the beginning.*

FARRELL: Great point. And there may be some match-making by the Ministry where certain providers got forgotten through the process. So we'll help cast the net wider.

ANGUS: And it's a continuous intake process. We won't cover the whole province in the first round. We want especially high-quality teams at the beginning. The first group will help us teach the rest and we'll learn together.

Q7d. COMMUNICARE THERAPY: *What role do you envision for LHINs in the home care space?*

FARRELL: There's a couple responses. We want the OHTs to determine how home and community care will be delivered and by whom. You'll need to think about all existing home care providers and what the service delivery model will be. When looking at your self-assessment, cast your net widely, and speak to LHINs who have contracts with service providers to better understand who those providers are.

Q8. NORFOLK GENERAL HOSPITAL: *I'm curious about the role or inclusion of county-funded services like EMS, public health, community housing, and health and social services?*

ANGUS: I used to be an urban planner, so I've always thought there is a great opportunity for health and social services to come together, especially for people who need to access both. These services may not be in funding envelope initially – we would need to work with other ministries to accomplish that – but thinking back to similar integrations, it didn't take long to start looking at these other services. I want OHTs to think about these kinds of services and come forward with innovative solutions.

ELLIOTT: That's really important. We want to provide wraparound services. We know social services will be important, especially community housing. I'm working with other Ministries on that and trying to break down silos not just within the Ministry of Health but also between Ministries.

Q9a. GP IN NORTH BAY: *Physicians have a big role to play. There's a big obstacle with the OMA's government compensation exclusivity. How do we work through that?*

ELLIOTT: We have a great relationship with the OMA. We really pressed the reset button with the arbitrator's decision. Both government and the OMA are happy to implement that decision together. We have had several discussions about our plan going forward. In groups I've met with physicians are at the table, whether they are part of FHTs or individual practitioners. It's really important that all

practitioners are working together and communicating together. I'm optimistic about them working together.

ANGUS: It really has been a real turnaround with the OMA. Also, looking at literature worldwide it's clear that primary care is really key. We're pleased with how this has been going so far.

Q9b. GP IN NORTH BAY: *Will physician remuneration be part of that single budget?*

ANGUS: We're in discussion with the OMA. I think there's an opportunity for physicians to be included in blended funding. I don't want to preclude those conversations but there are opportunities to have fee-for-service and other payment models incorporated.

Q10a. SCI ONTARIO: *I'm with SCI Ontario and also have had a spinal cord injury for 20 years. Support from SCI Ontario has been really key for me – peer support, information, system navitagion. They could play an integral role on OHTs. How do they position themselves to be at the table across the province?*

ELLIOTT: This is an area I've heard a lot about. I know SCI Ontario gives great support. But there's a role for government to play. When I first discussed our plan I spoke about a man who had a spinal cord injury and wound up in hospital for a year because there was nowhere else for him to go. That's not patient-centred care. So we look forward to working with you and SCI Ontario.

Q10b. SCI ONTARIO: *Does that mean we need to position ourselves to every OHT?*

ANGUS: This is where we can be helpful. We want to make sure models of care that work best are brought forward. We could include you in the roster of services avail to all OHTs and work with you on that.