

Rehabilitating Ontario's Healthcare System

The opportunity for rehabilitation services to shape care integration

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GTA Best Practice Day

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Introduction

1. What changes are happening in the Ontario Healthcare system – provincial, regional & local
2. Describe the Ontario Health Team Model
3. Opportunities for Rehabilitation Services during this Transformation
4. Opportunities for Questions/Answers & Discussion

Integrated Care – a movement for change

TOWARDS A CANADIAN MODEL OF INTEGRATED HEALTHCARE



LEAD PAPER

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CANADA DOES NOT HAVE INTEGRATED
HEALTHCARE. Canada has a series of
disconnected parts, a hodge-podge

better collaboration among providers
and providing better healthcare to the
population. However, regional health

“The Ideal Systemorganized delivery systems (ODSs) as "networks of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and who are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population being served." (Leatt, 2020)

Ontarians' expectations for digital health

What we heard from Ontarians...



Two thirds

of Canadians are interested in consulting with various health care providers through a virtual platform.



Three quarters

of Canadians are interested in using patient portals.



Six in 10

Canadians say they are excited about the impact artificial intelligence will have on health care.



Patients

- Want more choices in how they interact with the health system, including virtual care.
- Want to easily access and control their health information.



Providers

- Want to spend less time on paperwork, and searching for patient records, and more time treating patients.
- Want a better work experience.



Innovators

- Want the health system as an asset to support economic growth and job creation.
- Want secure, responsible access to data for research and development.

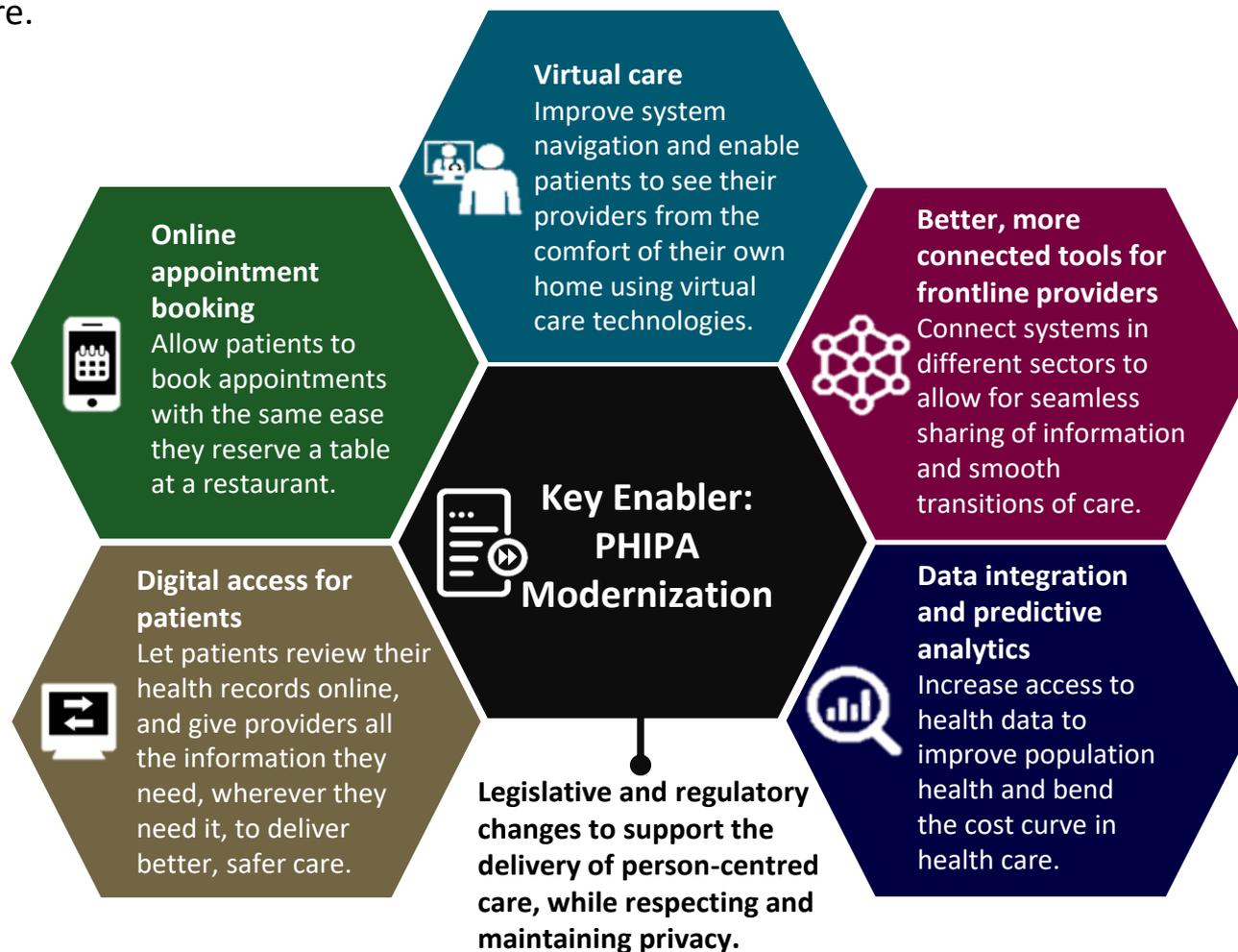


Government & the Broader Health System

- Want to leverage existing data to support decision making and end hallway health care.
- Want more efficient and streamlined digital health delivery.

The Digital First for Health strategy

Digital First for Health is central to the government's efforts to transform the health care system so that it is integrated, sustainable, and patient-centred. Strong digital capabilities are critical to enable system integration and the sharing of information throughout the health care system so that patients receive seamless care.



What is PHIPA Modernization



Improved integration of health information for patients, providers, health system planners and researchers across the system using any mode of communication

Enabling data sharing and information flows that support the public interest

Leveraging data to support digital innovation



Improved patient access to their PHI

Patients would be able to access their PHI more easily, more quickly and from ANY health provider, health institution in their circle of care.



Improved health provider access to integrated health information

Providers would be able to share PHI far more readily, to support the delivery of care

Enable establishment of OH and OHTs

OH and OHTs would have access to PHI and will be able to disclose and use PHI to support better care and support system transformation.



Enable innovators and researchers access to data

Innovators and researchers would have access to de-identified health information to stimulate research, innovation, and economic development.

Integrated Care - A Case for Change

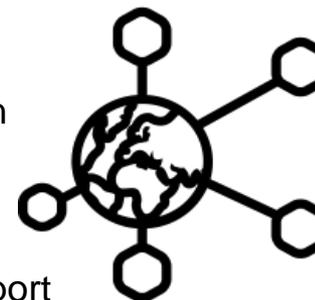
- Ontario has world-class health care services provided by some of the best health care workers. However, over time the province's health system has become fractured and disconnected.
- Demand for home care is rising due to an aging population, increased patient complexity and more people being cared for in the community.
- The capacity challenges across the system have resulted in growing hallway health care in hospitals throughout the province.
- Many of the current health system challenges arise from the disparate ways different health services are planned, managed, and delivered at the local, regional, and provincial levels. Specifically:
 - Siloed local care delivery,
 - Fragmented oversight and duplicative administration, and
 - Fragmented and ineffective supply chain management.



Learning from Jurisdictions, Setting our Own Path

Across the industrialized world, governments face similar challenges:

- Many providers across multiple care sectors, results in gaps in care, duplication and lack of coordination
- Over-reliance on hospitals and under-reliance on primary care
- Little attention to self-management and preventative health care
- Poorly aligned financial incentives that locks value into silos, and does not support care integration



In response, Integrated and Accountable Care Systems have been emerging that share the following features:

- Organizations share financial and clinical accountability for quality of care, experience and total costs of care for their patients
- Services are integrated, focused on and driven by primary and community care
- Payment methods and incentives are built to deliver value, not simply pay for volume
- Flexible approach that allows for innovation and tests of changes

In Ontario, we have been learning from other jurisdictions' implementation of these integrated systems and created an Ontario-based model of care called
Ontario Health Teams

Ontario Health Teams Vision for Integrated Care

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

- ✓ Provide a **full and coordinated continuum of care** for an attributed population
- ✓ Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience **seamless transitions** throughout their care journey
- ✓ Be measured, report on and **improve performance** across a standardized performance framework based on the 'Quadruple Aim'
- ✓ Operate within a **single, clear accountability** framework and funded through an **integrated funding** envelope
- ✓ Have better access to secure digital tools, including online health records and **virtual care options** for patients

Successful OHTs will be defined by their ability to provide fully-integrated care to a distinct patient population in a way that delivers on the quadruple aim:



Better patient & population health outcomes



Better patient, family, & caregiver experience



Better provider experience



Better value & efficiency

Quadruple Aim

New Incentive / Performance Framework

The Quadruple Aim

Institute for
Health
Improvement



Evaluation of
integrated care
services in Catalonia:
population-based
and service-based
real-life deployment
protocols – E Baltaxe

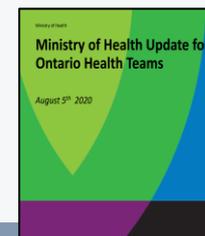
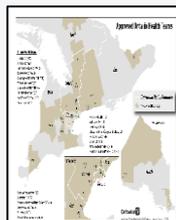
Toronto Central
Primary Care
Rehabilitation
Network -
Evaluation Report
-
E Stevenson

Ontario Health Team Journey to Date

- In early 2019, Ontario Health Teams (OHTs) were introduced as a new model to integrate health care delivery.
- By early January 2020, 24 OHTs had been approved to begin implementation and over 50 teams were actively advancing their readiness to form OHTs.
- There are currently 42 approved Ontario Health Teams, and other regions continue to develop

April 18, 2019 – Bill 74 passed and receives Royal Assent

March 2020 - COVID-19 Pandemic hits Ontario



February 26, 2019
The Ontario government introduces Bill 74: *The People's Health Care Act, 2019*

May 15, 2019
First call for OHT applications; Over 150 submissions received from across the province

November 25 – December 9, 2019
24 approved OHTs announced

December-February, 2020
New submissions & progress reports received

July 2020
17 teams invited to full application, 5 additional teams approved, Implementation, funding announced, Ministry releases guidance on collaborative decision-making

Aug 5, 2020
Minister's webinar to reaffirm commitment to achieve provincial coverage

24 Teams

29 Teams

Reflections from COVID

The power of local integrated partners

Ontarians and clinicians are willing and ready to adopt virtual care as part of their health care journey across the health care system.

Streamlined navigation services are critical for finding and accessing the right health care services. A single “digital front door” is required.

It remains challenging to follow a **single patient across different episodes of care**. Digital identity, modernized infrastructure and Interoperability needs to be prioritized.

Local integrated care improves the local COVID response

Healthcare Quarterly 23(3) October 2020 : 15-23.doi:10.12927/hcq.2020.26338

Responding To The Covid-19 Pandemic

Mobilizing a Whole Community: Policy and Strategy Implications of an Integrated Local System Response to a Global Health Crisis 🏠

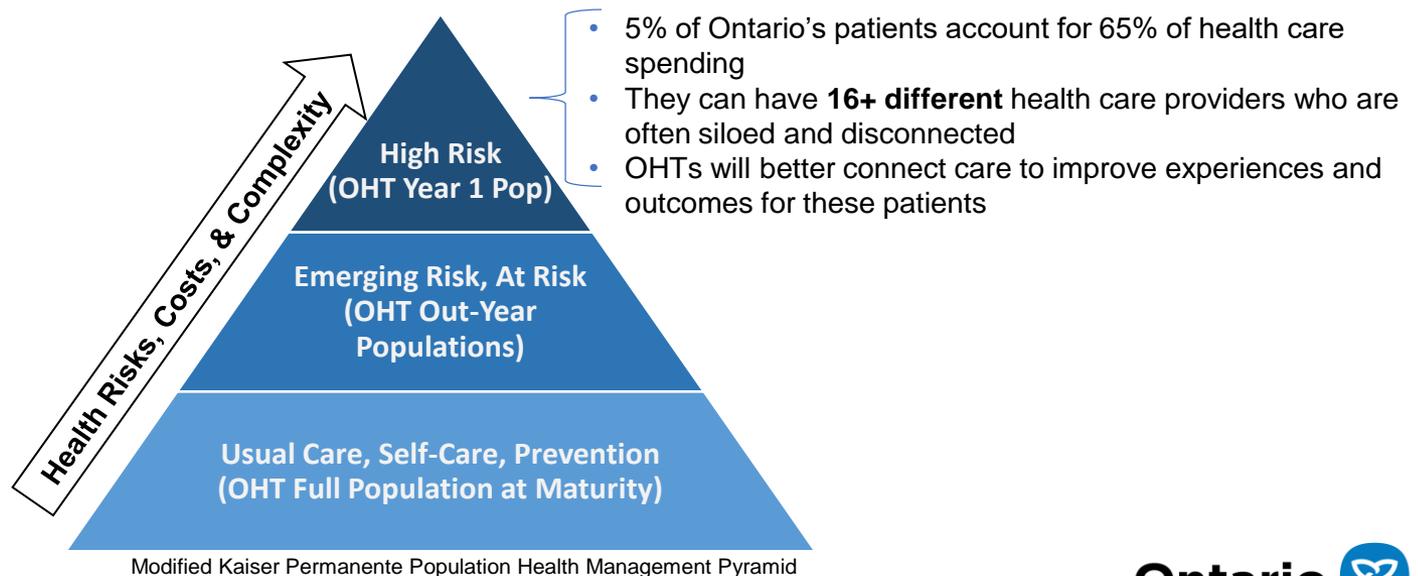
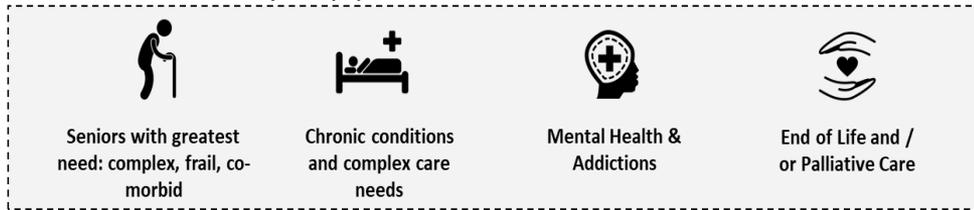
Anne Wojtak, Jason Altenberg, Carol Annett, Anne Babcock, Keith Chung, Sarah Downey, Mark Fam, Ian Fraser, Kate Mason, Thuy-Nga (Tia) Pham, Jeff Powis, Ashnoor Rahim, Jarred Rosenberg and Catherine Yu

OHTs & Population Health Management

OHTs will transition from siloed, sector-based approaches, to managing the health of a population.

- OHTs will work to achieve specific targets related to the care experiences and health outcomes for their year 1 priority populations
- They will then build on these experiences by steadily expanding their reach in later years, with the goal of eventually optimizing care experiences and outcomes for their full population

Common areas of focus for year 1 populations



Integrated Care & Role of Rehabilitation Services

- As OHTs mature there will likely be the development and shift of services to primary care and community based services
- Hospital services will focus on their highest value proposition
- Care pathways will be executed by interdisciplinary teams
 - Support other rehabilitation services
 - Connect and collaborate with colleagues in other sectors
- Start thinking about the full continuum of care and the Quadruple aim

Questions / Discussion