Hill+Knowlton Strategies

MEMO:

To: Health Public Affairs Clients

From: Hill+Knowlton Strategies

Subject: Ontario Health Teams Town Hall, Ministry of Health

Date: July 18, 2019

Overview

Presenters

- Hon. Christine Elliott, Minister of Health
- Helen Angus, Deputy Minister of Health
- Melanie Fraser, Associate Deputy Minister, Health Services
- Patrick Dicerni, Assistant Deputy Minister, Strategic Policy and Planning
- Greg Hein, Assistant Deputy Minister, Digital Health Secretariat
- Allison Costello, Director, Policy and Innovation

Ontario Health Team (OHT)

- 157 total self-assessment applications received by the MOH
- 31 applications will move forward to "full application"
    - These teams were identified to be in full readiness for implementation
- 43 teams identified as "in-development"
    - These teams are close to being ready to complete the full application, demonstrating a high degree of readiness, but need a bit more work
    - Ministry will provide targeted supports to help them move to full application in the next stage
- All other teams have been designated "in discovery"
    - These teams have shown full support of the OHT model, but need more work to build and expand partnerships across the health sector
- Teams "in discovery" may wish to look to partner with an OHT in their community or region that is in development or working toward full application
- A small number of OHTs have been categorized as innovative models and the ministry will be working with them to explore how they may fit in an integrated system and be able to support a number of OHTs for a certain level, or specific type of care

Q&A

QUESTION 1: What is the difference between full applicant, in development and in discovery?

ANGUS: Will post shortly the full application guidance material that sets out some additional information that the Ministry is looking to collect. Those moving to full application will be required to proceed to fill that in and to do the work required. The others (in development and in discovery) will be assigned a relationship manager and work with those applicants to get ready to do the work required to move to full application.

FRASER: The difference between someone moving to full application and someone in development is a very small difference. There is a spectrum of partnerships and readiness with a lot of partnerships being very well developed. For those proceeding to full application, distinguishing markings of these teams were that they represented partnerships across the continuum of care. In talking about OHTs, it was critical that the core services were brought together and, in

a position, to be able to navigate those transitions between the most common care settings—primary care, hospitals, home care. Those proceeding to full application, additionally, represented partners in care settings beyond those core services. For those in development, they have the beginnings of some great partnerships across that continuum of care but may need more work to develop that full spectrum of partnerships or to solidify or mature those partnerships. That is where the Ministry as well as some experts will come in with some supports to help learn from those who have gone before and can build and sustain very integrated partnerships across all different sectors in the health sector with a focus on patients and help bring those learnings to those in development and help push them through to the application phase. We expect those in development to be moving to full application in the not too distant future.

QUESTION 2: Will the ministry post which teams have moved on to full application and which are in development?

COSTELLO: What we wanted to encourage was to have the system be aware of the great work that is underway and so those who are receiving letters today will note that we are asking for their confirmation of contact information so that hopefully, by the end of the month we can make available a list of those proceeding to full application and those in development. For the group locally that will want to sort of know what's going on within their region so that they might be able to partner and that group of teams that might be in discovery, I would really encourage them to partner if that is the case, that is the link that we we wanted them to make so we will be making that available hopefully by the end of the month.

ANGUS: The intention has always been that the OHTs will learn from each other and that they can connect around common challenges about how to improve care around patients. Excited about the connection between teams and how we are going to accelerate learning and improvement by working all together across the OHTs.

ELLIOTT: The other opportunities here is for teams to learn from each other, but also about the great innovation that is happening. We want to be able to blue-sky this in terms of health care, we want people to come forwards with innovative ideas that we can bring forward on a provincial basis as well.

QUESTION 3: Where can we find the digital health playbook that is referred to in the OHT full application document?

ANGUS: It’s coming. We’re putting some final touches to the digital playbook. The catalogue (accompanying document) puts, for the first time all in one place, all the digital assets across the province into one document so that you can see the kinds of investments that have been made and how you can leverage them.

HEIN: We’ve spent a lot of time polishing it, making it very readable. It has a very coherent listing of all the assets, but also opens the door for acquisition of new products where there is a case to be made for that and having some high-level guidance around evaluation.

QUESTION 4: Can individual teams now communicate their status locally?

ANGUS: I don’t see why not. Should be proud of the work that has been done, and that the people who you serve and the patients that are part of your community and who access your health care services should know that you are working together to try to better their experience of care. We’ve talked about patient and family engagement in the next phases of work as well, and that is an expectation in addition to the Patient and Family Advisory Group at the Ministry. The expectation is that OHTs will also get direct input from patients, so will want the community to be well aware of what you are doing.

ELLIOTT: When you’re trying to build a system around the patient and caregivers and family, then you need to be in direct communication with them on a regular basis to understand whether their needs are being served or whether they have other ideas about bringing care forward. We had several interesting meetings about ways that you can help offer solutions to them and in a different way than perhaps you’ve delivered care in the past.

QUESTION 5: The number of digital platforms used across healthcare is recognized as a barrier to integrated care. Is the MOH investigating a unified provincial strategy for provincial health records?

HEIN: Excited to be developing a digital first for health strategy that accomplishes a number of objectives. One is to make health information more accessible to patients and that access should be easy access. A second is, it's time in Ontario to make virtual care an important part of how health services are delivered. There are some fundamental challenges in the number of points of service systems, whether they are hospital information systems or EMRs, we have too many instances of them. We also have some provincial assets that need to be streamlined and improved. It's a really ambitious strategy that is shaped around the patient and we hope to learn a lot through engagement with OHTs on how to refine that strategy so that its effective over the next decade.

QUESTION 6: For the 31 teams going to full application, what role will volunteer patient and family advisors have in providing feedback on the further development of the teams?

ANGUS: There is a pretty clear expectation that patients, families and caregivers will be involved in both the development, but also making sure that the things that are being put into place are actually making a difference for patients.

COSTELLO: Those proceeding to full application, would be those, at least on our assessment of the self-assessment, that did have a strong involvement with patients to date in the work that they've been doing, but how that can be strengthened and how groups will be able to go about it in the most effective way and based on best practices is part of the supports that the Ministry wants to offer across a number of different providers to help in developing the best approach to get partners around the table and then how they can lend their advice. We see this as a key element moving forward which has been highlighted in the guidance document to date and through the application, when it is available, we are really emphasizing the strong involvement of communities in care redesign and all elements of OHT development.

QUESTION 7: Will all the OHTs be based on geography, and how will the Ministry deal with overlaps and gaps?

ANGUS: OHTs are largely a geographic concept, but we did talk about some of the integration ideas that have come forward around specific populations that have great interest for the Ministry. Ministry will be working with those applicants as well on how to bring those ideas to life. In terms of overlap, in general, our preference would have been for those to come together and have a conversation about how they might work together to make sure they are really collaborating around a population of patients. We have a role to play to ensure we get to full coverage, so if we see partnership opportunities that haven't been realized on the ground, our job will be to help try to facilitate those relationships as much as possible.

COSTELLO: In a lot of areas we want to undertake a specific discussion for how the ministry will undertake attribution and use the data to help inform how those partnerships might best come together based on how patients are currently experiencing the care across them. In a lot of cases, I think we will find that where there is overlap, it may relate to how providers have identified themselves in the self-assessment and through that data we can help to solidify where the partnerships might lie. A lot of this will be assisted through the data discussions we will be having with the teams over the next little bit.

QUESTION 8: How can I find a group looking for partners?

COSTELLO: We want to be able to encourage locally, what the knowledge of what's happening in the region. We'll understand over time what that care for specialized care or specialized pathways that people are trying to encourage or promote, but locally, we want to encourage that if you're within the region and you can see what's happening right now, then you have a contact person to reach out to. We want to encourage that local energy and find out over time what that broader opportunity is for some more clinical services if that's the case. We will be trying to make the information of

those undertaking full application available as soon as possible, and those in development that will be over time will be completing a full application.

QUESTION 9: How many of the 31 teams that were selected for full application will be announced as OHTs candidates in the fall?

ANGUS: I'm optimistic that they all will be. We set a high bar. These are applicants where their relationships are well developed, there's a coherence of vision, there's an ability to move some of the things that are important to patients in the right direction; so, I'm not sure that any of them aren't going to make it.

FRASER: There's no limit here. Our desire is to see the whole province to move forward, to be covered by OHTs and to support these teams and partnerships as they come forward in reaching that bar. Because so many (applicants) were so advanced and have put so much work into integrating across sectors, I think we're well positioned to have a number of OHTs as candidates very early on and to continue on that path as we move forward throughout the year ahead.

QUESTION 10: What will be the relationship between the OHTs and the new Mental Health and Addictions Centre of Excellence in order to improve mental health care in Ontario?

ELLIOTT: This is an important aspect of the work that we're doing. One of the biggest mandates is doing this transformative exercise for healthcare, but also to develop a comprehensive and connected mental health and addictions system. We know that mental health is health in the same way that physical health and so the two of them must each be met by each local OHT. What we've heard from hospitals it that, while they'd like to get more resources, they really want to build up the mental health and addictions supports in the community so that people don't end up in a crisis and end up, by default, in an emergency department when they really need help. We need to make sure we move forward with both mental and physical health with the local teams, but the Centre of Excellence at the provincial level is really the foundation upon which we are going to build the mental health strategy. We have great mental health services across the province, but it's grown-up without that basic framework that you have for groups like Cancer Care Ontario that builds on best practices and then disseminates the care across the province and does its best to ensure that it's equal care, wherever a person lives. That's what we want to do for mental health and addictions as well. The Centre of Excellence will do the data collection, collect the best practices, help build a basket of services across the province to enable the local OHTs to do their work. This is key as we build that basic foundation.

QUESTION 11: Primary care engagement, participation and leadership within the OHTs has been shown to be an essential element for success within integrated care health systems around the world. Is there any guidance and support from the Ministry to assist with this goal?

ANGUS: I was struck by some of the applicants and how much work they had done around engaging primary care, both in community health centres, AHACs and structured models, but also the deep outreach that has already happened. I think we can learn from that.

COSTELLO: We were really encouraged through the self-assessments about the level of engagement of primary care and have been encouraged by our partnerships with our association partners for sector and other groups that have really encouraged and supported the message and understand the value proposition from their providers of the OHT model. We hope that the positive work that has been done to date will further the primary care engagement. As part of the work that we do to grow the supports that providers might need locally or provincially to understand how best to engage and understand the best approaches to work with their primary care partners. We want to build this out. We're working with partners like AFHTO and OCFP as well as the general section within the OMA, wanting to get the feedback from the field and from those they most often interact with to understand what will be most effective. We've seen from other jurisdictions that successes of these models do really depend on a strong basis of primary care, but also a strong leadership role for those teams as well.

QUESTION 12: How and when will the Ministry of Health be facilitating any match-making discussions? Should these be pursued prior to the completion of the full application, or at a later date?

ANGUS: Some of this work is already happening at the local level as well. It's never too soon to reach out and to look for partners. I would say that my observations are that, even in developing the application and working together to form a proposal or do the self-assessment, we're already seeing some benefits for patients emerging from the collaborations that are developing on the ground.

COSTELLO: We do want to encourage that by posting what's underway locally, encourage that people will, if they didn't know who to reach out to, that they now will know who to reach out to. Over time, we will have a greater understanding of who's actively participating in the model and who we may need to reach out to specifically. We're still hoping that there's a lot of interest locally of reaching out and making that connection and as we understand where we can help or what might be the thing that people need to understand how they can participate and benefit, that we can flush that out and understand how to support that.

QUESTION 13: Of the 31 invited to full application, are any Indigenous-lead OHTs?

COSTELLO: With the submissions that we saw, we've certainly included strong requirement for engagement of indigenous communities. Across the ones that we did see, we saw that included, but we also have a partner that is lead by an Indigenous group in the north that we are really encouraged to understand the potential there and the benefit and what we can also learn from that group as we move forward with transformation initiatives more broadly.

DICERNI: There was one indigenous-lead proposal from northern Ontario that is moving forward with full application, but there are a host of others that are in the in-discovery category. The two comments that I'd make is that the groups that are moved through to the full application phase that have noted some degree of indigenous partnership, community partnership, that we've really stressed with those applicants that they need to meaningfully, and in a culturally safe and appropriate way, engage with the communities that they have included in their application. That is something that we are going to be looking at and watching quite closely. That needs to be meaningful and true engagement as equal partners. With respect to the indigenous lead proposals that are in the in-discovery phase, the supports that will be coming forward from the Ministry will be trying to round out that proposal into a full continuum of care and again, I want to stress doing that in a culturally safe and appropriate manner.

QUESTION 14: Can you describe how the French language services capacity of the OHT applicants was assessed?

COSTELLO: Part of our evaluation lens related to equity, including care for francophone populations. As mentioned in the guidance document, teams have a responsibility to respect the role of francophone populations in planning and delivery. We know that a lot of teams have reached out to their local French planning entities to start their work, whom we've reached out to as well, so we've had some strong support from our Ministry French languages services area as far as what the act entails and what that means, so we did have a strong lens in the francophone area as we did that review and are certainly emphasizing that in the applications as we go forward, broadly in respect to equity, but specifically with respect to francophone populations.

QUESTION 15: Do the teams that are in-development and in full application cover all parts of the province?

ANGUS: With over 150 applications, we've got pretty good regional coverage. There may be some gaps, but generally, we've got excellent coverage across the province and we're going to learn a lot about the different contexts for OHTs.

COSTELLO: Certainly we've received applications from every corner of the province and we've been happy to move a lot of those through, so a really good regional coverage—urban and rural mix, as well as the populations that we've spoken about (francophone, Indigenous) to make sure that we're learning from what we are supporting through full application to start. That will really help us to understand what we need for provincial spread, how we can identify those partners locally that are not yet at the table and could be over time and what that could mean, I think we'll also learn a

lot thought that initial phase about how the attribution approach will cover the patients that they're serving and what that will mean for what we need to do next as we move toward full coverage as we move the full applicants and in-development through the process.

QUESTION 16: (To Minister Elliott) Are you surprised by the response from the health sector?

ELLIOTT: Very pleasantly surprised. We anticipated that we would get a number of applications, but 157 applications is wonderful and indicates to me that there is great health provider interest in this, that people have been wanting to work together because they know there are some gaps in service and that patients aren't always receiving the kind of service and care that they want to deliver and that they were trained to deliver. So, having groups come together like this is wonderful; to show the readiness, but also the enthusiasm for the whole transformative process. It's very encouraging to us.

QUESTION 17: How do you expect OHTs will contribute to ending hallway healthcare?

ELLIOTT: There's a whole number of ways. Ending hallway healthcare is not a simple issue, there are many factors that lead to hallway healthcare. I think one aspect is being able to look with a lens at the entire healthcare needs in the community and deal with things like chronic disease management, for example, that often ends up having people put into hospital where they might not necessarily need to be if people are connected to the home care services and so on that they need. The other aspect is having the comprehensive mental health and addictions plan in place that will increase community resources that local OHTs can call upon and build upon to make sure that people can receive the help they need in the community and not in the hospital. There's also a lot of work that we've done and that the local OHTs can help continue, is to help people who are ALC—patients that are in hospitals, that are there not because they need to be there, but because they are not quite ready to go home or they may need to go to long-term care. There is work being done in places across the province sort of as a reactivation care centre. We announced one yesterday at the old Humber River Church St. site, for Trillium Health Care where people can leave the hospital, go to these sites and receive the physical and/or mental rehabilitation that they need. What they are finding is that many people can actually go home from there—they don't need to go to long-term care—which is tremendous because that's where people really want to go: home. So I think there is a tremendous amount of work that the local teams can do to build on what we are trying to do provincially, but to bring that locally into their own community and to fit it into the needs of the people that live there to keep them healthy and out of hospital as much as possible.

QUESTION 18: Given that palliative care crosses all ages, diagnoses and health care sectors, is there a plan for OHTs to incorporate palliative care services?

ELLIOTT: I would say yes, we have some great places where people can go for palliative care services, but they don't exist in every community. I think it's an area where home care services are looking at taking on more and more to be able to allow people to be comfortable in their own homes, with their family around them, with things that are comfortable and familiar, the foods that they want to have if their able. I think that's an area that we will be moving towards more and more and that the local OHTs will be able to help facilitate that work, working with home care.

QUESTION 19: How are submissions reviewed and who reviewed them?

COSTELLO: The submissions were reviewed through a rigorous evaluation process that was developed in conjunction with an expert panel and carried out by the ministry. They were reviewed on the basis of their alignment with the OHT model as was set out in the guidance document and each of those components. We also assessed the readiness to proceed to the next stage of the readiness assessment, which is the full application, and overall coherence and clarity. So, we had the alignment of the model and the readiness to move forward as the two main elements that we were looking for, with those in-development being very close to full application. We also overlooked the portfolio, making sure we had good regional coverage, good coverage across our specialty populations and a good mix of urban and rural so we could understand the opportunities moving forward as we spread.

FRASER: A very rigorous review process that we, as a ministry, wanted to learn a lot from as we support these teams going forward, but this was really about setting a high bar and a promise for what the OHTs would deliver and how this actually makes care better for patients. So, throughout the process that was really the key—will these serve patients and care for patients, navigate for patients, in their communities and are they sensitive to local issues.

ANGUS: The only other things is that, we learned a lot already. I think some of the ideas around barrier removal are important and as we think about the things the ministry may have put into place in years past, that are actually barriers to connecting care around patients, we are taking a very close look at those to see if we can provide more flexibility to really make care more patient-centred than it has been. That has been very instructive and, I think, will contribute greatly to the overall modernization agenda.

QUESTION 20: (To the Minister) How will this improve care for patients in the short and longer term?

ELLIOTT: It's going to improve care by connecting care for patients. That's one thing that I've heard since becoming Minister and what I heard during my time as Ombudsman; that people often felt that once they were discharged from hospital, for example, that they were essentially shut-out of their healthcare system and that they had to navigate their way back in. We've seen the results of that. That people who are discharged from hospital may not receive the care that they need in a timely manner and end up back in hospital with complications. So, we need to connect the care for people to ensure that if they are leaving hospital and they need homecare that they know before they leave hospital who the home care provider will be, what they will be doing, and when they will be arriving. Also, to make sure the home care provider is connected back with the hospital so that if there are complications that arise in the home, that they can be treated in the home—that the home care provider can be connected back to the hospital, back to the physician or the nurse practitioner, whoever they've been dealing with, and can get advice on how to treat that person within the home. That is the goal of this exercise: to create better, fasters, more connected care for patients, regardless of where they are in their health care journey. That is both the short- and the long-term goal.