Connected Care Halton
ONTARIO HEALTH TEAM

CONNECTED CARE HALTON OHT: FULL APPLICATION SUMMARY

October 30, 2019

BACKGROUND

On June 18, 2019 the Connected Care Halton Ontario Health Team (CCHOHT) received correspondence from the Ministry of Health (MOH) that the Connected Care Halton OHT Readiness Assessment had been evaluated and that we were **one of 31 proposals asked to proceed to the next step of submitting a 'Full Application'**. The CCHOHT Collaborative Committee reconvened to begin coordinating and planning for our response to the Full Application.

This involved a comprehensive communications protocol to ensure that our co-signatories and those who signed an Expression of Interest (EOI) were informed of the correspondence as well as our anticipated next steps.

In July and August, a series of work streams and advisory working groups were activated, comprised of individuals from across the health system including representation from Patient and Family Advisors. In addition to work streams focused on the two sub-populations of interest (palliative care and mental health & addictions) the following advisory/working groups were established to advance the CCHOHT Full Application:

- **Physician Advisory Group**
- **Patient and Family Advisory Group**
- **Decision Support Working Group**

These working/advisory groups drew people from across the Region of Halton, including those primary care physicians and health service providers who had signed an EOI and, where appropriate, included representation from each of our OHT application co-signatories. In total, over **450 individuals were engaged** as a part of our CCHOHT Full Application Process.

On **October 4, 2019, the Connected Care Halton OHT Full Application was submitted** to the MOH for their review and evaluation. We are grateful to each of our health system partners, subject matter experts, and every individual who assisted in the development of the Full Application.

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CORE ELEMENTS OF THE CCHOHT FULL APPLICATION

OUR ATTRIBUTED POPULATION

In the Connected Care Halton (Halton Hills, Milton and Oakville) OHT (CCHOHT) **Readiness Assessment, it was identified that the population served by the CCHOHT in 2019 is approximately 350,000**. This population was largely derived through examination of the 2016 and forecasted population statistics provided by municipal planning estimates through the Region of Halton.

During the summer 2019, the MOH evolved the methodology by which population estimates were derived for Ontario Health Teams and introduced the concept of "Attributable Population". Based on a 2006 Institute for Clinical and Evaluative Studies (ICES) study that analyzed both physician billing codes and patient utilization patterns, the revised methodology suggests that the place of origin of a patient does not determine where health services will be accessed and utilized; more important to this equation are the variables of patient choice and/or physician referral patterns.

In July 2019, the CCHOHT received a data package from the MOH that defined our attributable population based on the methodology outlined above is **397,436. This is both larger and more geographically heterogeneous than we previously assumed**. Our analysis suggests that the attributable population assigned to the CCHOHT will serve as a starting point around which population health statistics can be derived and through which health planning can occur.

YEAR 1 TARGET POPULATIONS

Throughout August and September 2019, a series of working sessions were held, each focused on **generating consensus around our Year 1 target populations as well as populating key sections of the Full Application**. Feedback from our partners was to **focus on establishing trust, strong partnerships and demonstrate progress on a targeted population in our first year**. While the CCHOHT will address broader and larger groups of residents and disease states in future years, Year 1 will focus on **building partnerships, Information Communication & Technology (ICT) infrastructure, leadership structures around two sub-populations: palliative care and mental health & addictions**.

These populations are outlined below:

Palliative Care

Through our preliminary work in our Readiness Assessment, the subsequent work of our CCHOHT Decision Support Working Group and analysis of the second Data Package provided by the MOH, we determined that the CCHOHT will focus on specific populations accessing Palliative Care Services in our communities in Year 1.

We continue to see variation in both the utilization and availability of palliative services offered to our population, in each of our key catchment areas. For example, we see significant variation in the amount of home care and physician services in the last 90 days of life utilized by palliative patients, **particularly in Halton Hills where a robust, 24/7 palliative care service is not in place**. We also see a **higher percentage (58.5%) of palliative patients in Halton Hills needing to utilize the Emergency Department (ED)** in the last 30 days of life versus 51.9% and 49.1% in Milton and Oakville respectively. The over-utilization of ED for these patients in Halton Hills is often a leading indicator that appropriate palliative services are not in place to support symptom and pain management at the patient's place of residence.

With these measures and indicators in mind, our Palliative Care work stream identified a sub-population of patients that met our selection criteria but also were identified as 'problematic' for primary care physicians. Specifically, the inclusion criteria for this population included ***adult patients with a life limiting illness with an estimated prognosis of less than 12 months, who are accepting of palliative care services.*** Specific exclusions from this population included *Youth & Adolescent Palliative Patients, Palliative Patients in a Long Term Care Facility, and Patients who refuse a palliative designation or services. These exclusions* were identified as potential Year 2 target populations.

For Year 1, Mississauga Halton Palliative Care data would suggest that **number of patients meeting the inclusion criteria in FY17/18 for Halton is equal to approximately 1,600 individuals.**

Mental Health & Addictions

Through our preliminary work in our Readiness Assessment, the subsequent work of our CCHOHT Decision Support Working Group and analysis of the second Data Package provided by the MOH, we determined that the CCHOHT will focus on specific populations accessing **Mental Health & Addiction Services** in our communities in Year 1.

Through data analysis we were able to determine that a specific sub-population represented a significant volume of patients moving through our central intake process on an annual basis and for whom access to community-based services was essential but currently a challenge. The patients, referred to as **"LOCUS Level 3" patients, are individuals requiring mental**

health and addiction services, do not require hospitalization, but if left unmanaged without regular support, could easily degrade and require immediate hospitalization.

The LOCUS Level 3 population represents a significant proportion (57%) of the population served by our e-referral system (e.g. one-Link) and anecdotally, it has been suggested by our primary care collaborators that this population (typically presenting in their offices with clinical indications of depression, anxiety, mixed anxiety/depression, addiction to alcohol and/or cannabis, post-traumatic stress disorder (PTSD), eating disorders or psychosis) **represents, on average 40% of a primary care physician's daily caseload**.

Our CCHOHT Decision Support Working Group reviewed the last three years of data and identified both the referrers and requesting locations (offices) as sending more than 50% of referrals to one-Link where the individual was from Oakville, Milton or Halton Hills and attributed them to our CCHOHT. The result of this analysis suggests that approximately **1,600 referrals came through one-Link in FY18/19 for LOCUS Level 3 from these locations**. *Youth & Adolescent patients and all other LOCUS levels (1, 2, 4, 5 and 6) were excluded from this analysis.*

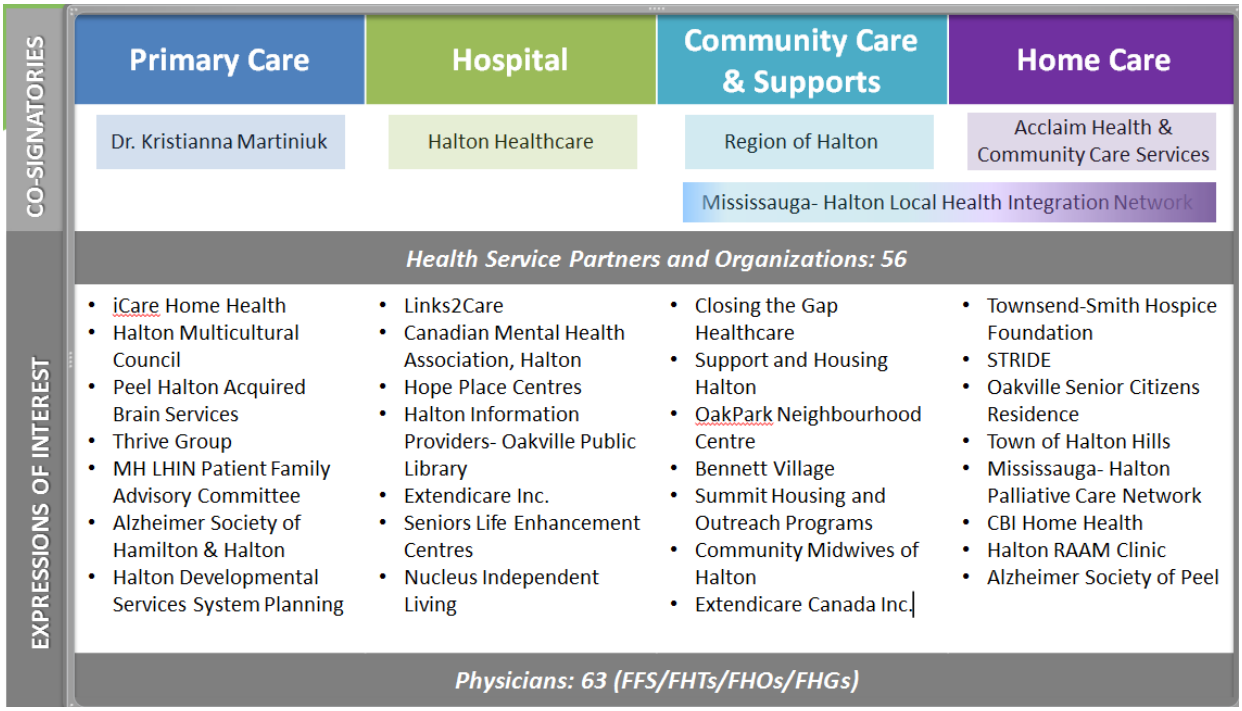
The focus of our first year efforts should be the 1,600 patients estimated to be part of our palliative care sub-population and the 1,600 individuals who are included in our LOCUS 3 Level mental health & addictions population. **Approximately 3,200 individuals will serve as an appropriate Year 1 sub-population**. Although small (approximately 1% of our attributable population) we do believe that this population will serve as a credible base upon which strong, trusting partnerships can be established along with necessary health system structures (e.g. leadership and governance) and ICT solutions.

OUR TEAM

Our working groups drew people from across the Region of Halton including those primary care physicians and health service providers who had signed an EOI and, where required, included representation from each of our CCHOHT application co-signatories. As a reminder, our co-signatories for the application were:

- Acclaim Health and Community Services
- Dr. Kristianna Martiniuk
- Halton Healthcare
- The Mississauga Halton LHIN
- The Region of Halton

In total, over **450 individuals were engaged** as a part of our CCHOHT Full Application Process. Upon submission of our Full Application, we had the support of **our five co-signatory organizations as well as EOI from over 63 physicians and 56 health service providers and health service organizations**.



HOW OUR OHT WILL WORK TOGETHER?

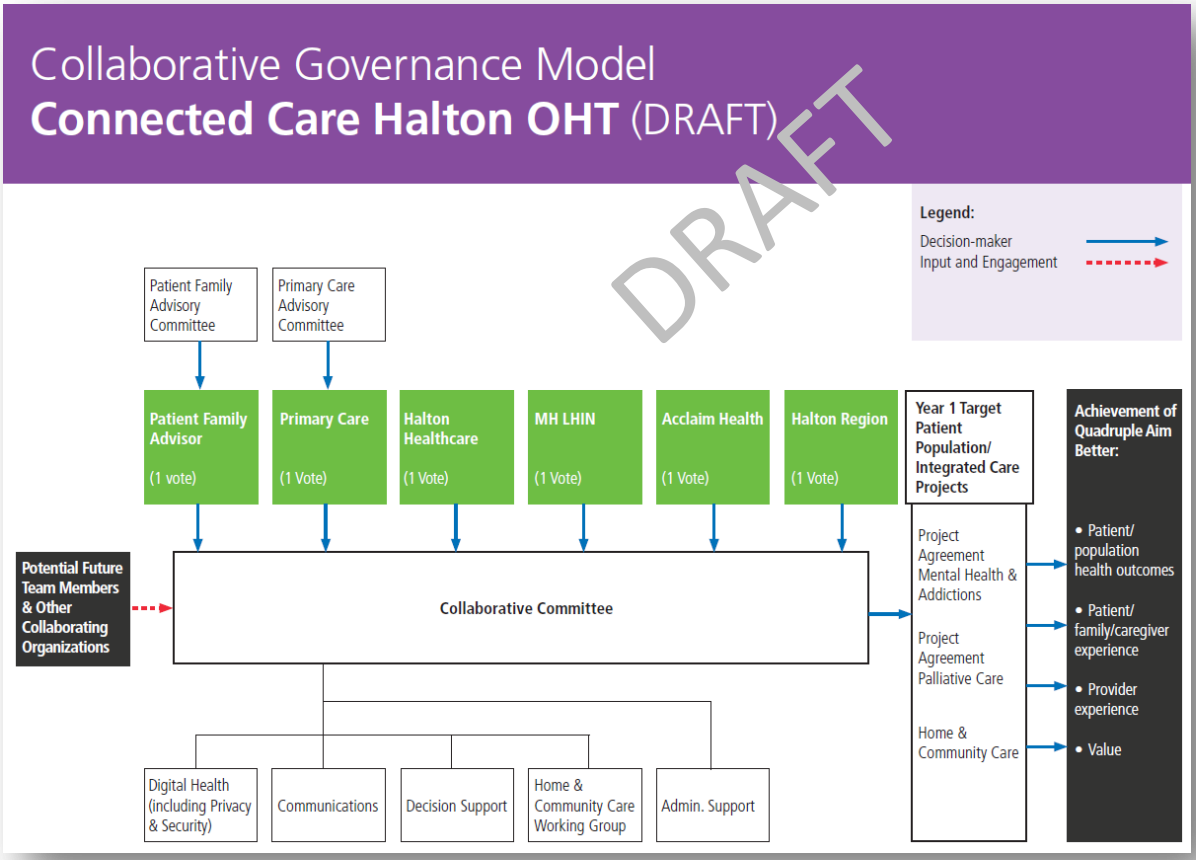
In our full application submission, we were asked to outline how we would govern ourselves, provide leadership and work together to make shared decisions. Establishing this for the CCHOHT was an important undertaking.

With this context in mind, the CCHOHT **Collaborative Committee has developed a DRAFT Governance Model for the CCHOHT**. This model seeks to identify the key elements of decision making, processes and supporting structures. Although we recognize that this model may evolve over time, a **draft** graphical representation of this model is shown below.

The draft model contains a Collaborative Committee with six signatories as members. Each member has one vote. Informing the Committee are Patient & Family Advisory Committee, Primary Care Advisory Committees and a number of working groups including Digital Health, Communications, Decision Support, and Home and Community Care. Additional working groups may be added as required. There are also a number of Integrated Care Projects that

represent our sub-populations as well as Home & Community Care. All these elements inform the Collaboration Committee in its decision making activities.

It is important to understand that the "draft governance model" is really a decision making structure to support Year 1 activities. The CCHOHT has determined **all six members have a single and equal vote and that the model will not impact existing local governance structures.**



It is important to note that Primary Care in our Region is largely diverse and distributed across our geography. The **CCHOHT will not 'prescribe' a governance structure for our primary care partners** and we continue to work with our Primary Care partners to understand how they would like to be represented on the CCHOHT Collaborative Committee.

We also recognize the **importance of representation of patients and families** within the leadership and governance model of the CCHOHT. Across each of our partner organizations,

we have engaged and activated a series of patient and family advisor channels including, but not limited to, Patient Family Advisory Councils (PFAC), Community Advisory Committees, and Patient Representation on Committees and Project Working Groups. We are committed to ensuring that this representation continues with the CCHOHT moving forward.

IMPLEMENTATION PLAN & NEXT STEPS

The OHT Full Application delineates a plan for implementation in Year 1. We will leverage initiatives currently underway or completed to date. Work plans for 30, 60, 90 days, as well as six months are being developed with a focus on:

- Advancing clinical coordination work for our targeted sub-populations;
- Developing strong relationships and trusted collaborations;
- Establishing comprehensive decision making structures;
- Ensuring strong mechanisms for primary care engagement;
- Enabling patient/family/community engagement in system planning, design and evaluation

With respect to **Home and Community Care**, our application articulated a future vision for home and community care where individuals receive high quality, patient-centred, integrated services needed to live well in their community and, that are financially sustainable. There are significant provincial considerations regarding the implementation of the future home and community care model, which will need to be addressed by the Ministry of Health and Ontario Health, working in close **collaboration with the OHTs**.

With respect to Digital Health we will focus our Year 1 effort in a number of key areas:

- **Virtual Care:** We are well-positioned to achieve the target of 2-5% of Year 1 patients receiving a virtual encounter particularly through our sub-populations.
- **Digital Access to Information**: The one-Link solution that supports e-Referral has been in place for many years and we will expand our use of this platform to include more clinical pathways.
- **Digitally Enabled Information Sharing**: We will implement the provincial e-Notification system to ensure Home & Community Care and Primary Care providers are notified when their patients are seen in the ED, admitted to hospital, and discharged.
- **Digitally Enabled Quality Improvement**: We will focus on leveraging existing assets and education to help foster adoption and performance improvement. Facilitation of longer term planning will include a full inventory of data sources and architect a regional OHT data warehouse to facilitate system level planning, quality and performance improvement.

We await feedback from the Ministry of Health (MOH) on our Full Application and have been notified that the evaluation will be completed in late fall. Updates, key information and FAQs are posted on our website at https://connectedcarehalton.ca/.