CITY OF HAMILTON
HEALTHY AND SAFE COMMUNITIES DEPARTMENT
General Manager's Office

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	September 16, 2019
SUBJECT/REPORT NO:	Ontario Health Teams Update (BOH19020(b)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Aisling Higgins (905) 546-2424 Ext. 2643
SUBMITTED BY: **SIGNATURE:**	Paul Johnson General Manager Healthy and Safe Communities Department

RECOMMENDATION(S)

(a) That the General Manager of Healthy and Safe Communities be authorized and directed to continue to participate in the local planning and development of Hamilton's Ontario Health Team application including the goals, principles, and objectives of Year 1 in accordance with the application;

(b) That staff be directed to report back to Board of Health with any updates on Hamilton's Ontario Health Team (OHT) proposal development including updates on the Ministry's process, future agreements, proposed changes to the provision of services, reallocation of resources related to the local Ontario Health Team planning; and,

(c) That the Mayor and City Clerk be authorized and directed to execute the Hamilton Health Team application in advance of the October 9, 2019 deadline to the Ministry of Health (MOH).

EXECUTIVE SUMMARY

Hamilton, like communities across Ontario, has been given an opportunity to transform and shape the future of local health service delivery and coordination by proposing new models of care to the Ministry of Health (MOH) through the development of local Ontario Health Teams (OHT). OHTs are groups of providers and organizations that, at maturity,

will be clinically and fiscally accountable for delivering a full and co-ordinated continuum of care to a defined geographic population. The Ministry's goal is for all health service providers to eventually join or become an Ontario Health Teams at maturity.

Through "OHT Readiness Assessment" process, the MOH established a multi-stage application and review process that enables local health care providers and organizations to self-organize and plan towards the development of an OHT. The implementation of full scale operational Ontario Health Teams will be incremental and will take many years to achieve full maturity. The OHT Model from Readiness to Maturity Summary document (attached as Appendix "A" to Report BOH19020(b)), outlines the Ministry's readiness criteria and expectations for the implementation of this transformative model of care and local health service delivery.

Over the summer, Hamilton's OHT Project Team worked through a period of intense planning and development of the OHT Full Application proposal in keeping with the Ministry's October 9, 2019 submission deadline. In Year 1, the Hamilton Health Team's initial focus will be on improving care for seniors with multiple chronic conditions, adults with mental health and addictions concerns, and children and youth with mental health and addictions concerns. For these initial priority populations there will be three levels of intervention building on proven strategies and methods focused on a proactive system of care that identifies concerns early and provides right supports and right time to change trajectory for the individual; targeting geographic clusters where improved service delivery could make a significant impact on health and health care use; and seamless transitions from hospital to the community.

This next step in the Ontario Health Team (OHT) Readiness Assessment process requires Hamilton's proposed OHT to demonstrate to the MOH that it is capable of successfully implementing the OHT model, and that the team has completed further development around the Year 1 objectives.

At this stage in the review and application process organizations are required to receive Board/Governing Body level sign off on the Full Application proposal as part of the submission. While at maturity Ontario Health Teams will operate under a single accountability framework and an integrated funding envelope, at this stage of the Ontario Health Team planning there are no changes to governance and decision-making related to local health services. By signing off on the OHT Application proposal the City is committing to continue engagement and participation in shaping this local health system planning process for the benefit of the health of residents into Year 1. At such a time that the Hamilton Health Team moves towards a single accountability framework for funding, decision-making, the terms of that relationship to City services will be brought back to Council for consideration.

Alternatives for Consideration – See Page 7

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: Staff will report back with a plan and associated costs related developing this model.

The intent of Ontario Health Teams is that at maturity this will be a single clinical and fiscal accountability that will operate under an integrated funding envelope. At this stage there are no changes to funding and accountability, though at such a time that there are changes to funding, accountability, and service delivery relative to City services those terms will be brought back to Council for consideration.

Staffing: There are no staffing implications associated with Report BOH19020(b).

Legal: At this stage in the review and application process organizations are required to obtain authorization to submit the Full Application proposal as part of the submission. While at maturity Ontario Health Teams will operate under a single accountability framework and an integrated funding envelope, at this stage of the Ontario Health Team planning there are no changes to governance and decision-making related to local health services. The OHT Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry, the applicant (the Hamilton Health Team) or the City of Hamilton[1].

By signing off on the OHT Application proposal the City is committing to continue engagement and participation in shaping this local health system planning process for the benefit of the health of residents into Year 1. At such a time that the Hamilton Health Team moves towards a single accountability framework for funding, decision-making, the terms of that relationship to City services will be brought back to Council for consideration.

HISTORICAL BACKGROUND

Chronology of Events

2016: a formalized group of health and social service providers, named The Hamilton Community Health Working Group (HCHWG) which was born out of Hamilton's Anchor Institution Leadership Group (HAIL), began working together to examine how to improve health and well-being of the population in Hamilton through better coordination of services, with a view to making patient care experiences more seamless and integrated.

[1] Source: Ontario Ministry of Health. Toronto, ON: Queen's Printer for Ontario; 2019. Available from: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_Full_Application_EN.pdf.

February 2019: As outlined in Report BOH19020, the Ministry of Health and Long-Term Care (MOHLTC) (now the Ministry of Health (MOH)) announced reforms earlier this year intended to better connect the health care system by implementing local Ontario Health Teams (OHTs). *The People's Health Care Act, 2019* introduced health care system reforms centred on consolidating health care oversight agencies into a 'super-agency' called Ontario Health, and the development of Ontario Health Teams to integrate health and social service organizations at a local level for improved delivery of services.

April 2019: *The People's Health Care Act, 2019* receives Royal Assent and the MOH releases a prescribed, multi-phased "OHT Readiness Assessment" process for formal applications by health and social service agencies seeking to be selected as an early implementer of the OHT concept.

May 15, 2019: A group of over 20 health and social service providers from across Hamilton, including hospitals, family medicine and primary care, home care, the City's Healthy and Safe Communities Department and other community agencies, co-chaired by two patient advocates, submitted an expression of interest (a self-assessment proposal) to be considered as an early implementer of the Ontario Health Team (OHT) model.

July 18, 2019: Upon review of self-assessment proposals from across the province, the HHT self-assessment submission was selected as one of 31 teams identified to move immediately ahead in the next phase of the "OHT Readiness Assessment" process amongst a group of over 150 applicants from communities across Ontario. The Ministry established a deadline of October 9, 2019 for Full Application proposal submission.

Summer 2019: Hamilton's OHT Project Team worked through a period of intense planning engaging over 200 individuals representing local health and community service providers, family medicine and primary care, and patient representatives in the development of the OHT Full Application proposal.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The People's Health Care Act, 2019 introduced health care system reforms centred on consolidating health care oversight agencies into a 'super-agency' called Ontario Health, and the development of Ontario Health Teams to integrate health and social service organizations at a local level for improved delivery of services. The MOH has articulated vision for all health services providers to eventually join or become an Ontario Health Team at maturity. The implementation of full scale operational Ontario Health Teams will be incremental and will take many years to achieve full maturity. The OHT Model from Readiness to Maturity Summary document outlines the Ministry's readiness criteria and expectations for the implementation of this transformative model of care and local health service delivery across eight domains. Successful applicants at

this next stage may be invited by the Ministry to participate in a community visit and may become chosen to become an OHT Candidate. The process for becoming a designated OHT is outlined in The Maturation of Ontario Health Teams document (attached as Appendix "B" to Report BOH19020(b)).

RELEVANT CONSULTATION

Legal Services was consulted and provided input to this Report.

Hamilton Health Team Partnership Council:

- Alzheimer Society of Hamilton
- Canadian Mental Health Association – Hamilton Branch
- City of Hamilton Healthy & Safe Communities Department
- De Dwa Da Dehs Nye>s Aboriginal Health Centre
- Department of Family Medicine, McMaster University
- Good Shepherd Centres
- Hamilton Family Health Team
- Hamilton Health Sciences
- Indwell
- Lynwood Charlton Centre
- McMaster Family Health Team
- McMaster University (Digital Health focus, School of Nursing)
- Ontario Telehealth Network
- Patient Representatives (co-chairs)
- St. Joseph's Health Care Hamilton
- St. Elizabeth's Health Care
- Thrive Group
- Wayside House of Hamilton
- Wesley Urban Ministries

Through the OHT Full Application proposal development, over 200 individuals representing local health and community service providers, family medicine and primary care providers, and patient representatives have been engaged in this process.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

A. Provincial vision for health system reforms

The province and community is moving forward with the development of OHT's. As indicated by the province, at maturity all health services in Ontario will be part of an Ontario Health Team. At present, local teams have the opportunity to self-organize to be early adopters of this model. Early adopters of this model, like the Hamilton Health Team, have the opportunity to shape the development of local care transformation and serve as a model for the rest of the province.

B. Alignment with City Vision and Healthy and Safe Communities Department Priorities

Local OHT development and implementation will contribute to overall improvements in the health, well-being, and quality of life of populations that are important to the City of Hamilton and directly contribute to the City's Vision to be the best place to raise a child

and age successfully. The Healthy and Safe Communities Department (HSC) is a service provider, service system manager and funder of many program areas identified by the MOH as partners for these reforms including primary care clinical activities, long-term care, paramedic services, housing, addiction and mental health services, and community support programs.

HSC has been actively engaged in local OHT planning, with great interest in the role that the many programs in HSC can play in the Hamilton Health Team and improvements in care coordination, experience, and outcomes for populations that are a priority for the City. The Hamilton Health Team Full Application proposal commits to planning toward long-term improvements in overall health and well-being of the whole community, and balancing a short-term Year 1 focus on redesigning how care is connected, coordinated, and delivered to better serve three priority populations:

- Adults with mental health and addiction concerns
- Children and youth with mental health and addiction concerns
- Older adults with multiple chronic conditions

Recognizing the significant influence of the social determinants (including housing, income, public health, and the early years) in preventing illness and keeping people healthy, continued involvement of HSC in OHT planning will ensure the broader health needs and critical social supports are considered in local health system and service coordination planning and implementation. Better coordination of services could contribute to fewer ambulance offload delays, better home and community care coordination and supports in housing for vulnerable seniors, and better access to and coordination of the full continuum of mental health and addictions services and supports.

The Hamilton Health Team is taking a comprehensive approach to its Year 1 targeted population and goals supported by local population health data. Improvements in the delivery of care will be focused in three areas:

Early Identification:	Develop a proactive system of care that identifies concerns early and intervenes before issues/illness begin to take hold.
Geographic Clusters:	A place-based approach in areas where strengthened service coordination and service delivery will make a significant impact on the health of populations, and health care utilization.
Transitions from Hospital:	Seamless transitions from hospital for patients with complex mental illness and addiction conditions, and seniors with chronic conditions.

Continued participation in this process presents an opportunity to deepen connections to community partners to improve the coordination, delivery, and care experience for Hamilton residents, and in the long term contribute to improving population health.

C. Digital Transformation and Smart City Vision

These improvements in local health and social service coordination will be supported and enabled by new digital health tools, including virtual care, better information sharing that will ensure patients/clients don't have to tell their story time and time again to different care providers as they transition to different care settings. City participation in local OHT planning, development, and implementation also contributes to Hamilton's digital transformation which enables government to modernize services in a way that makes delivery both more efficient, effective and more client-centred.

ALTERNATIVES FOR CONSIDERATION

The City of Hamilton could abstain from further engagement and participation in the local Hamilton Health Team planning process and not sign-off on the OHT Full Application.

This is not recommended given these health care reforms are enshrined in provincial legislation and the MOH's vision. The MOH has indicated through new legislation the vision for local health system delivery and transformation and that all services are expected to join an OHT at maturity.

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to BOH19020(b): Ontario Health Teams Model from Readiness to Maturity Summary

Appendix "B" to BOH19020(b): The Maturation of Ontario Health Teams

Ontario Health Team Model: From Readiness to Maturity Summary

	Readiness Criteria for Ontario Health Team Candidates	Year 1 Expectations for Ontario Health Team Candidates	Ontario Health Teams at Maturity
Patient Care & Experience	Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.	Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the Team's services are in place. Expanded virtual care offerings and availability of digital access to health information.	Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.
Patient Partnership & Community Engagement	Demonstrated history of meaningful patient, family, and caregiver (P/F/C) engagement, and support from First Nations communities[7] where applicable. Plan in place to include P/F/C in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient engagement framework, and patient relations process. Adherence to the *French Language Services Act,* as applicable.	Patient Declaration of Values in place. P/F/C included in governance structure(s) and patient leadership established. Patient engagement framework, patient relations process, and community engagement plan are in place.	Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers, and the communities they serve.
Defined Patient Population	Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1.	Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population.	Teams will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care.
In-Scope Services	Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in full continuum of care and include or expand primary care services.	Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary care coverage for a significant proportion of the population.	Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.
Leadership, Accountability, and Governance	Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for team, reflecting a central brand, and where applicable, putting in place formal agreements between team members.	Agreements with Ministry and between Team members (where applicable) in place. Existing accountabilities continue to be met. Strategic plan for the Team and central brand in place. Physician and clinical engagement plan implemented.	Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls.
Performance Measurement, Quality Improvement, & Continuous Learning	Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality improvement activities, engage in continuous learning, and champion integrated care.	Integrated Quality Improvement Plan in place for following fiscal year. Progress made to reduce variation and implement clinical standards/best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative.	Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be reported.
Funding and Incentive Structure	Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fund holder, and reinvesting savings to improve patient care.	Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data.	Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.
Digital Health	Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners.	Harmonized Information Management plan in place. Increased adoption of digital health tools. Plans in place to streamline and integrate point of service systems and use data to support patient care and population health management.	Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

[7] For a map of First Nations communities and reserves, please refer to the following link: https://www.ontario.ca/page/ontario-first-nations-maps [link]

The maturation of Ontario Health Teams

The path to becoming a designated Ontario Health Team consists of four steps[4]:

1. **Self-Assessing Readiness – 2. Validating Provider Readiness – 3. Becoming an Ontario Health Team *Candidate* – 4. Becoming a Designated[4] Ontario Health Team**

1. Self-Assessing Readiness	Interested groups of providers and organizations assess their readiness and begin working to meet key readiness criteria for implementation.
2. Validating Provider Readiness	Based on Self-Assessments, groups of providers are identified as being *In Discovery* or *In Development* stages of readiness.
3. Becoming an Ontario Health Team *Candidate*	Groups of providers that demonstrate, through an invitational, full application, that they meet key readiness criteria are selected to begin implementation of the Ontario Health Team model.
4. Becoming a Designated Ontario Health Team	Ontario Health Teams Candidates that are ready to receive an integrated funding envelope and enter into an Ontario Health Team accountability agreement with the funder can be **designated[5]** as an Ontario Health Team

Ontario Health Team: Assessment Process

To onboard interested groups of providers and organizations on this path, the Ministry is launching a readiness assessment process[6] to:

- Determine which groups currently (or with some assistance) meet the key readiness criteria to begin implementation of the Ontario Health Team model, i.e., those who will be Ontario Health Team Candidates
- Identify groups who are not yet ready to begin implementation but who can be actively supported to work towards readiness, i.e., those who are *'In Development'* or *'In Discovery'*.

[4] This process is not intended to be a formal legally binding offer to enter into a contract, and does not constitute a commitment by the Ministry to enter into a funding or accountability agreement with any person or organization.
[5] If passed, Bill 74, *The People's Health Care Act, 2019*, would allow the designation of integrated care delivery systems (Ontario Health Teams). See s.29 of the Connecting Care Act, 2019 – Schedule 1 of Bill 74.
[6] This process is not intended to be a formal legally binding offer to enter into a contract, and does not constitute a commitment by the Ministry to enter into a funding or accountability agreement with any person or organization.

The readiness assessment process has three components:

1. **Self-Assessment:** Interested providers or groups of providers are invited to complete a Self-Assessment guided by an *Ontario Health Team Self-Assessment Form.* This stage allows teams to familiarize themselves with the model and required components, and work through together how they would meet the minimum criteria.
    - Self-Assessment submissions will be reviewed and those deemed to be in the beginning stage of readiness will receive access to supports to continue working towards further readiness. These teams will be considered as *'In Discovery'*.
    - Those teams that demonstrate a higher degree of readiness to become Ontario Health Teams (i.e., *'In Development'*) will be invited to prepare and submit a Full Application.
    - *Note: Where appropriate, groups may be asked to collaborate with additional providers to re-submit a joint Self-Assessment.*

2. **Full Application:** Invited providers or groups will submit a Full Application to demonstrate, with evidence, their ability to meet the Ontario Health Team Candidate readiness criteria set out in Appendix B. The *Ontario Health Team Full Application Form* will be provided to those proceeding to this stage.
    - Full Applications will be reviewed and evaluated and those that demonstrate a higher degree of readiness for implementation will be invited to participate in an In-Person Visit.

3. **In-Person Visit**: Invited providers or groups of providers will be assessed through a final in-person visit in order to identify those who are demonstrably ready to continue to become Ontario Health Team Candidates.
    - During this visit, providers will be expected to present a comprehensive current state assessment of their system and a vision for the future of patient care in the near and longer-terms. Groups may be required to provide supplementary documentation to support this visit, such as information about digital and information management capacity. Further details will be provided to groups selected for an in-person visit.
    - Following the in-person visits, providers that demonstrate full readiness for implementation will be categorized as 'Ontario Health Team Candidates' and will go on to implement the Ontario Health Team model. Remaining providers will remain '*In Development*' and will continue working towards full readiness.

The assessment process will be repeated until full provincial coverage is achieved. Providers or groups of providers who are not ready to participate in the first round will have further opportunities to participate, with additional dates to be announced. All providers and organizations who participate in the assessment process will have access to supports that will help improve readiness and eventual implementation.

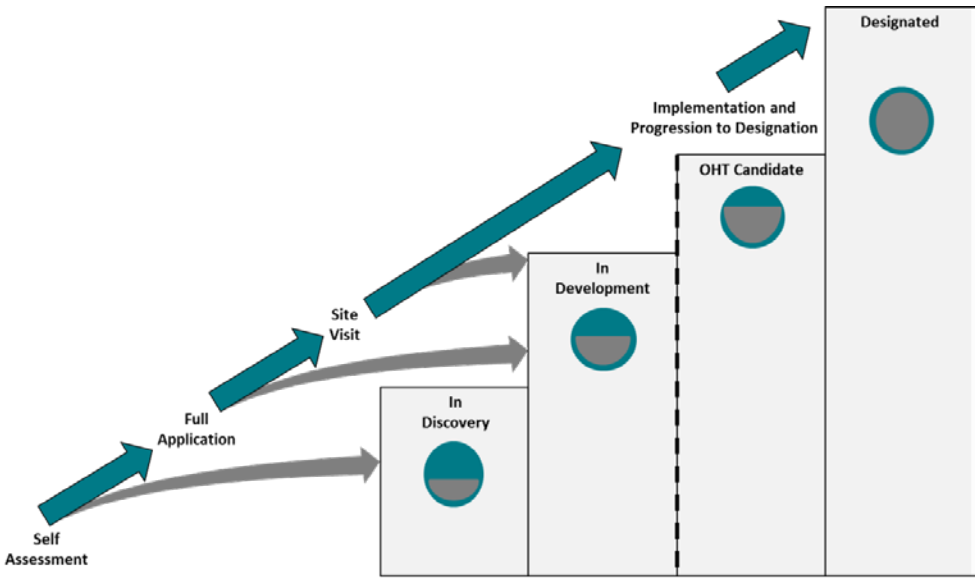

Figure 1: Readiness Assessment and Ontario Health Team Designation Process

Source: Ontario Ministry of Health. Toronto, ON: Queen's Printer for Ontario; 2019.
Available from: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf.