BACKGROUND

Earlier this year the Ministry of Health (MOH) launched a low rules and self-organizing process to create OHTs. The purpose of OHTs is to deliver an integrated and coordinated continuum of care and facilitate information sharing so that patients, families and caregivers have a seamless service experience when they access health services. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions between service providers will be seamless.

OHTs 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. They 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.

It is reasonable to anticipate the transition to this service delivery model will take several years. Health care services are complex and there are many stakeholders' views that need to be addressed when designing a new service delivery model and during the related transition process. Therefore, each OHT will determine its own governance structure(s).

Over time, each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls. Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations. OHTs 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.

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 will measure performance and evaluate the extent to which Teams are providing integrated care, and there will be accountability reporting. Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

ANALYSIS

The OHT Application Process

The application presented in Appendix A reflects coordination among over 36 local health and social services providers. Since the province's announcement in the second quarter regarding the formation of OHTs, these organizations have been meeting to understand the nature of the potential changes offered by the OHT model, apply context based on their experience providing care in the Greater Sudbury area, and design an approach for introducing the OHT model here.

In May, local health care providers began meeting and indicated their interest in the formation of an OHT to the province. The province then invited the group to make a full application for an OHT. Appendix A reflects the results of their efforts, using the province's prescribed format for OHT applications.

The application would be submitted by December 19 to the Ministry of Health for further consideration. Applications will be evaluated by third-party reviewers and the Ministry of Health according to standard criteria that reflect the readiness and ability of teams to successfully

implement the model and meet Year One expectations for Ontario Health Team Candidates. Following evaluation of the Full Application there are two possible outcomes. Teams will either: 1) be invited to move to the final stage of evaluation, or 2) continue to work towards readiness as a team 'In Development'.

In addition to the application, the OHT is proposing a memorandum of understanding (MOU) to summarize the commitment of members, followed by an Interim Collaboration Agreement. The MOU is expected to be signed when the application is submitted, with the agreement following in the first quarter of 2020. Further, a Steering Committee would be co-designed and appointed by OHT Members in the first quarter. It would consist of approximately 12 members who would serve as an interim non-binding governance arrangement of the OHT activities between April 1, 2020 and the end of the first year of operation of the OHT. That Steering Committee would include primary care providers and patient and family advisors, among others.

Opportunities Presented by Participating in an OHT

OHTs are expected to improve the experience of care, health outcomes, system sustainability, and provider experience. They expect providers will find new ways to share information and work together to deliver a modern and high functioning health care system. In Year One, the expectation is that persons living with dementia (PLWD) and their caregivers will experience better linkages between their primary care providers and other health services, as well as better coordination and navigation of those services. Generally, this segment is estimated to be approximately 1,655 individuals in the City of Greater Sudbury, plus their caregivers, but not all are expected to access the "integrated care" proposed in Year One.

This population segment was chosen because of the high degree of complexity inherent in the dynamics of a diagnosis of dementia and the impact of that care journey on one's family and loved ones. The OHT recognizes the demographic imperative for improving "senior friendly care" strategies across our system and ensuring older adults are able to age in their place of choice for as long as they choose. In addition, the OHT identified PLWD as its Year One focus because it is confident about its ability to develop system improvements to better support the experience of care for individuals, their families, and health care providers.

There are other opportunities that, with time and experience, the OHT will produce. For example, purposefully integrated and team-based models of care that are linked to one's primary care provider have the opportunity to improve health outcomes. By removing barriers and silos that have traditionally separated some health care services, there will be greater abilities to develop coordinated care plans, wrap care around individuals and their families, and complete "warm hand-offs." Further, integrated pathways and information systems will ensure that navigating the system is easy and straightforward, and that one's information is always up to date and available.

Additionally, digitally enabled models of care and virtual services have the opportunity to dramatically improve access to care. This opportunity is especially impactful given that travel distances in Greater Sudbury are significant—and further exacerbated for those who rely on transit—and that winters are often long and marred by treacherous weather and driving conditions. Expanding these capabilities will drastically improve the ability of caregivers to monitor individuals' health status and to support virtual visits, where appropriate.

The City of Greater Sudbury's Role

As a provider of Long Term Care, Paramedic service and social services the City of Greater Sudbury has been an active participant of the OHT development from its outset. This is particularly important given the year one population of people living with dementia and other conditions where the City of Greater Sudbury already plays an important role through programs such as the 32 bed secured dementia unit at Pioneer Manor and the community paramedicine program.

Next Steps

If approved as presented, staff will continue collaborating with health care sector colleagues to finalize the OHT application and establish a memorandum of understanding and subsequent Interim Governance Agreement for the OHT. Subject to the province's disposition of the application, staff will continue participating on working groups designed to advance the OHT's development in Greater Sudbury.