INTEGRATED CARE: THE PAST; THE PRESENT; AND THE FUTURE?

MARCH 4, 2020

PREFACE

THE OPINIONS SHARED IN THIS PRESENTATION ARE PERSONAL AND REFLECT MY FRONT ROW SEAT ON AN EXCITING HEALTH CARE JOURNEY.

WARNING: I AM HOPEFUL AND OPTIMISTIC ABOUT THE FUTURE OF OUR GREAT HEALTH CARE SYSTEM

FOR THE PURPOSE OF THIS PRESENTATION, I OFFER LESSONS LEARNED, SUCCESSES, AND OPPORTUNITIES AS WE CONTINUOUSLY CHALLENGE OURSELVES TO DELIVER TO OUR PATIENTS, CLIENTS, CAREGIVERS, FAMILIES, COMMUNITIES, CITIZENS, AND RESIDENTS A WORLD CLASS HEALTH CARE EXPERIENCE

IN MY DIALOGUE WITH BRIAN, WE CAN EXPLORE SOME OF THESE AREAS IN FURTHER DETAIL

RECALL: BREAKFAST WITH CHIEFS - 2018

IN 2018, I PRESENTED *INTEGRATED HEALTH DELIVERY SYSTEMS*. THE FOLLOWING SLIDE REFLECTED MY VISION FOR WHAT AN INTEGRATED HEALTH DELIVERY SYSTEM IN ONTARIO WOULD LOOK LIKE.

IN A FUTURE STATE, WE WILL:

- CHANGE HOW WE ALLOCATE FUNDING TO MATCH POPULATION NEED
- FACILITATE INTEGRATIONS TO ACHIEVE DELIVERY NETWORKS
- SUBMIT COLLABORATIVE QIPS TO HQO
- REPORT ON HEALTH OUTCOMES AND EXPERIENCE AT THE SUB-REGION LEVEL
- MANAGE A SINGLE ACCOUNTABILITY AGREEMENT WITHIN EACH SUB-REGION
- PROVIDE ONE SIMPLE AND COORDINATED ACCESS SYSTEM FOR CARE THAT WILL INCLUDE ONE NUMBER TO CALL

What will an integrated health delivery system look like?

Funder

One needs-based funding allocation (population based, sub-region)

Integrator

One locally integrated service delivery network with **One** collaborative Quality Improvement Plan (QIP)

Performance Manager

One publicly reported population and person-centred scorecard with **One** outcome-based shared accountability agreement

Service Provider

One simple and coordinated access system for care

WHAT IS INTEGRATED HEALTHCARE?

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

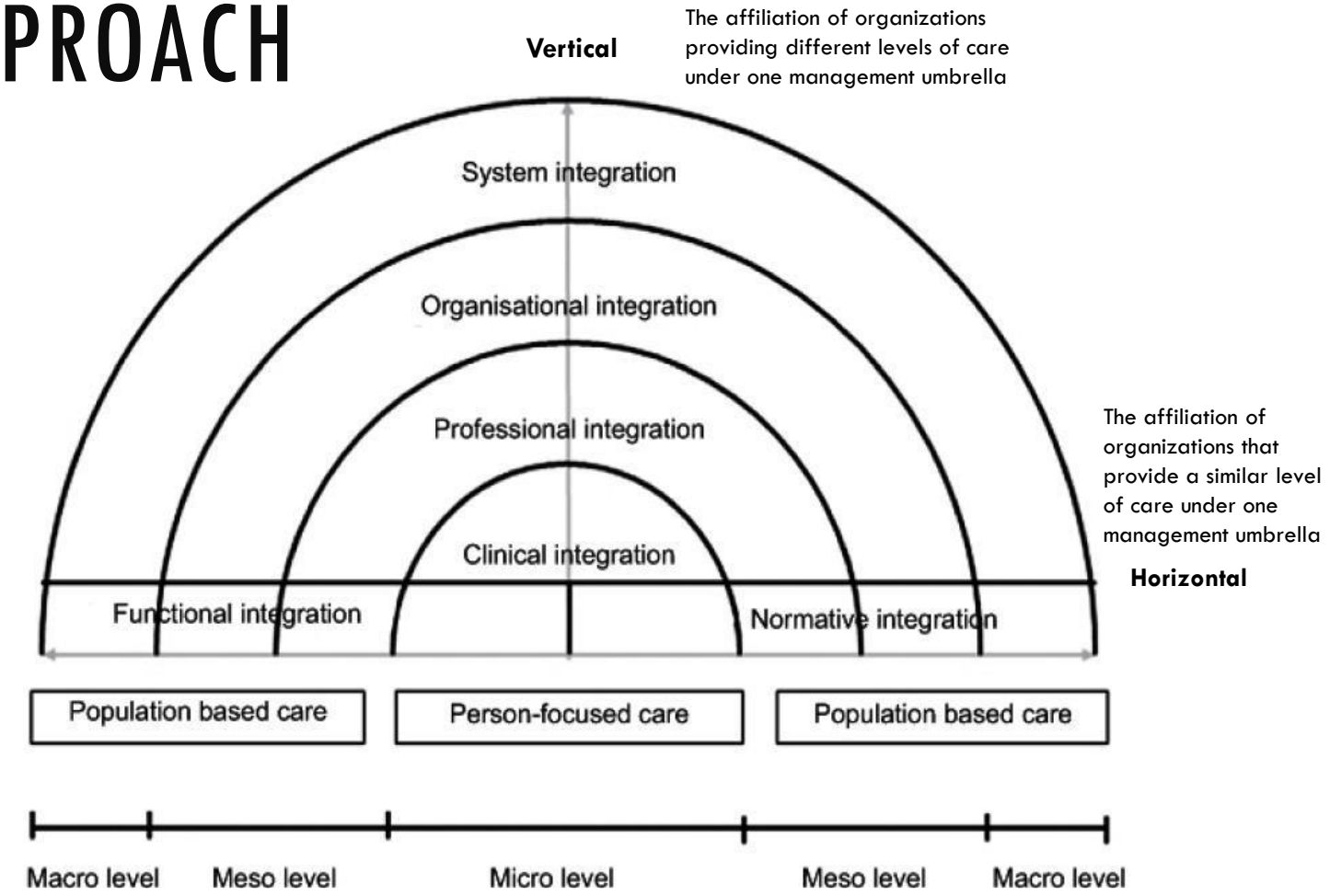
Characteristics of an ideal organized health system

- focusses on meeting the community health needs
- matches service capacity to community
- coordinates and integrates care across the continuum
- has information systems to link consumers, providers, and payers across care continuum
- provides information on costs, quality, outcomes, and consumer satisfaction to multiple stakeholders
- uses financial incentives and organizational structure to align governance , management, physicians, and other providers to achieve objectives
- is able to continuously improve the care it provides
- is willing and able to work with others to ensure objectives are met

Peggy Leatt, George Pink, Michael Guerriere
Towards a Canadian Model of Integrated Healthcare

A COMPREHENSIVE APPROACH

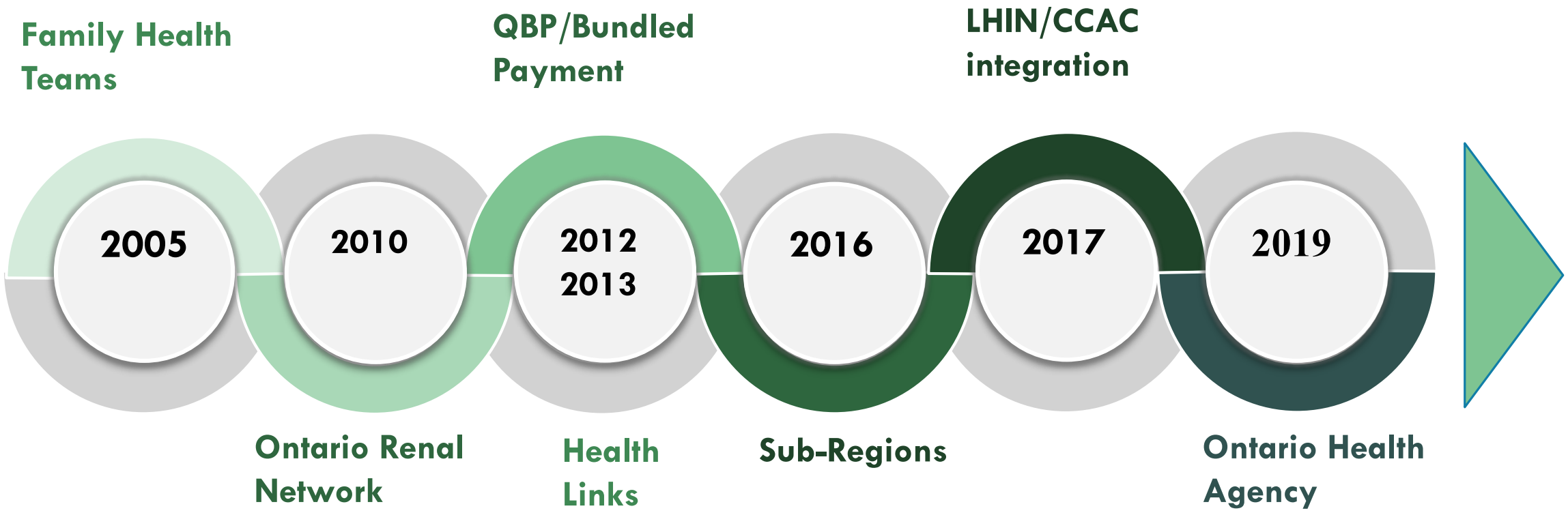
Integration is best pursued at multiple levels within a system in order to facilitate the continuous, comprehensive, and coordinated delivery of services to individuals and populations



Valentijn, P. P., Schepman, S. M., Opheij, W., & Bruijnzeels, M. A. (2013). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care.*International Journal of Integrated Care*,*13*, e010.

WHAT IS INTEGRATION IN THE ONTARIO CONTEXT?

Key Milestones over the past 15 years



We've been coming at integration on multiple fronts for many years, building the foundations that will move us to a fully integrated health system

1. FAMILY HEALTH TEAMS
2. QUALITY-BASED PROCEDURES
3. BUNDLED PAYMENTS
4. ONTARIO RENAL NETWORK
5. HEALTH LINKS

THE PAST:
1995 to 2015

FAMILY HEALTH TEAMS 2005

Primary Care Health Care Professionals coordinate services across disciplines

Primary health care organizations with a team of family physicians, NP's, registered nurses, social workers, dieticians and others who work together to provide primary health care for their community. Since 2005, there are 184 FHT's with over 3 million Ontarians enrolled across 200 communities

An Integration Milestone:

- Professionals coordinate services across various disciplines *by bringing* health care professionals into the same management structure (e.g. NP; pharmacist)
- Early move to ***functional integration*** *(explain)*

Why Does it Matter?

- The functions of primary care – first contact, continuous, comprehensive, and coordinated care - make primary care the starting point from where to improve and integrate care
- We can't reach full health system integration without strong primary care integration *(add medical home)*

ONTARIO RENAL NETWORK 2010

Structures, processes, and programs to fit the needs of a patient population

Fund, organize, and manage the delivery of chronic kidney disease services with the aim to reduce the burden of disease on patients and the health care system. An evidence-based approach supports effective planning, programming, and funding to continuously improve care. Historically part of CCO.

An Integration Milestone:

- Systems integration of a disease burden replicating successful CCO model.

Why does it matter?

- Demonstrates a replicable model for acute diseases
- Early leader in implementing QbP for CKD

QUALITY-BASED PROCEDURES 2012

Health Care Professionals coordinate service across various disciplines

Specific groups of services that offer opportunity for health care providers to share best practices to achieve even better quality and system effectiveness. cross-sectoral, multi-geographic, and multi-disciplinary including participation including patients. QbP's account for about 14% of the hospital budget at approx. $3.5 billion annually.

An Integration Milestone

- Uses financial incentives and organizational structure to align care to achieve objectives

Why Does it Matter?

- The use of best practices promotes the standardization of care by reducing inappropriate of unexplained variation.

BUNDLED PAYMENT 2013

Patient Care services are coordinated

Bundled care is a service delivery and funding model that is designed to promote integration, drive quality, improve patient outcomes and experience. St. Joseph's Healthcare Hamilton's Integrated Comprehensive Care Demonstration Project (ICCP) was the first team to pioneer the bundled model in Ontario. Key successes include reductions in length of stay, readmission, and ED visits while also improving patient and provider experience.

An Integration Milestone

- A group of providers receive a single payment to cover the care needs of an individual patient's full spectrum of care for a specific issue

Why it Matters

- Bringing funding together across silos
- Evaluating success across the health continuum
- Focus on patient and provider experience

HEALTH LINKS 2013

Coordinating services across organizations to link-up care

A team of providers in a geographic area (primary care, hospital, home and community care, long-term care and other community partners) working together to provide coordinated health care to patients with multiple complex conditions (often seniors) with the patient at the center. Providers working together with patients and families design a care plan to ensure they receive the care they need. There are 82 Health Links.

An Integration Milestone

- Created coordinated care plans across a continuum of services and providers all developed with the patient

Why Does it Matter?

- Built ensuring relationships with providers; built trust and learned how to work together
- Brought primary care into strong role
- Shifted focus to patients and families and involved them in planning

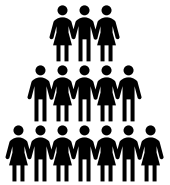
LHIN: 1. SUB-REGIONS
2. LHIN/CCAC INTEGRATION
3. HEALTH SERVICE PROVIDER INTEGRATIONS

ONTARIO HEALTH: 4. MERGER OF 20 AGENCIES

THE PRESENT
2015 to 2019

LHIN: SUB-REGIONS 2016

Coordinating services across organizations tailored to the community



An Integration Milestone:

- Building on Health links experience, shifted to a community focus

Why does it matter?

- Shifting from coordinating care for a single patient to a community
- Deepening understanding of the community and the providers
- Engaging new partners: Public Health, Cities, Municipalities
- Successful applications for OHT: East Toronto and North Toronto

	**Population: 347,820** **Males: 48.8%** **Females: 51.2%** **% Children and Youth (ages 0-19): 13.2%** **% Seniors (ages 65+): 12.9%**	• **2nd highest proportion of immigrants (37.4%), but relatively low rate of recent immigrants (4.9%)** • **Highest rate of individuals with no knowledge of English or French compared to other local regions.** • **Most common non-English languages are Portuguese, Mandarin, and Cantonese** • **Mid-West Toronto has the 2nd highest number of homeless shelters in the LHIN (24) totaling 1,099 beds** • **Other than diabetes, rates of chronic \disease slightly lower compared to other local regions in 2016-17**
	**Population: 158,730** **Males: 52.0%** **Females: 48.0%** **% Children and Youth (ages 0-19): 12.9%** **% Seniors (ages 65+): 12.8%**	• **Highest proportion of seniors living alone (43.9%) in Toronto Central LHIN** • **North St. James Town and Regent Park have particularly high levels of marginalization** • **Highest number of homeless shelters in the LHIN (31) with the highest number of beds (1,911 beds)** • **Slightly lower rates for all chronic diseases (except COPD) among the local regions for adults 20+ years in 2016-17**
	**Population: 245,490** **Males: 48.2%** **Females: 51.8%** **% Children and Youth (ages 0-19): 18.9%** **% Seniors (ages 65+): 14.9%**	• **Slightly higher proportion of residents who speak English (80.6%) compared other local regions** • **Almost half of West Toronto neighbourhoods have more than a third of seniors that live alone in private households** • **Higher levels of marginalization in Rockcliffe-Smythe and Mount Dennis. South Parkdale has a large potentially vulnerable population with high rates of persons with low income** • **Slightly higher prevalence of chronic diseases compared to other regions**
	**Population: 203,700** **Males: 46.2%** **Females: 53.9%** **% Children and Youth (ages 0-19): 22.0%** **% Seniors (ages 65+): 16.0%**	• **Highest proportion of seniors aged 65 years and older in 2016 (16.0%) amongst local regions, and the 2nd highest rate of seniors living alone (35.9%)** • **Highest proportion of high income households compared to other Toronto Central LHIN regions** • **Mount Pleasant West neighbourhood in particular has a potentially vulnerable population with a high rate of residents with low income (20.9%) and high rate of seniors living alone (55.1%)** • **Lowest prevalence rates for Diabetes, Mental Health Visits and chronic obstructive pulmonary disease (COPD) of all local regions in 2016-17**
	**Population: 275,385** **Males: 48.3%** **Females: 51.7%** **% Children and Youth (ages 0-19): 23.1%** **% Seniors (ages 65+): 13.7%**	• **Highest proportion (23.1%) of children and youth (0-19 years) in 2016 among the local regions** • **Highest proportion of recent immigrants (arrived between 2011-2016) with top three countries being: Bangladesh (14.8%), Philippines (12.2%) and Pakistan (10.8%)** • **Most heavily represented visible minorities relative to Toronto Central LHIN are South Asian, West Asian and those identifying as Black** • **Highest prevalence rate for all chronic diseases (except asthma) among local regions for 20+ years**

LHIN/CCAC INTEGRATION 2017

Key functions and activities are coordinated to add value

Create a strong integrated leadership to support ongoing transformation to a more patient-centered system that delivers high-quality integrated care. The merger initially contributed to health system efficiency as a result of bringing two organizations together with similar corporate functions with a commitment to improve integration, planning, access and accountability by bringing LHIN HSP relationships and home care closer together.

An Integration Milestone

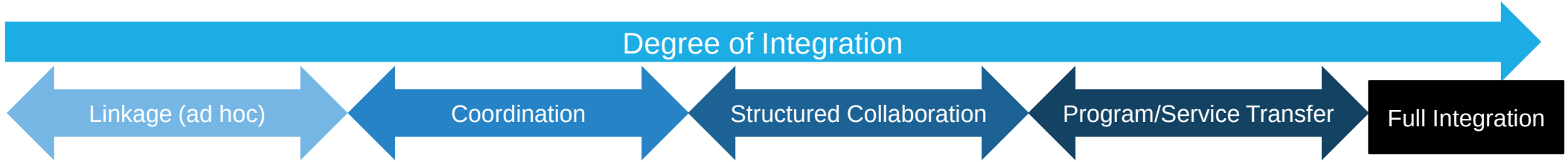
- Finding value by bringing 2 organizations with different mandates together: planning and funding with direct service delivery

Why does it matter?

- Focus on home care and integration brought together
- What can happen when home care is more directly linked to primary care and community health service providers?

LHIN: HEALTH SERVICE PROVIDER INTEGRATIONS

Patient care services are coordinated across various professional, institutional, and sectoral boundaries; key support functions are coordinated across organizations to add greatest value



Based on Kodner's model

What is integration at an organizational level?

- It reflects a continuum of approaches from informal relationships to structured collaboration to organizational integration

Why does it Matter?

- There are over 1800 HSP's ranging from budgets of $100k to $1 billion
- In Toronto Central, there were 180 health service providers over 5 sub-regions. The logistics of coordinating care can be challenging!

ONTARIO HEALTH: MERGER OF 20 AGENCIES

Key support functions, activities, services are coordinated across operating units to add greatest value

Building a health system that works for everyone by integrating provincial health agencies and programs to improve the patient experience. Ontario Health is responsible for **developing a modern and connected health care system** for every Ontarian by **bringing together the strengths of 20 agencies**, and the unique expertise of their highly skilled staff, and applying the best of what they do to benefit all Ontarians.

- Expansion of the current **exceptional clinical guidance** and quality improvement practices
- Application of current **best-in-class models** to other parts of the health sector such as mental health
- Consistent oversight of **high-quality health care** delivery across Ontario
- More efficient approach to coordinating health care services for patients, improving the **patient experience** and enabling innovation
- Advancement of **digital first** approach to health care, such as virtual care
- **Clear accountability** for monitoring and evaluating the quality of health care services

ONTARIO HEALTH

20	agencies

- ✓ Health Quality Ontario
- ✓ Cancer Care Ontario
- ✓ Trillium Gift of Life Network
- ✓ Health Shared Services
- ✓ eHealth Ontario
- ✓ Health Force Ontario
- ✓ 14 Local Health Integration Networks

140+	sites across the province
11,800+	staff
$6B	operating budget
$25.5B	transfer payments to health service providers
1,851	accountability agreements with health service providers
1,022	quality improvement plans
2,000+	digital assets (systems and databases)
2,000	patient and caregiver advisors

HOME CARE PROGRAM

14	home care programs
7,000+	staff support or provide home care
~$888M	home care operation
~$2B	home care service contracts

- ✓ ~150 home care service provider organizations;
- ✓ ~250 contracts

1. POPULATION HEALTH/SOCIAL SERVICES

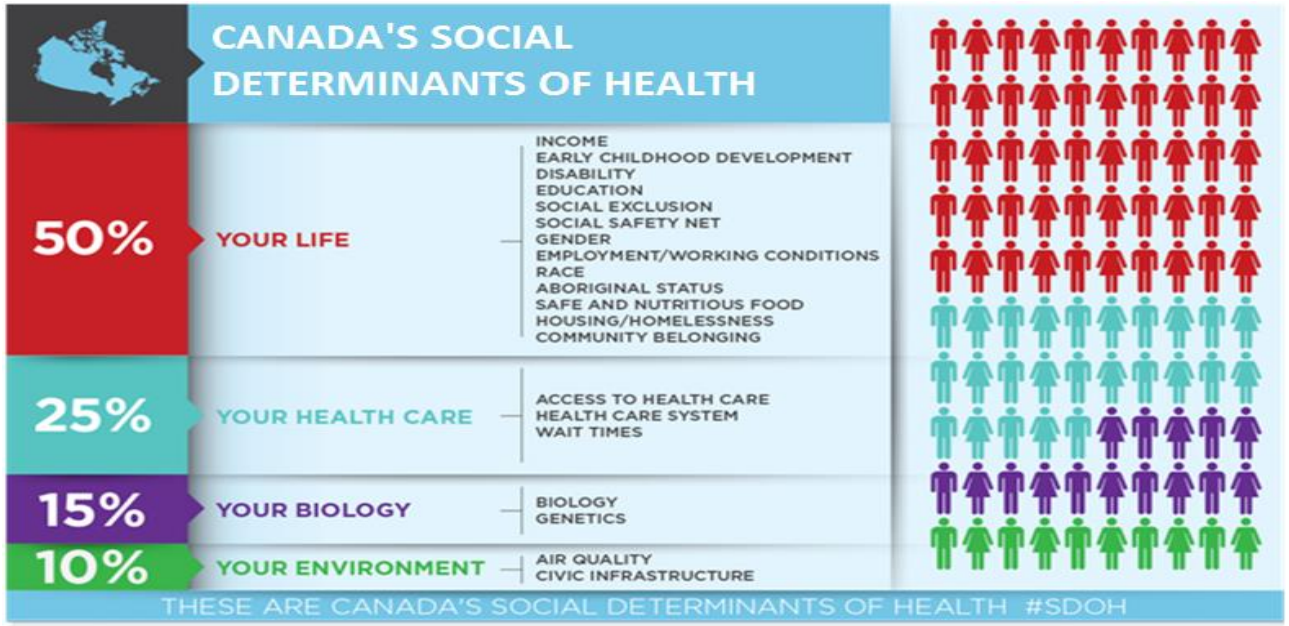
THE FUTURE? 2020 ONWARDS

POPULATION HEALTH: HEALTHY NEIGHBOURHOODS, THRIVING NEIGHBOURHOODS

- There is an increasing recognition amongst health system planners that **it takes more than a well-connected health care system to keep people healthy.**

- At the population level, **health care accounts for only 25%** of what affects our health.

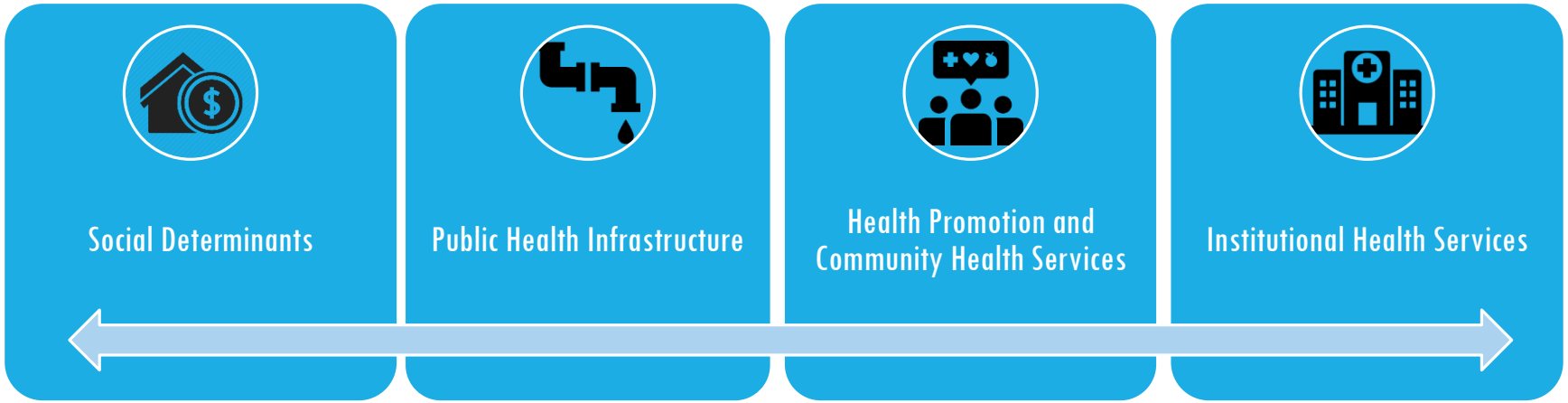
- **Partnerships** across organizations are critical to design communities with the broader array of supports that influence health and well-being.



SOCIAL SERVICES: SHARED RESPONSIBILITIES ALONG HEALTH CONTINUUM

UHN has provided for a unique affordable housing project in partnership with the City of Toronto and United Way as part of a Social Medicine Initiative

Service Resolution Tables to collectively work towards creating more appropriate care outside of hospital



- Education, income, employment
- Inclusion/ social connection
- Culture
- Healthy food
- Affordable housing
- Safety
- Political empowerment

- Air, water, waste
- Sanitation
- Transportation
- Parks and green space
- Childcare facilities
- Emergency Response

- Primary care
- In home health and social supports
- Supportive housing
- Community mental health and addictions
- Immunizations
- Nutrition
- Recreation

- Hospitals
- Long-term care
- Assisted living
- Mental health and addictions facilities

Working with Toronto Community Housing to align on-site heath services for seniors designated buildings

Inner City Health Associates provides health services to Toronto's homeless population including primary care, mental health and addictions at the City's shelters

The diagram reflects the understanding that all levels of government have a role to play in ensuring our population stays healthy.

CLOSING REMARKS

- Ontario is poised through the Ontario Health Teams initiative to significantly advance our progress towards full health system integration.
- There are 24 OHT's in the first cohort who are leading the way, and can build on experiences to date and lessons learned.

THANK-YOU