Ontario Health Team in Mississauga

Information Session

August 23, 2019

Agenda for this meeting

- Provide a summary of where we are now in the planning process
- Offer an introduction to our population and its demographics
- Describe where we are in the planning process and our approach to engagement
- Share information about next steps and how individuals can stay involved

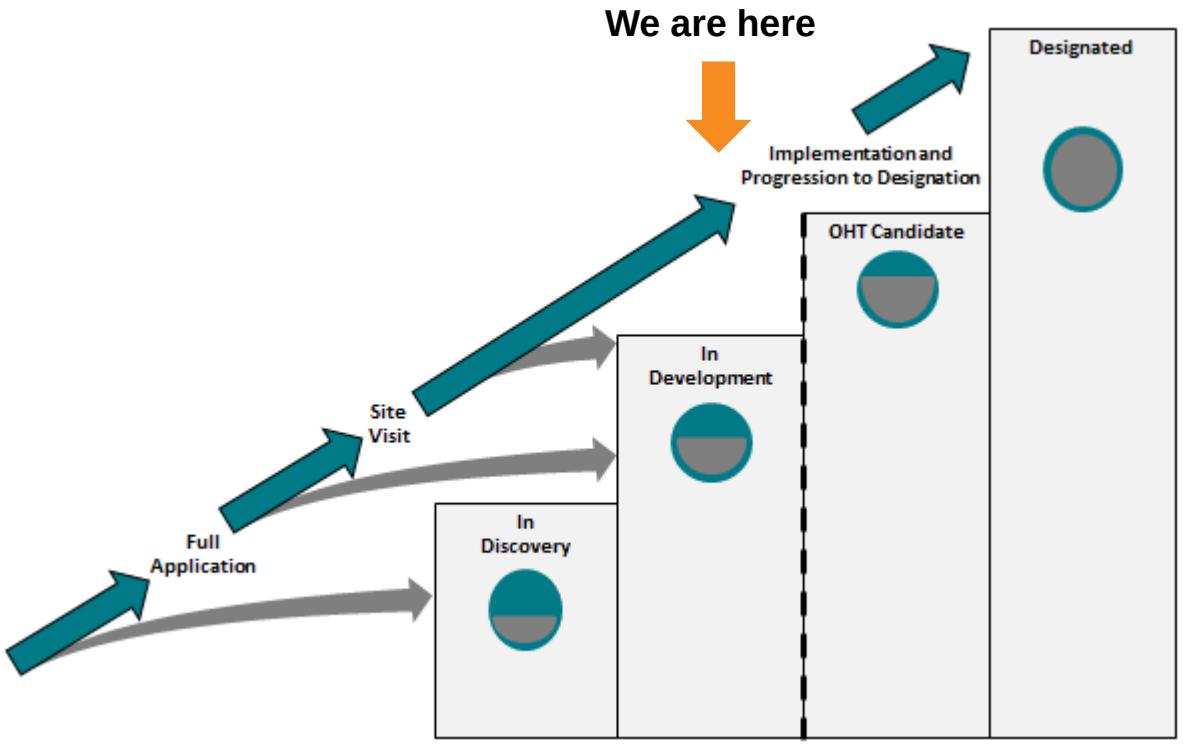
Ontario Health Teams

The vision for Ontario Health Teams (OHTs) as set out by the Ministry of Health and Long-Term Care (MOHLTC) is to create integrated care systems in Ontario to improve health outcomes, patient and provider experience, and value.

The OHTs will consist of groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. OHTs will:

- Provide a full and coordinated continuum of care for an attributed population within a geographic region
- Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey
- Be measured, report on and improve performance across a standardized framework linked to the ‘Quadruple Aim’: better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value
- Operate within a single, clear accountability framework
- Be funded through an integrated funding envelope
- Reinvest into front line care
- Improve access to secure digital tools, including online health records and virtual care options for patients – a 21st century approach to health care

Where we are now



Assessment Process	Dates
✓ Open call for self-assessments	April 3, 2019
✓ Deadline to submit self-assessments	May 15, 2019
✓ Selected groups will be invited to submit a full application	July 18, 2019
Deadline to submit full applications	October 9, 2019
Announce OHT Candidates	Fall 2019
Deadline for Second Round of self-assessments	December 4, 2019

According to Ministry guidance, both “In Development” and “OHT Candidates” will:

- help demonstrate the impact of the model on quality of care, patient and provider experience, and cost, and will provide important lessons for implementing the model across the rest of the province
- set course for system-wide transformation
- prioritized for future investments and receive incentives based on performance
- have access to tailored supports

*Note: Ministry site visit has not yet taken place and will depend on Ministry timelines

Who we are

Our core partners for the application

Primary Care	Hospital	Home Care	Community
Credit Valley FHT	Trillium Health Partners	Home care*	Metamorphosis Network of 45 Agencies
Summerville FHT			
CarePoint Health			

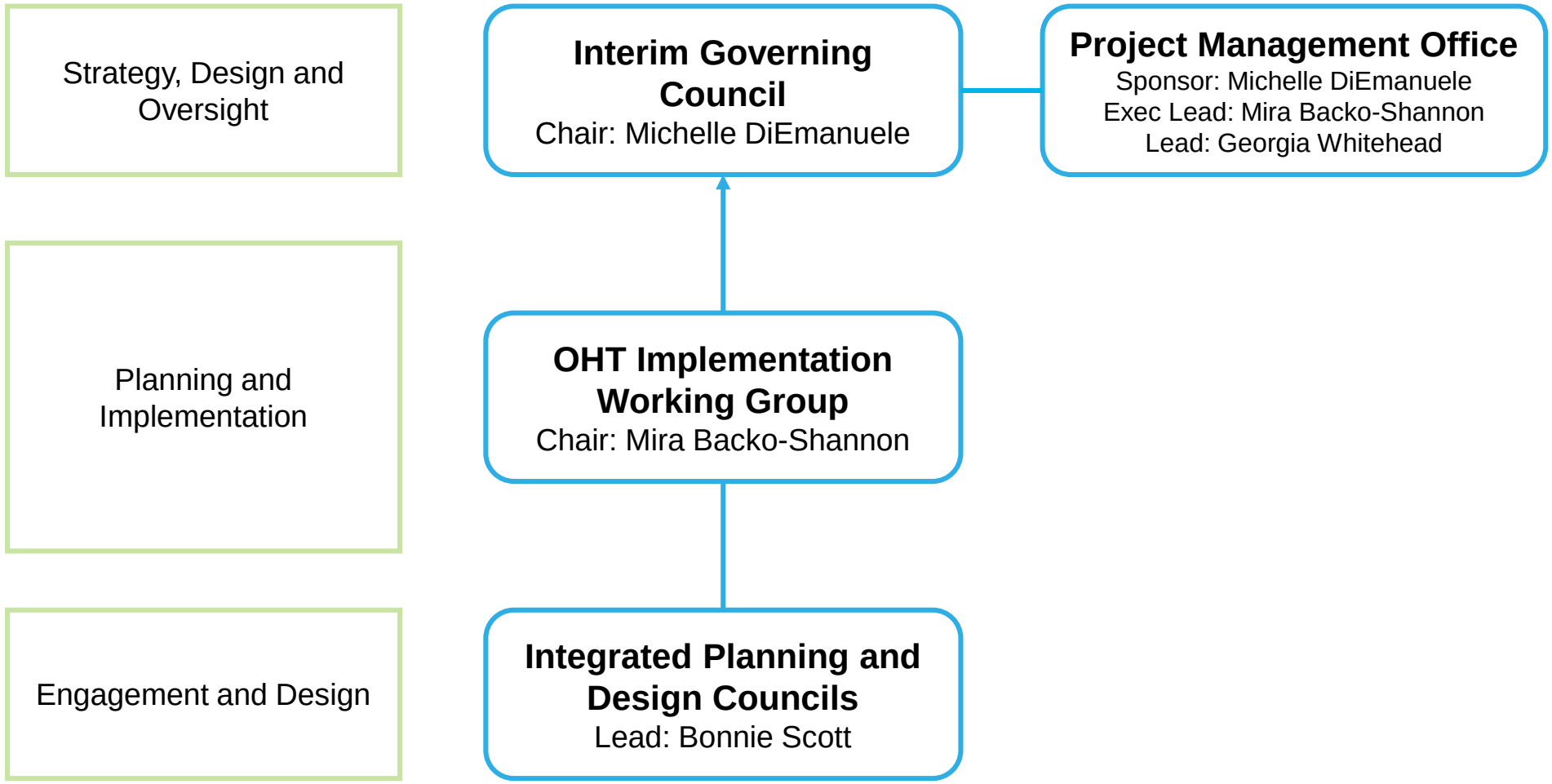
Our committed community partners

Representing diverse sectors, including mental health and addictions, palliative and long-term care and social services

AbleLiving Services
Alzheimer Society of Peel
AstraZeneca Canada Inc
Bayshore HealthCare
Beacon
Canes Community Care
CBI Health Group
City of Mississauga
Closing the Gap Healthcare Group
Dixie Bloor Neighbourhood Centre
Dorothy Ley Hospice
Dufferin-Peel Catholic District School Board
East Mississauga Midwives
ErinoakKids
Heart House Hospice
Seniors Life Enhancement Centres
Links2Care
March of Dimes Canada
Midwives of Mississauga
Mississauga Board of Trade
Mississauga Halton Palliative Care Network
Nucleus Independent Living
Nurse Next Door
Ontario Telemedicine Network
Peel Addiction Assessment and Referral Centre
Peel District School Board
Peel Public Health
Punjabi Community Health Services
Peel Regional Police
Peel Senior Link
ProResp
Region of Peel
Registered Nurses Association of Ontario
S.R.T. Med Staff
Saint Elizabeth Health Centre
Schlegel Villages
Sheridan College
Sienna Senior Living
Spectrum
TEACH - Centre for Innovation in Peer Support
United way of Peel Region
University of Toronto Mississauga
The Victorian Order of Nurses
West Park Health Centre
Yee Hong Centre
YMCA of Greater Toronto

*Over time, we envision home care as a core partner and service as part of the OHT. We will work in alignment with government direction to support the evolution of these services

The Mississauga Ontario Health Team: Interim governance model



Caring for our community

Ours is a large, diverse community with many different cultural and ethnic backgrounds.

This community is experiencing growth in populations across all ages, as well as increases in significant multimorbidity and social inequity.

In many cases, our health care infrastructure is stretched beyond capacity.

65% of our population are immigrants; 50% are visible minorities and 50% report a first language other than English or French*

15% of our population are seniors and more than 6.4% are over 75 years of age; 22% are children

Over 22% are living with at least one chronic condition, but this community currently has the fewest interprofessional primary care teams in Ontario, no youth mental health beds, the fewest long-term care beds

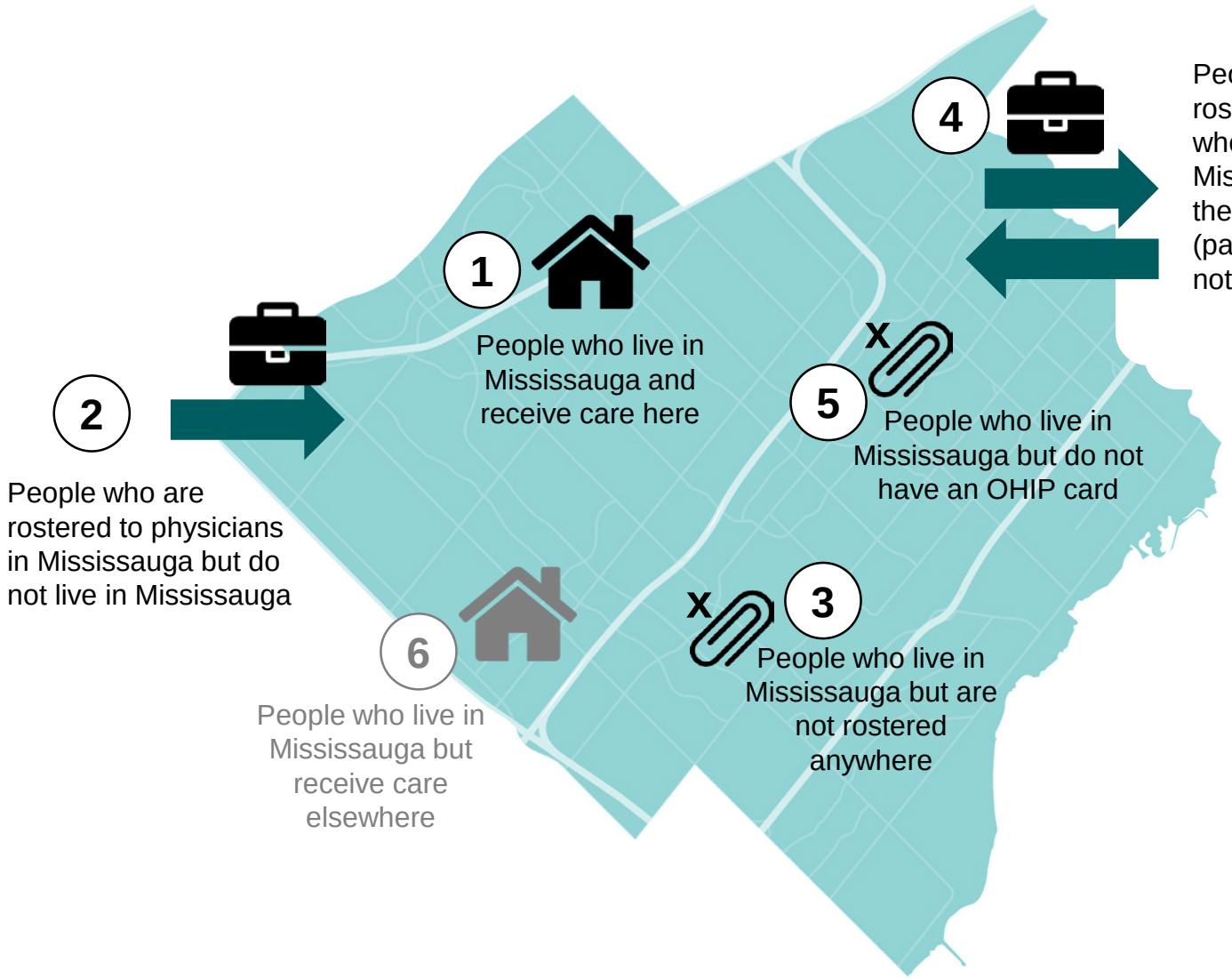
In 1980, only 2% of neighbourhoods were low income, while today, low- and very low-income neighbourhoods represent 51% of the community

We also have a diversity of strong community partners who have a history of collaboration and working together.

Through an OHT, there is an opportunity for providers to improve the health of our population by providing high quality, integrated care across the continuum, from prenatal care to birth to end of life.

* Population demographics based on initial population attribution methodology; to be updated as understanding of our attributed population evolves

Who is our population?



Understanding our Population

The Ministry uses an attribution methodology that is based on physician referral networks. Based on Ministry methods, groups 1, 2 and 4 are part of the population this OHT will be accountable for at maturity.

We are also considering groups 3, 5 and 6 as we plan to ensure that we are taking a holistic view of the people who live in the region.

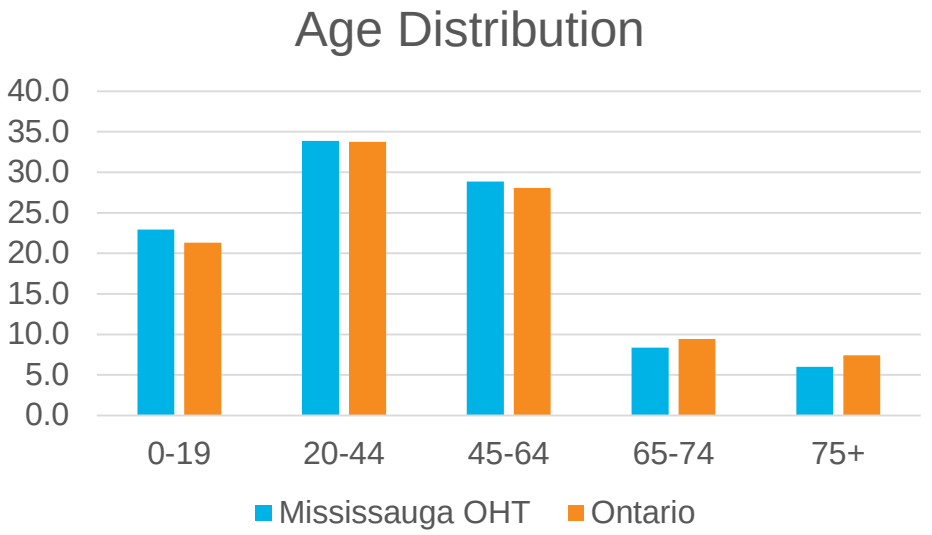
A few facts about our population:

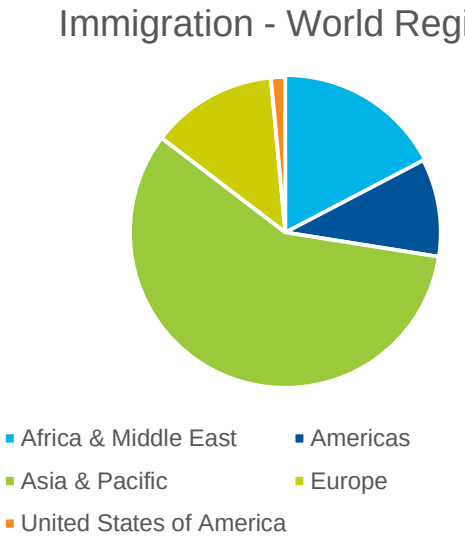
- According to the Ministry's methodology, we will be accountable for approximately 878,000 people at maturity
- About 50% of those people live in Mississauga and are rostered with primary care physicians located here

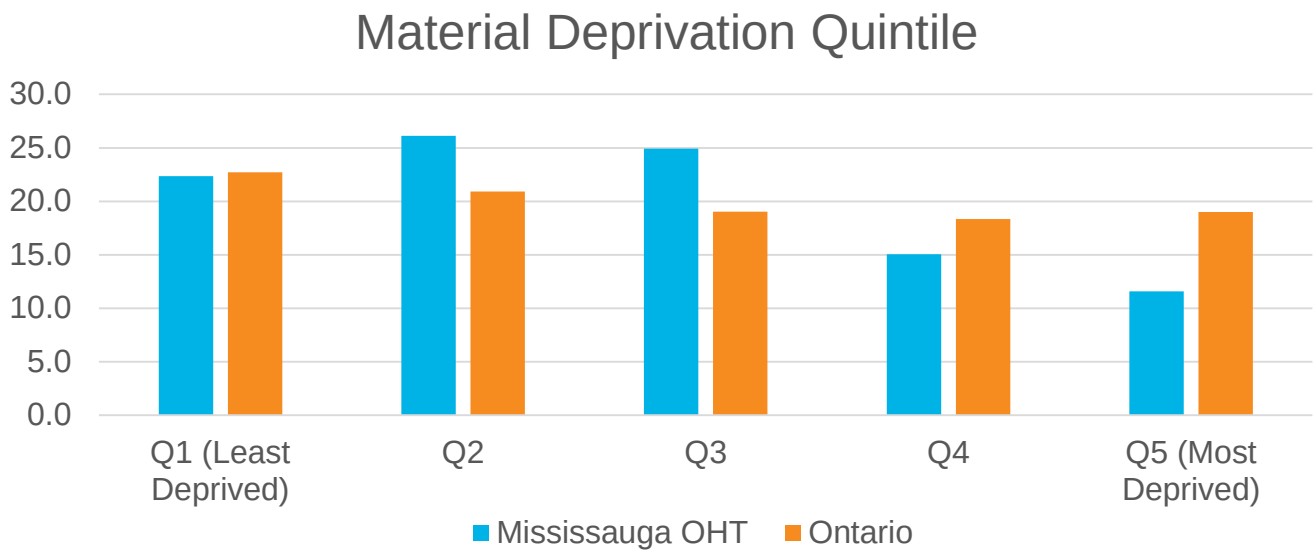
* As we work with the Ministry to further understand our population, this will continue to evolve; we will keep you informed as this develops

Understanding our population demographics

	Mississauga OHT	Ontario
Immigrant	29.3%	15.6%
Recent immigrant	3.8%	2.3%
Refugee	4%	3%

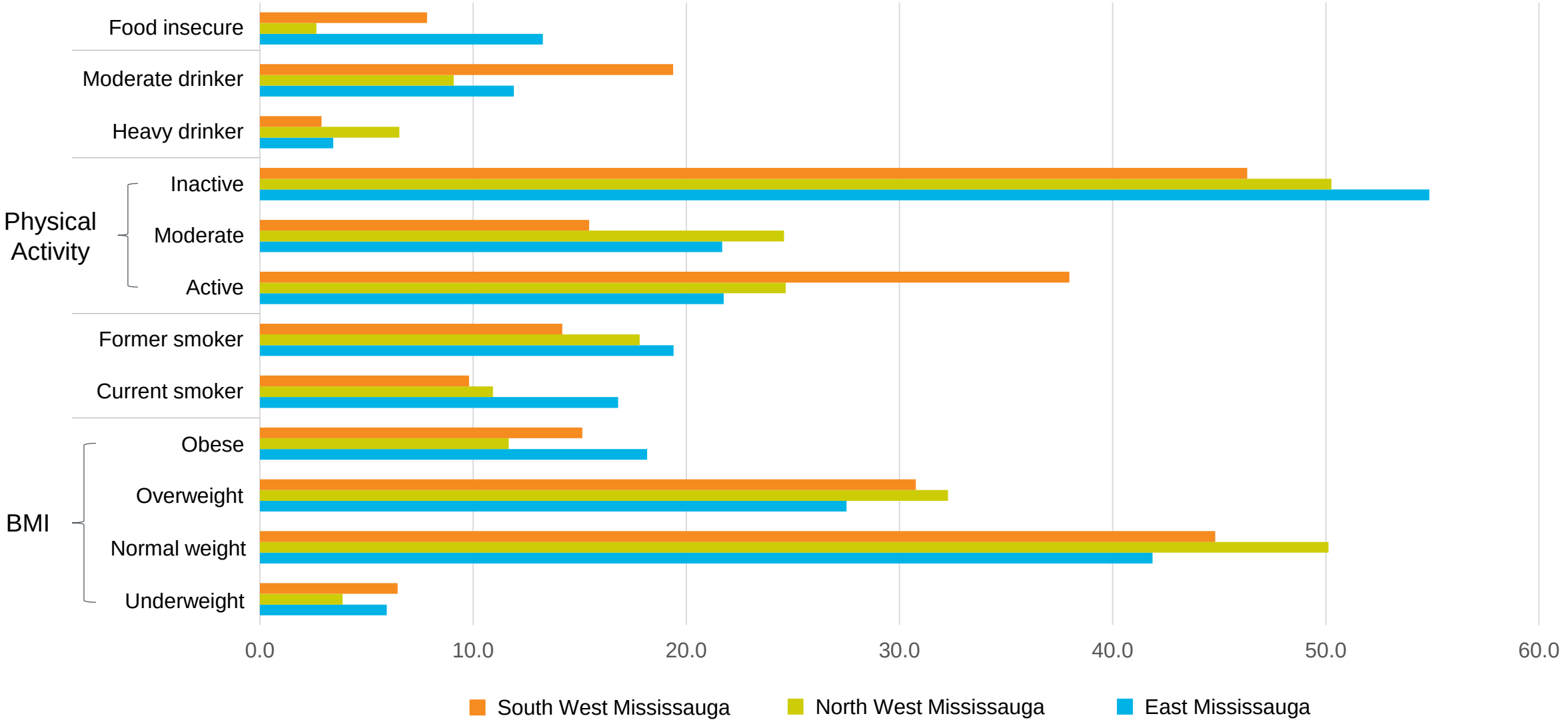






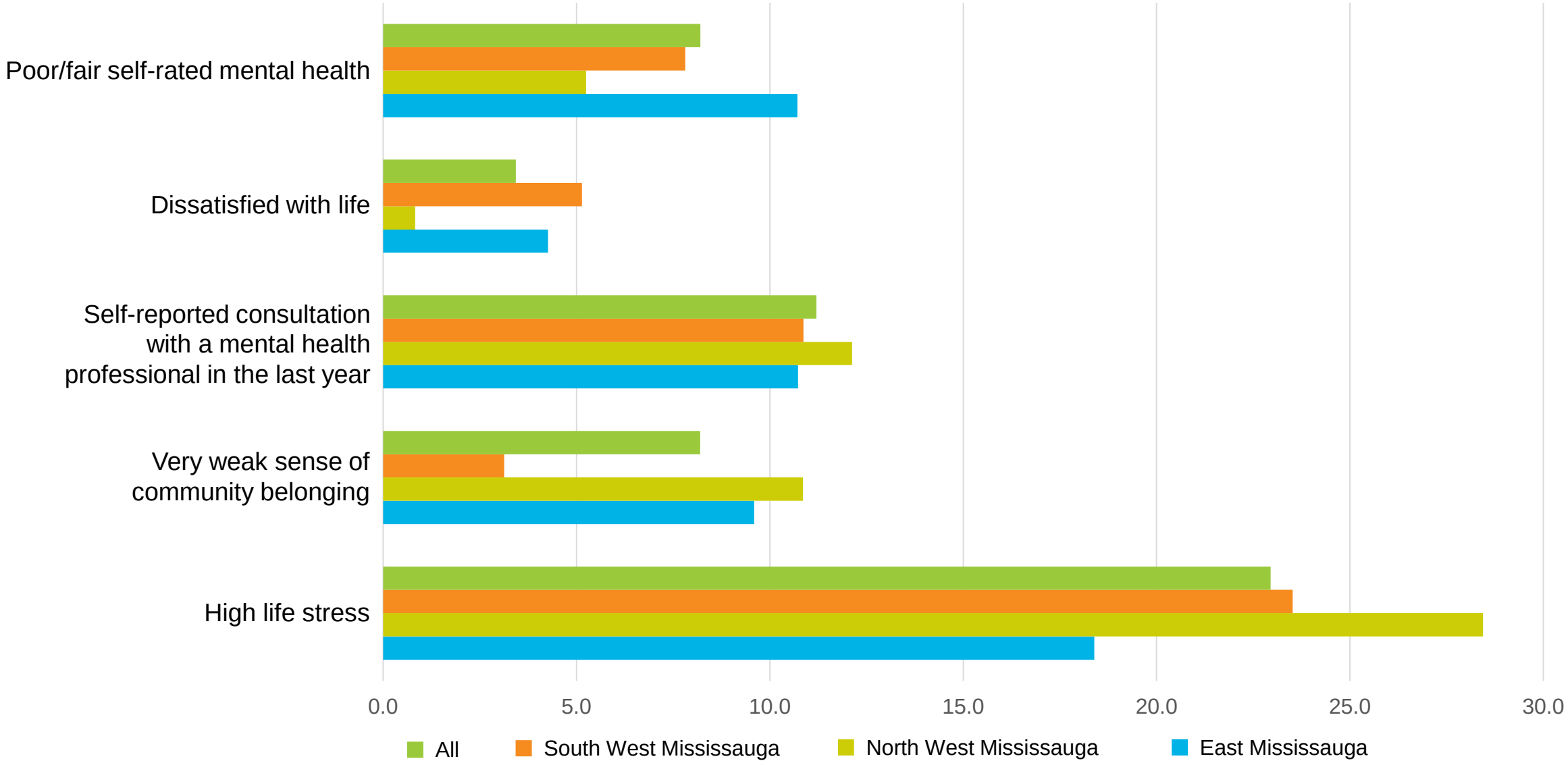
Data sources: Immigration, Refugees and Citizenship Canada Open Data; All data are proportional estimates and will depend on further defining population

Selected risk factors among people living in Mississauga



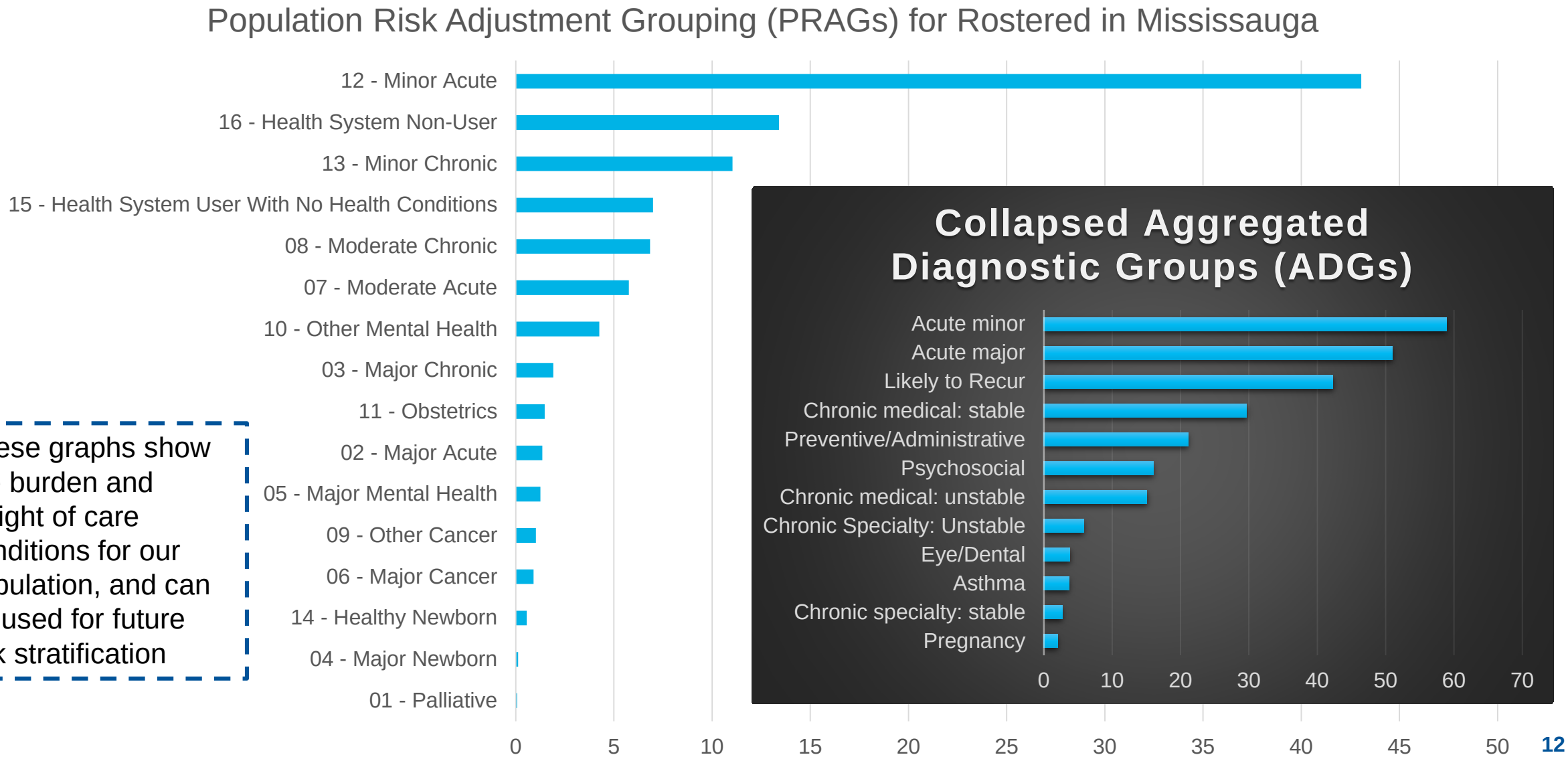
Data sources: Canadian Community Health Survey, 2013-14; Data are based on Mississauga geography and not on the complete attributable population

Community and life stress in Mississauga



Data sources: Canadian Community Health Survey, 2013-14; Data are based on Mississauga geography and not on the complete attributable population

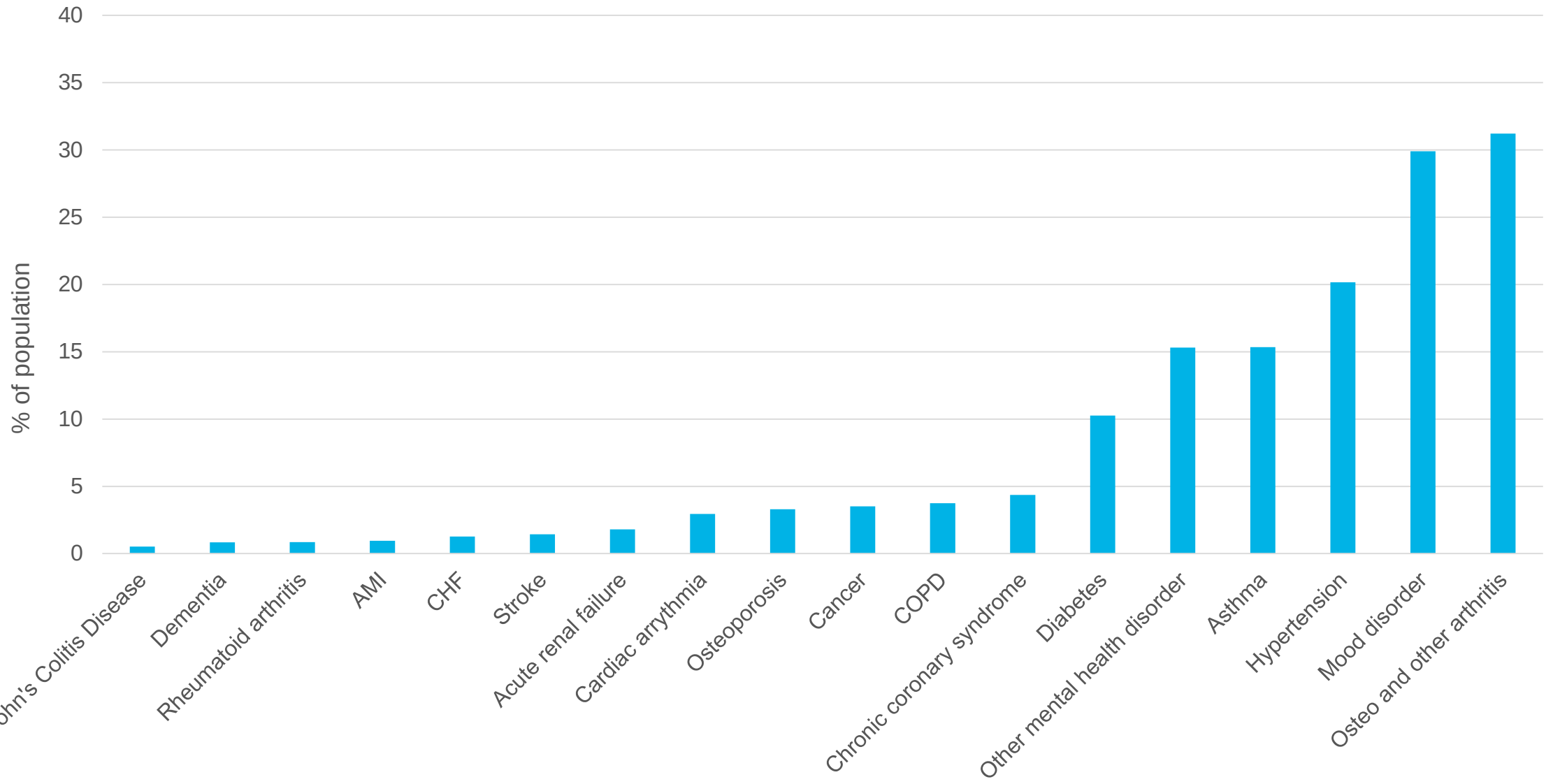
How our population uses health care



These graphs show the burden and weight of care conditions for our population, and can be used for future risk stratification

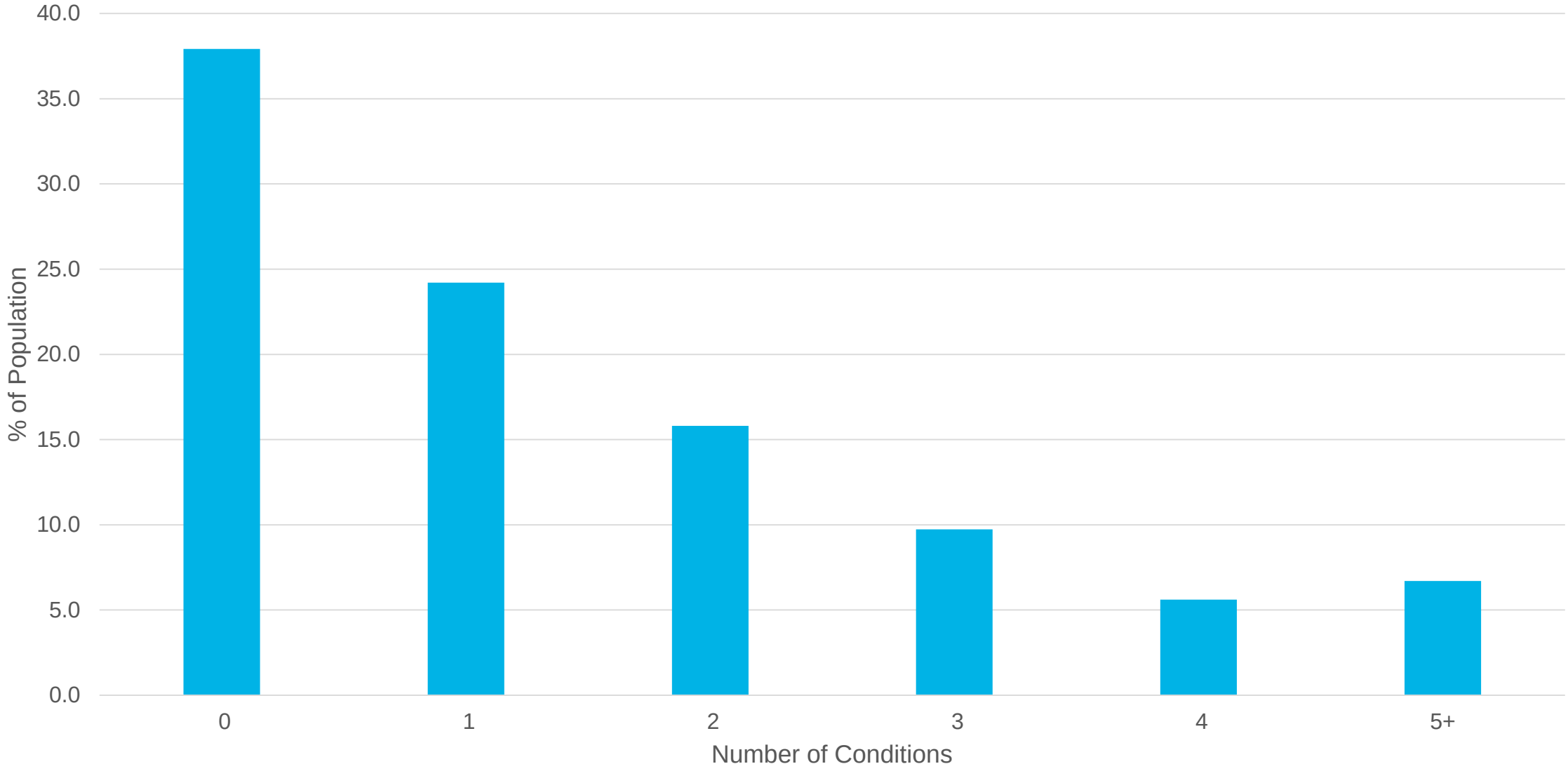
Data sources: CIHI DAD, NACRS and OHIP databases; John Hopkins ACG score; All data are proportional estimates and will depend on further defining population

Prevalence of conditions in our population



Data sources: CIHI DAD, NACRS, OHIP and ODB databases; All data are proportional estimates and will depend on further defining population

Multimorbidity of conditions in our population



Data sources: CIHI DAD, NACRS, OHIP and ODB databases; All data are proportional estimates and will depend on further defining population

Planning for an Ontario Health Team in Mississauga

Focus of the proposed OHT:

1. **Population health approach**
   - Use data analytics and a clinically significant risk stratification model to focus resources on people with emerging and high risk needs to improve health outcomes and better coordinate care
   - Simultaneously activate health prevention and promotion for all, including low risk populations
   - Support holistic mental and physical health needs rather than solely disease-specific health needs
2. **Implement integrated primary care model**
   - Standardize same-day access to primary care and access to 24/7 care coordination and navigation
   - Expand use of virtual care
   - Increase access to interdisciplinary team-based care
   - Provide prevention, health literacy and self-management support
   - Enhance integration across primary care, acute, home and community
   - Provide a digital portal to allow patients access to their health record across the continuum
3. **Integrated continuous care pathways**
   - In Year 1, particular focus will be placed on implementing existing regional prototypes of continuous care pathways that consider the needs of the whole person. This includes care for:
     - People at end of life and/or palliative care (to be further scoped by subject matter experts)
     - People who are healthy, but present with minor acute gastrointestinal/genitourinary (GI/GU) conditions
     - Seniors with dementia (planned for out-years)
   - Additional care pathways will be developed based on needs of the population

Potential populations of focus and our principles for decision-making

Impact

Improves the efficiency and effectiveness of our system to free up capacity and resources; influences highly prevalent/resource-intensive conditions; considers the diverse needs across our community and opportunities to improve outcomes across the lifespan

Feasibility

Supported by best-practice, proven pathways; leverages work underway and considers readiness of our partners; considers complexity/size of populations

Partnerships

Builds a strong foundation with our core partners through early, quick wins; sets us the partnership up to tackle more challenging issues together in future; initiatives resonate with teams and address the pressures affecting patients and families, primary care, home care, community and hospitals

People at end of life

- 46% of people who die in our community do so without receiving palliative care
- An average of 54 patients per day receive palliative care in the hospital. Many of these patients could receive care in the community
- The MH LHIN has one of the longest palliative home care wait times in Ontario

People presenting with gastrointestinal and genitourinary conditions

- Minor acute utilization of the emergency department, including for GI/GU, is the top category of utilization across all sectors
- Visits for these conditions account for 8.3% of all emergency department visits in a year

Seniors with dementia (future years)

- Dementia is one of the leading causes of death among residents in our community
- Of people living with dementia in our community, only 54% received home care in 2015/16

Sources include: Mississauga Halton LHIN IHSP, 2016-2019; Health Quality Ontario Dementia Quality Standard; ICES population data; Seow et al. BMC Palliative Care (2018) 17:70; Trillium Health Partners data

Identifying improvement opportunities

Healthy living and care across life-stages

Childhood → Adulthood → End of Life

	Criteria	Minor Acute		Adults with Chronic Disease (COPD or CHF**; to include a stream for comorbid mood disorder)	Seniors with Dementia	People at End of Life
		Children's Mental Health	People with gastrointestinal/ genitourinary (GI/GU)*			
Impact	Prevalence	Medium	High	High	Low	Low
	Cost drivers and utilization	Low – Medium	Medium	High	High	High
	Addresses capacity constraints	Low	Medium	Low – Medium	Medium	High
	Timeliness to see change	Medium	High	Low – Medium	Medium	Medium
	Patient/caregiver experience	High	High	Low - Medium	High	High
Feasibility	Active clinical leadership	High	Medium	Medium	High	High
	Work underway	Low – Medium	Low	Medium	High	High
	Degree of change required	Medium	Medium	High	High	Medium - High
	Hospital readiness (Y1 engagement)	Medium	Medium	Low	Medium - High	Medium
	Primary care readiness	Medium	High	Low	Low	Medium
	Home care readiness	Medium	High (N/A)	High	Low	Medium
	Evidence-based and proven pathways	Medium	Medium	High	High	High
Partnerships	Builds foundation (core partners)	Medium - High	Medium	High	High	High
	Partners already involved	Low	High	Medium	Medium	Medium

Social determinants of health and co-morbidities considered throughout

*Intervention to focus on comorbid mood disorders in the short-term, but will need to build beyond to encompass other comorbidities being managed by this population

Next steps

Over the coming weeks and into the fall, we will be engaging with patients, family members, providers and community members as we develop the Full Application.

This will include focused co-design sessions to understand the opportunities identified to improve care for our population on **August 27th**.

We will coming back with another information session in September to share the outputs of this co-design process and to keep you updated as this work continues to shape.

Our application is due to the Ministry on October 9th, 2019. While the goal is to have a high-level plan for Year 1 and out-years included, we will be continuing to shape our approach throughout the fall.

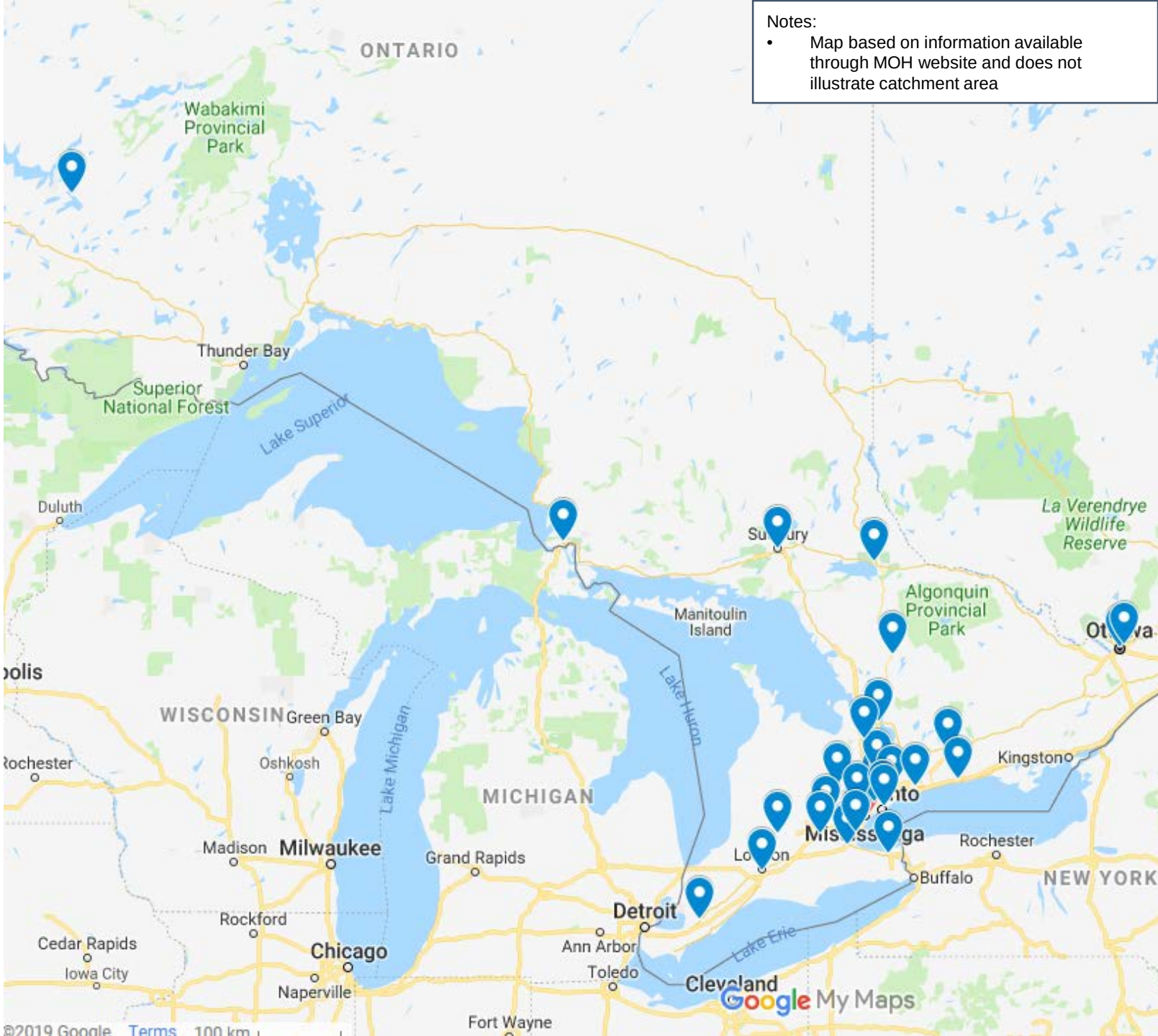
Please reach out if you would like to be included on our stakeholder distribution list, so you can continue to hear about future opportunities to engage.

Thank you again for your ongoing support for the creation of a Mississauga OHT.
If you have any questions, please contact info@moht.ca**.**

Appendix

OHTs in Full Application

Location	Team Name (Provisional)
Hunstville	Muskoka and Area OHT
Oakville	Connected Care Halton OHT
Orangeville	Hills of Headwater
Toronto - North West	North Toronto OHT
Richmond Hill	West York OHT
Toronto/North York	North York Central Health System OHT
Newmarket	Southlake Community OHT
Orillia	Couchiching OHT
Markham	Eastern York Region and North Durham OHT
Barrie	Great Barrie Area OHT
Guelph	Guelph and Area OHT
Mississauga	Mississauga OHT
Brampton	Brampton, Bramalea, North Etobicoke, Malton and West Woodbridge OHT
Peterborough	Peterborough OHT
Ottawa	Ottawa Health Team/Équipe Santé Ottawa
Cobourg	Northumberland OHT
Ottawa - East	ÉSO Ottawa-Est/Ottawa East OHT
Oshawa	Durham OHT
Kenora	All Nations Health Partners OHT (Kenora)
North Bay	Near North Health and Wellness OHT
Sault Ste. Marie	Algoma OHT
Sudbury	Équipe Santé Sudbury and Districts OHT
Toronto - North East	North Toronto OHT
Toronto/East York	East Toronto Health Partners
Hamilton	Hamilton OHT
Burlington	Burlington OHT
Stratford	Huron Perth and Area OHT
London	Western OHT (London)
Chatham-Kent	Chatham Kent OHT
Cambridge	Cambridge OHT
Niagara Falls	Niagara OHT



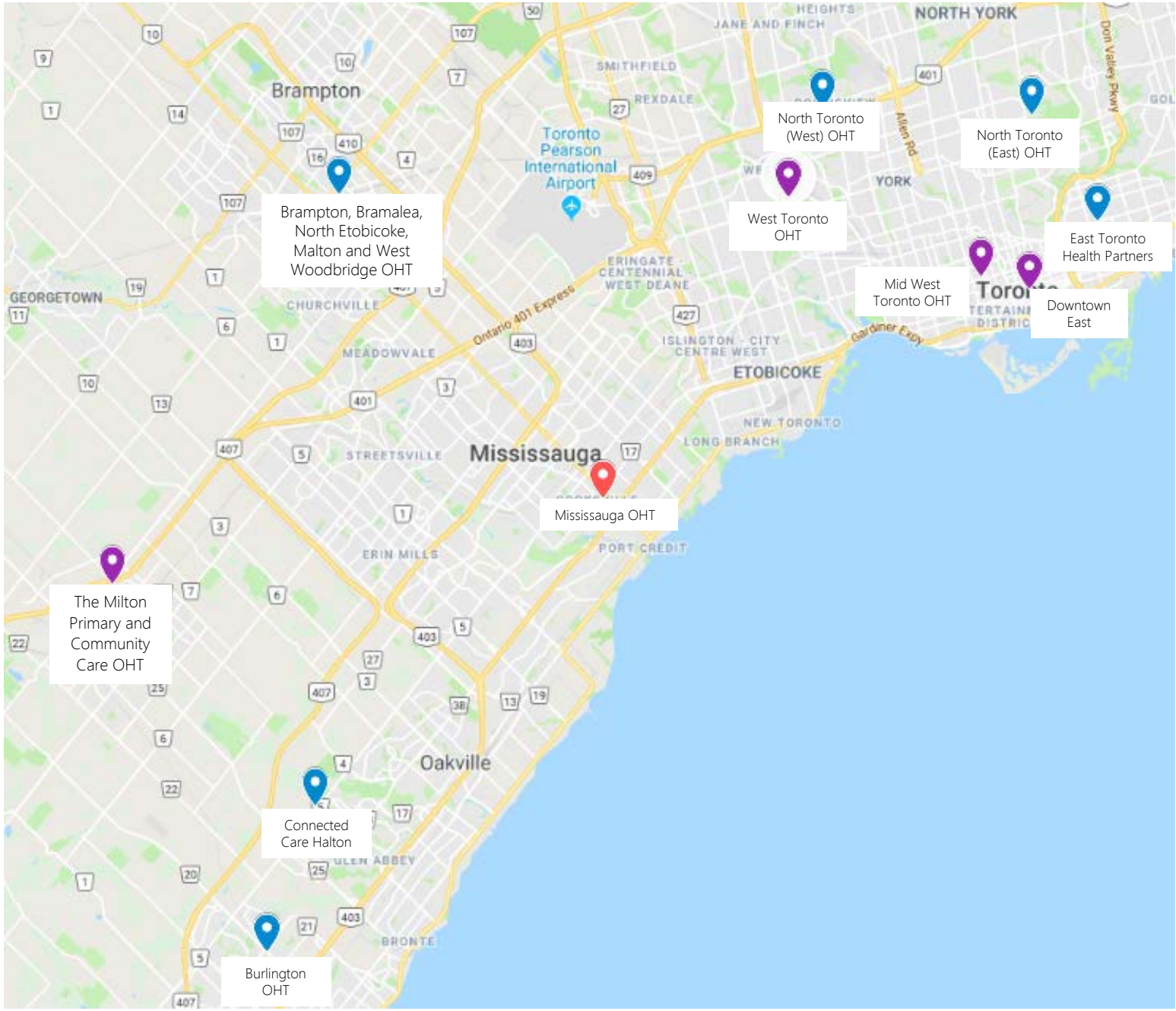
OHTs Bordering M-OHT

OHTs in **Full Application** that are in the same vicinity as the M-OHT include:

- Brampton, Bramalea, North Etobicoke, Malton and West Woodbridge OHT
- Connected Care Halton
- Burlington OHT
- North Toronto (East) OHT
- North Toronto (West) OHT
- East Toronto Health Partners

OHTs **In Development** include:

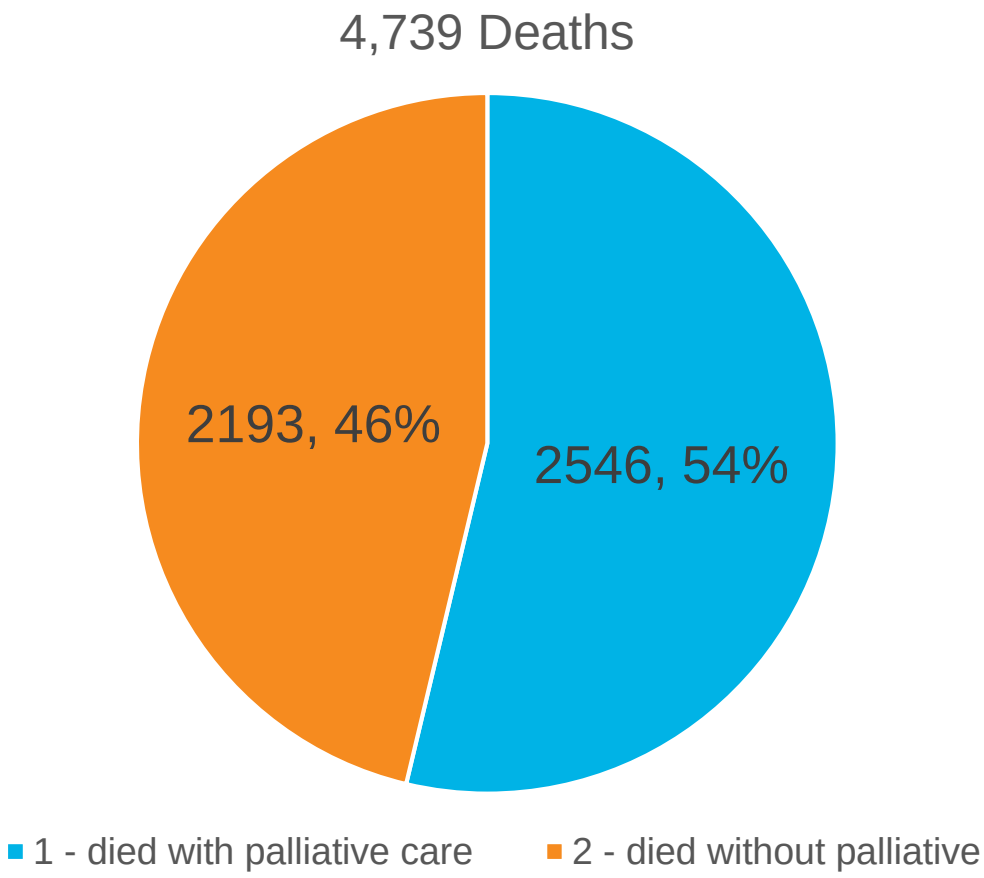
- The Milton Primary and Community Care OHT
- West Toronto OHT
- Mid West Toronto OHT
- Downtown East



Emergency department visits for minor acute conditions: Gastrointestinal and genitourinary

Data sources: CIHI DAD, NACRS and OHIP databases; All data are proportional estimates and will depend on further defining population

Palliative care in our population



21,188 Palliative care billings without death observed over one year

Data sources: CIHI DAD, NACRS, OHIP and ODP databases; Home Care, CCRS and CCC databases; All data are proportional estimates and will depend on further defining population