THE INTEGRATED CARE EXPERIENCE IN ONTARIO, CANADA

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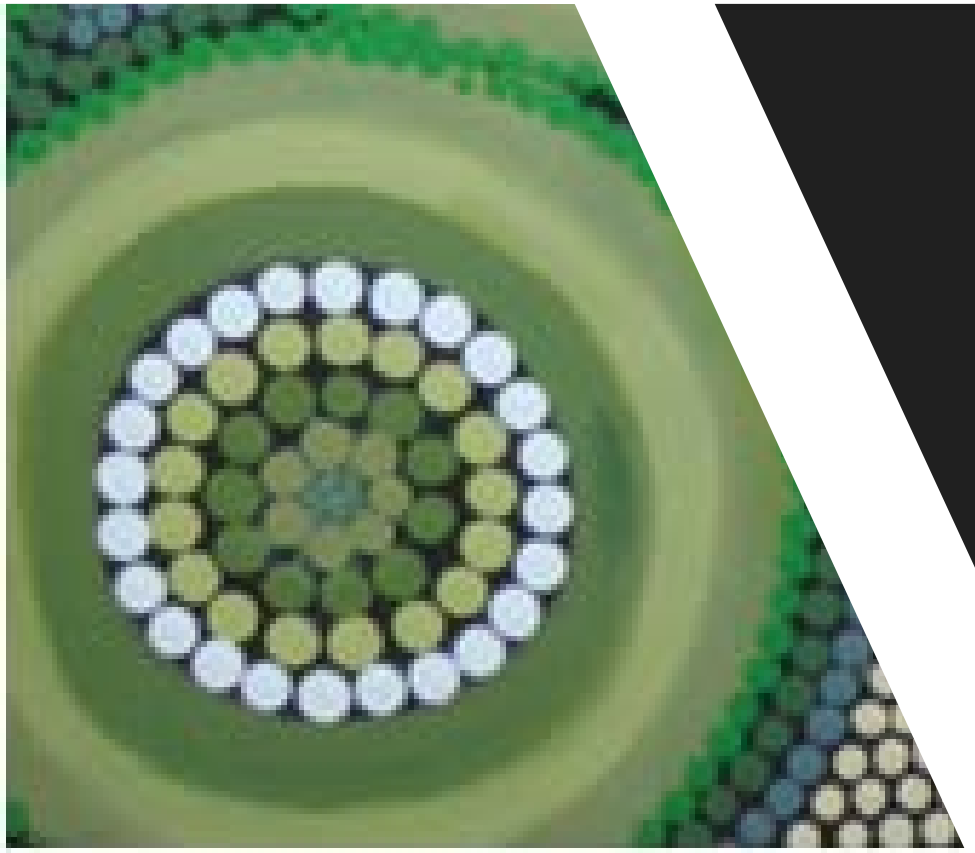
February 13 – Central Coast Research Institute for Integrated Care



Local Aboriginal Land Counc

DARKINJUNG

ACKNOWLEDGING A RICH HISTORY

REFLECTING ON POSSIBILITIES FOR COLLABORATION AND INNOVATION

MOTIVATING US TO SEEK BETTER WAYS TO DELIVER BETTER CARE AND BETTER OUTCOMES

TODAY’S AGENDA

1. Set the stage: explore integrated care
2. Describe the Ontario experience
3. Discuss lessons learned
4. Consider next steps (together)

MY JOURNEY

- Getting evidence into the hands of the people that can, and should use it is a challenge
- Co-production and integrated knowledge translation is essential
- Teams are (and always have been?) necessary for effective [healthcare]
- Context is complex and dynamic... and complex and dynamic

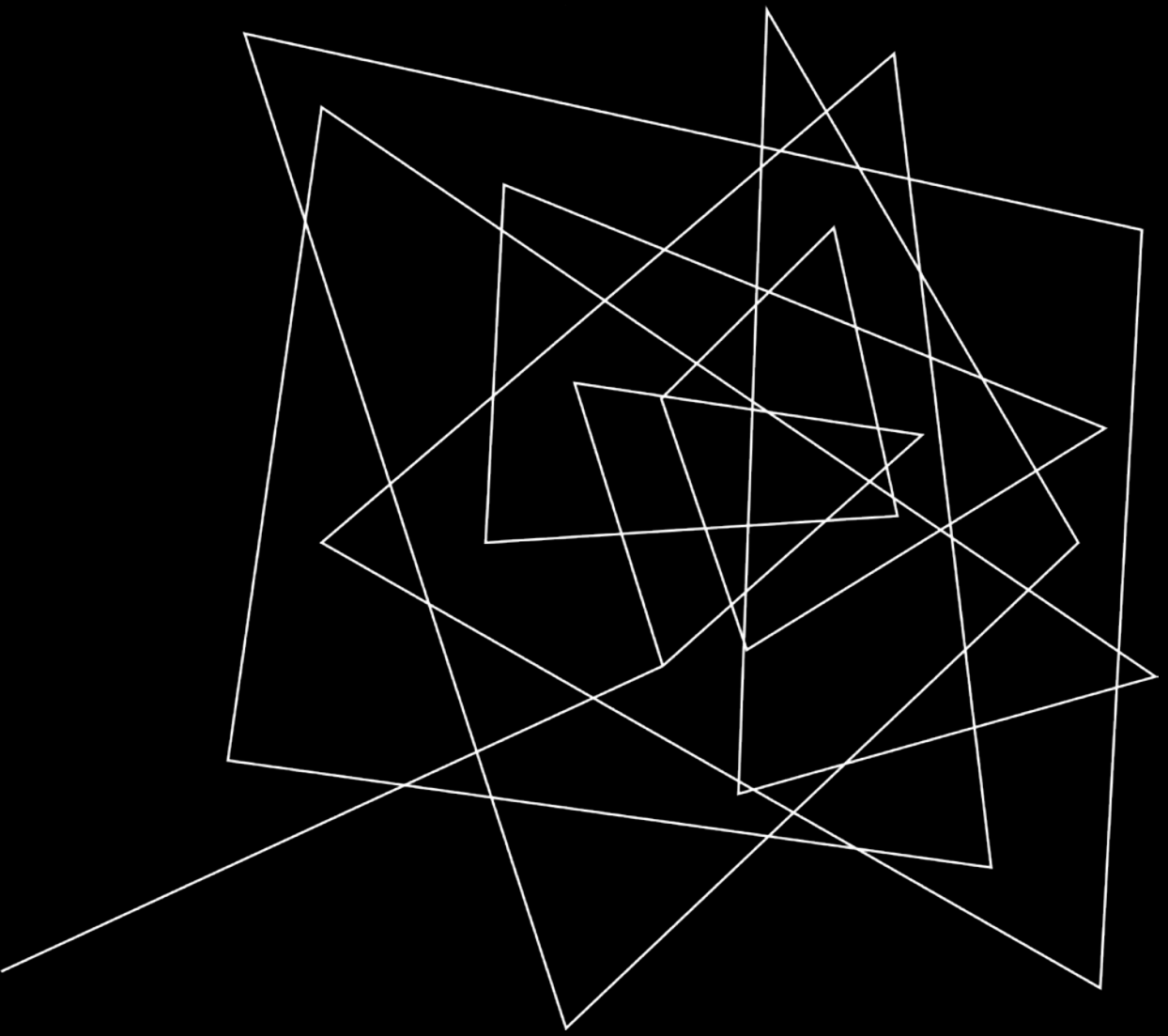
Western UNIVERSITY · CANADA

CANADA

38.25M (25.7M)

ONTARIO

- Population: 15 million (NSW: 8.1 million)(QSLD: 5 million)
- 1/13 Unique health care system
  - Guided by Canada Health Act
  - OHIP: Covers medically necessary services provided by family doctor and specialists
- 70% province; 30% private/out-of-pocket
- 30% from federal gov't (limited strings)
- CDA: 12.2% GDP (10% AUS)
- CDA: > 1.2% on LTC (lowest OECD)
- Health care premium (ON, BC, AB)



WHO SAID IT?

Canada or Australia

"When people can't access primary health care, they wait until it's too late, they wait until they get sicker. And so they present to hospital at a higher level of acuity than if they were able to access good primary health care with a general practitioner,"

AUSTRALIA

“Despite the national and international commitment to implement integrated delivery systems, there is an absence of national standards that support evidence-based design, implementation, and monitoring for improvement.”

CANADA

AUSTRALIA

“We have major issues with access, major issues with chronic disease management.”

CANADA

“Emergency departments have become the de facto route into the system for people who can’t get the care they need anywhere else,”

CANADA

“Burnt-out and exploited staff mean longer wait times, never-ending hallway healthcare, and clinical mistakes from exhausted minds and bodies.”

LET’S GET OUR TERMS STRAIGHT

confused by the term, clear on the concept?

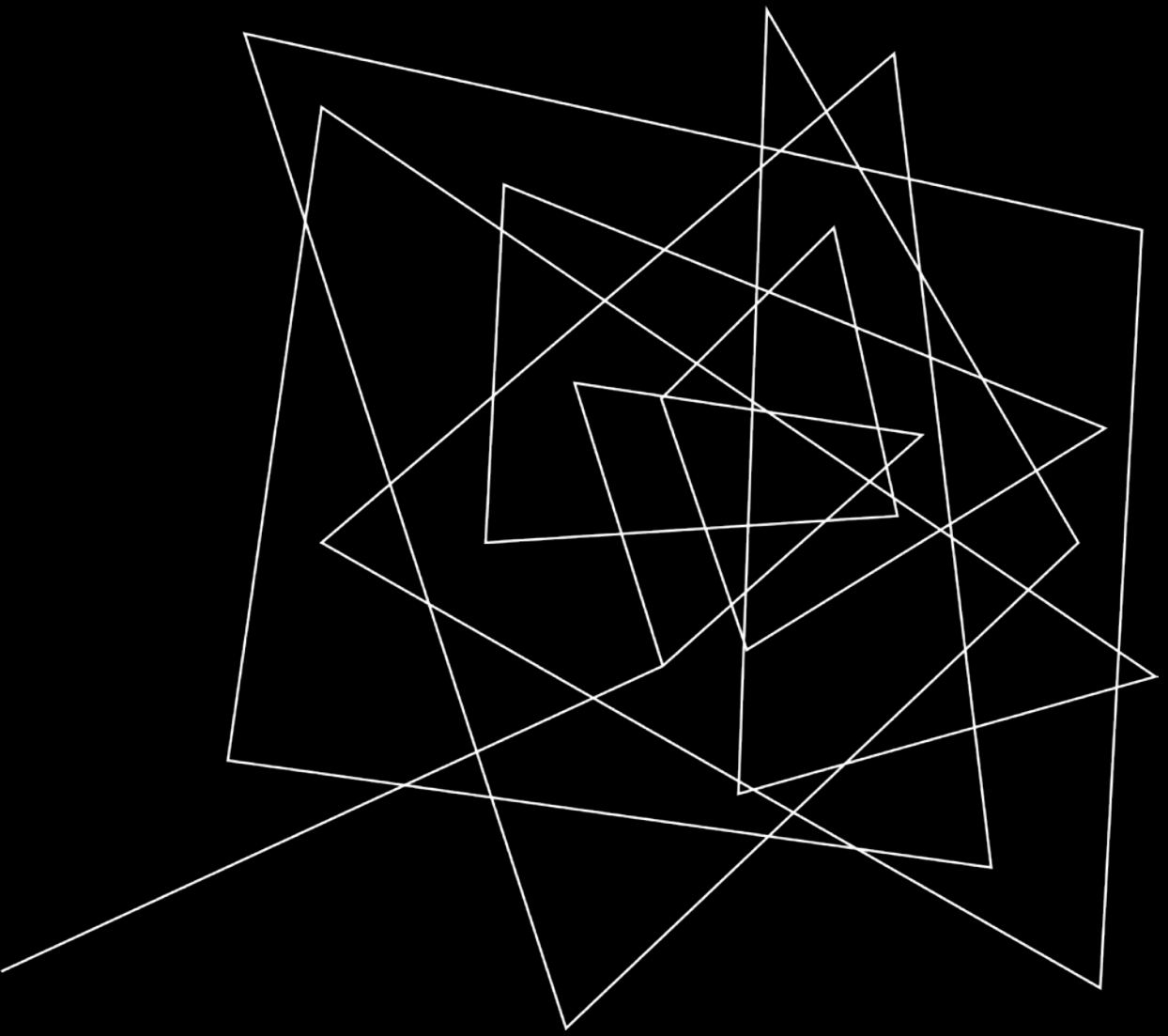
FIVE TYPES OF INTEGRATION – SINGER ET AL.'S FRAMEWORK

1. Structural Integration
2. Functional Integration
3. Interpersonal Integration
4. Normative Integration
5. Process Integration

THREE MODELS OF INTEGRATED CARE:

1. Individual models of integrated care
2. Group- and disease-specific models
3. Population-based models

SINGER ET AL., 2020



THE STATE OF INTEGRATED CARE IN CANADA

ACROSS THE COUNTRY

- The philosophy/ideal doesn’t match the division of power
- Most provinces/territories have some version
- Regionalization ≠ integration
- Not the first go at it in Ontario – LHINs; HealthLinks, Rural Hubs
- Recent federal announcement ($42.5M) > digital and shared priorities (mental health, family health/primary care, health workers)
- The stage is set.

- … each province does its own thing

ONTARIO'S INTEGRATED CARE POLICY WINDOW

- 2003-2018: Liberal (centre left) majority
- 2018: Conservative (centre right) majority
- 2019: Patient's First Act

voluntary, intersectoral networks of health organizations that jointly work towards achieving quadruple-aim outcomes (improved health outcomes, improved patient, family and caregiver experiences, keeping per-capita costs manageable, and improved provider experiences).

- 2022 November: Path Forward (7) > standardization
- 2022 December: Appeal Bill 124 > demoralized workforce
- 2023 January: Expanding the scope (5) > privatization

OHT DEVELOPMENT

- New way of organizing and delivering care in a coordinated team to achieve the quadruple aim
- clinically and fiscally accountable for delivering coordinated continuum of care to a defined population (population health management)
- a landmark development in Ontario's health system
- Combination of bottom-up and top-down actions; low-rules

- Leadership: **primary care, patients/caregivers + other (not necessarily hospital)**
- Supported by coaching, communities of practice, and evaluation team(s)

POPULATION HEALTH MANAGEMENT

Aims to address health needs at all points along the healthcare journey through participation of, engagement with, and targeted interventions for the population (as a whole and individuals within)

- Considers the health of everyone in our population
- Services are built around clients' needs with their primary-care provider centre
- Services are meaningfully co-designed with patient, family, and caregiver partners
- Equitably 'moving the needle' on quadruple-aim metrics for a defined population (called in 'attributed population')

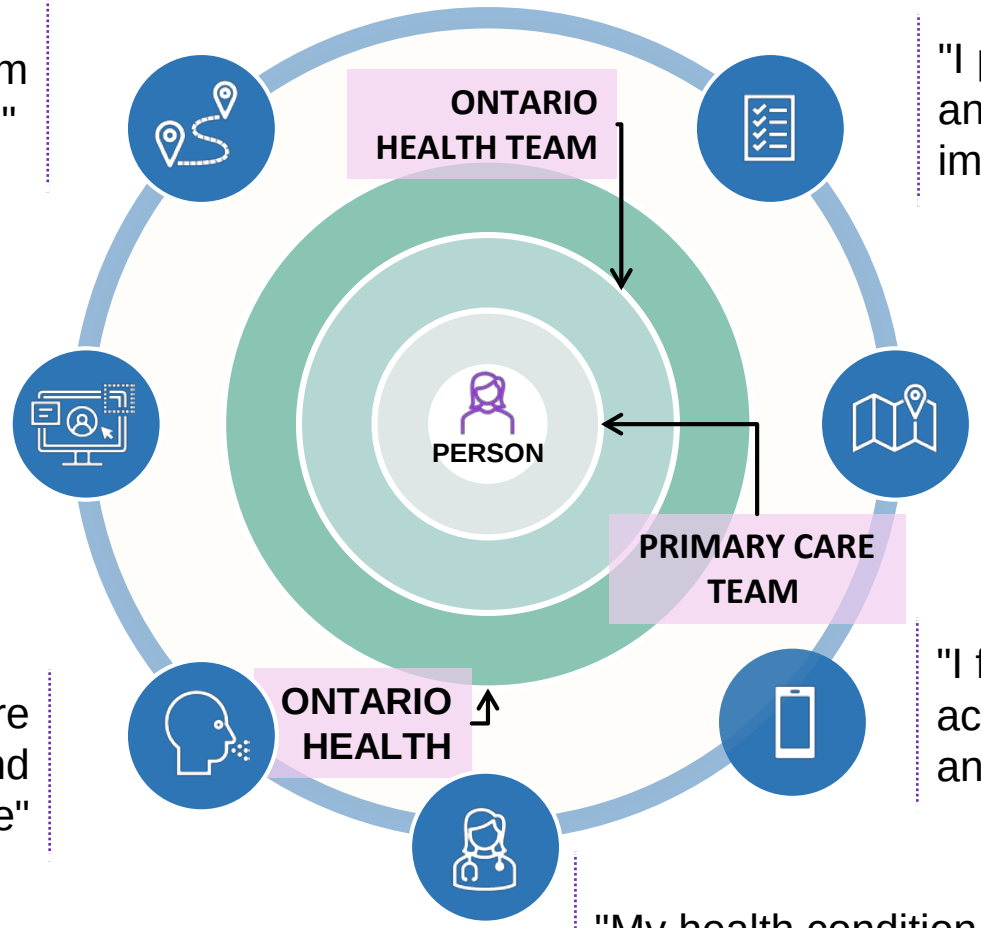
MIDDLESEX LONDON
Ontario Health Team

WHAT WILL PATIENTS EXPERIENCE?

"I transition easily between care team members and sites of care"

"I have 24/7 access to navigation resources to help access appropriate care"

"I am proactively engaged by my care team for routine screening and preventative care"



"I provide feedback on experience and outcomes that is used to improve care delivery"

"I am automatically enrolled in an OHT and I have flexibility to move between OHTs"

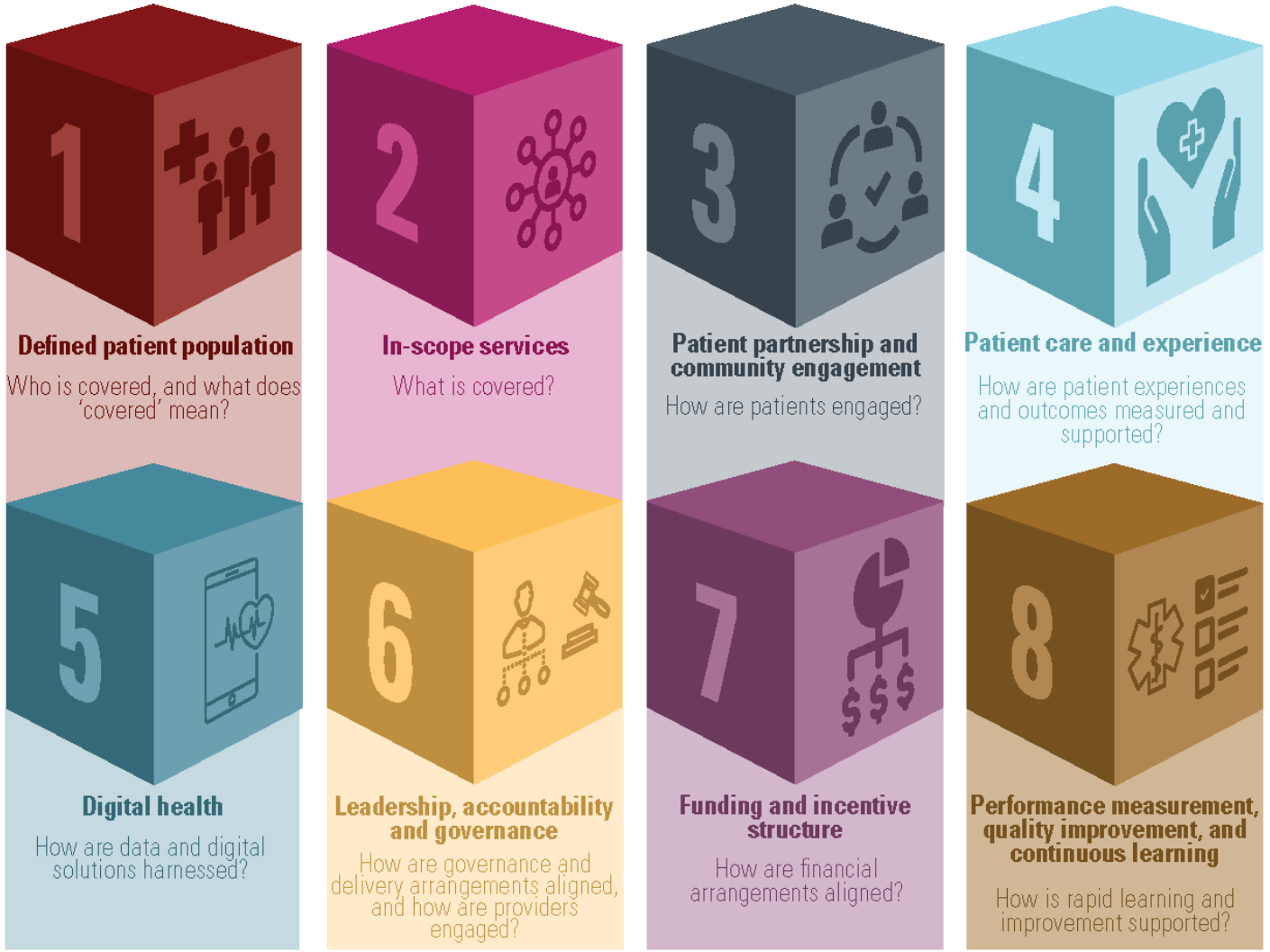
"I feel empowered because I have access to my information, care plan and self-care resources and tools"

"My health condition has improved because of the care I am receiving"

Ontario Health

RISE
Rapid-Improvement Support and Exchange

OHT BUILDING BLOCKS



McMaster University | HEALTH FORUM
The Ottawa Hospital | L'Hôpital d'Ottawa
Trillium Health Partners

Central OHT Evaluation

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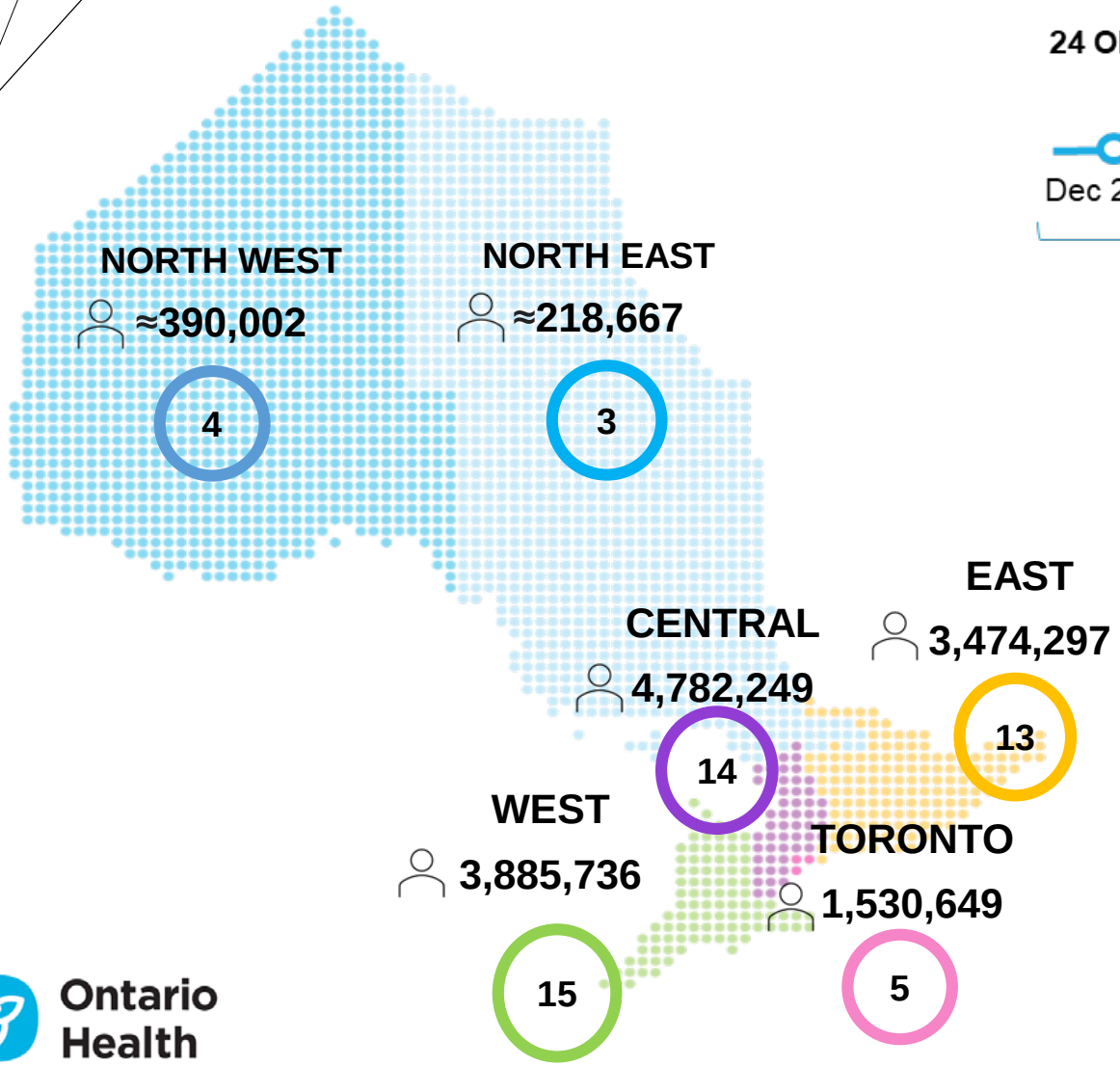
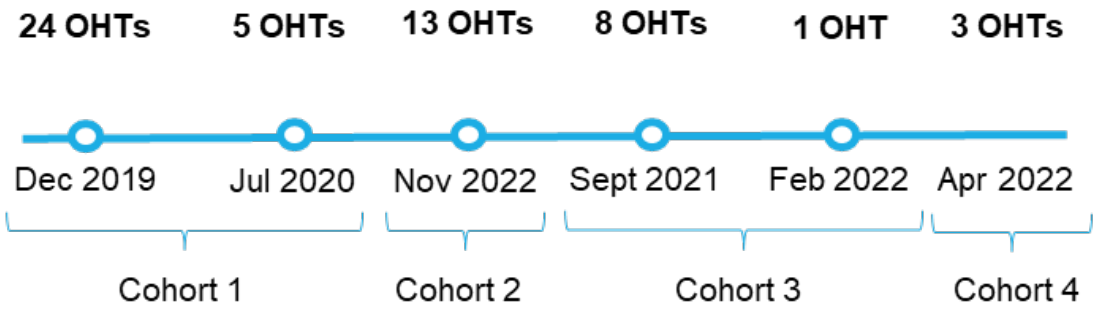
HSPN Health System Performance Network

OHTS CURRENT STATE: PROVINCIAL COVERAGE





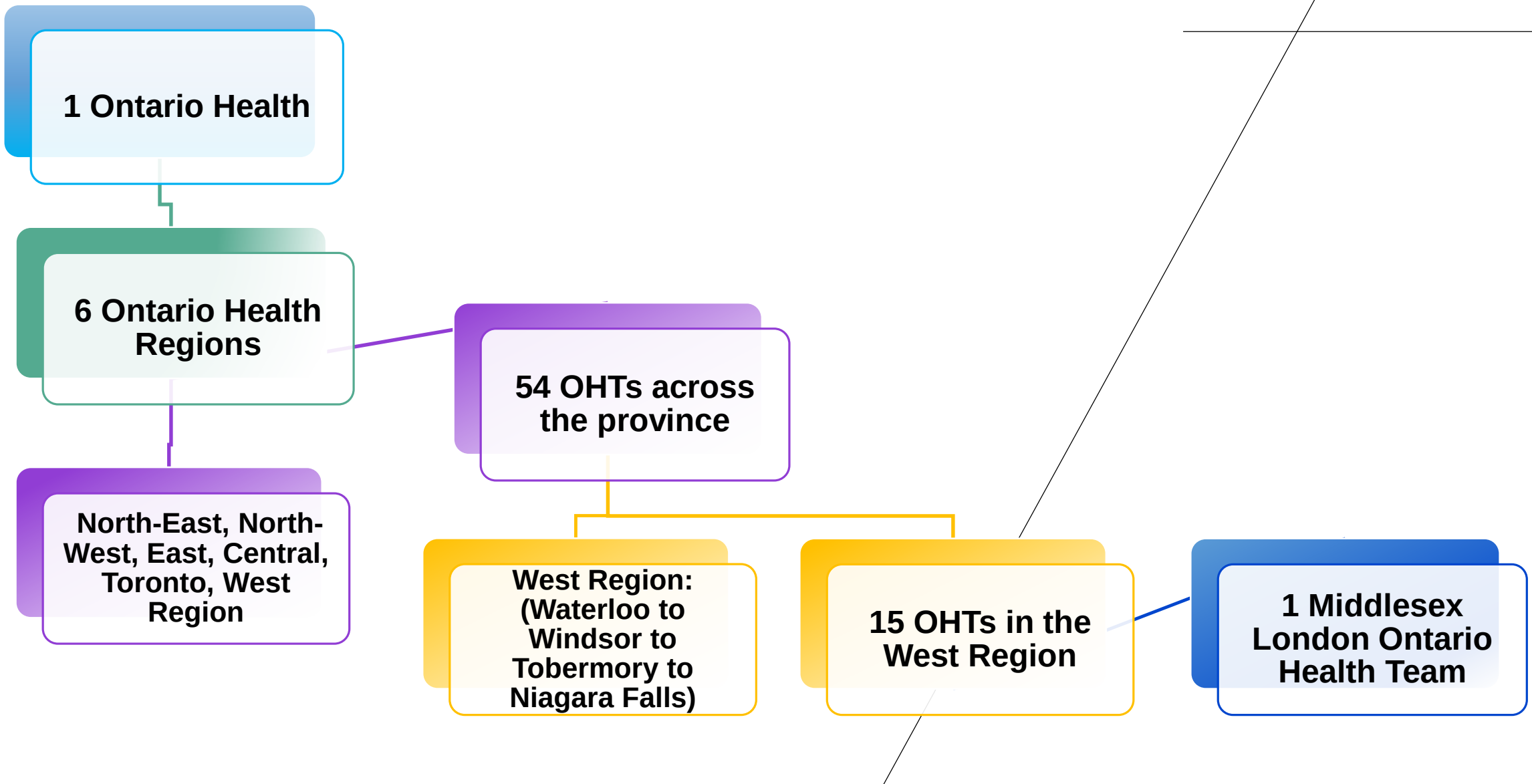
54 **Approved OHTs**

97 % **Provincial population coverage at OHT maturity**

Additional teams are **in development** or **have submitted full application** (primarily in Northern Ontario)

Ontario Health

REGIONAL CONTEXT



CRITICAL STEPS AND ESSENTIAL SUPPORT

1. Segmenting population
2. Co-designing care models, (in-reach services and out-reach services for each segment)
3. Implementing in ways that equitably reach and benefit all those who need
4. Monitoring reach and other process measures and evaluating quadruple-aim metrics

SUPPORTED BY:

- Near-real time, longitudinally linked, cross-sectoral client records
- Collaborative governance with a strong primary-care foundation
- Integrated funding envelope with funding flowing to partners
- Infrastructure for rapid learning & improvement (e.g., RISE), evaluation (e.g., HSPN), and performance management (e.g., ADVANCE and Ontario Health)

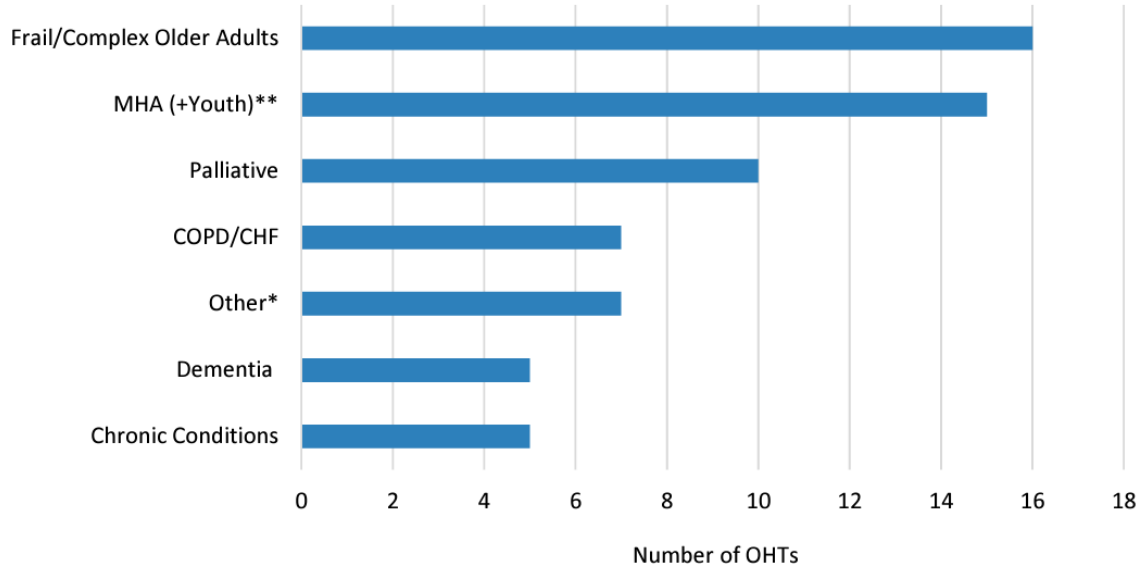
RISE
Rapid-Improvement Support and Exchange

CURRENT STATE

- Populations
  - Range from 50,000 to 870,000 people per OHT
  - ‘Attributed’ based on care patterns, not aligned with boundaries for local governments (which are responsible for public health and for social services)

USING THE ‘CLINICAL’ POPULATION-MANAGEMENT APPROACH

Figure 1: Year one target populations selected by OHTs



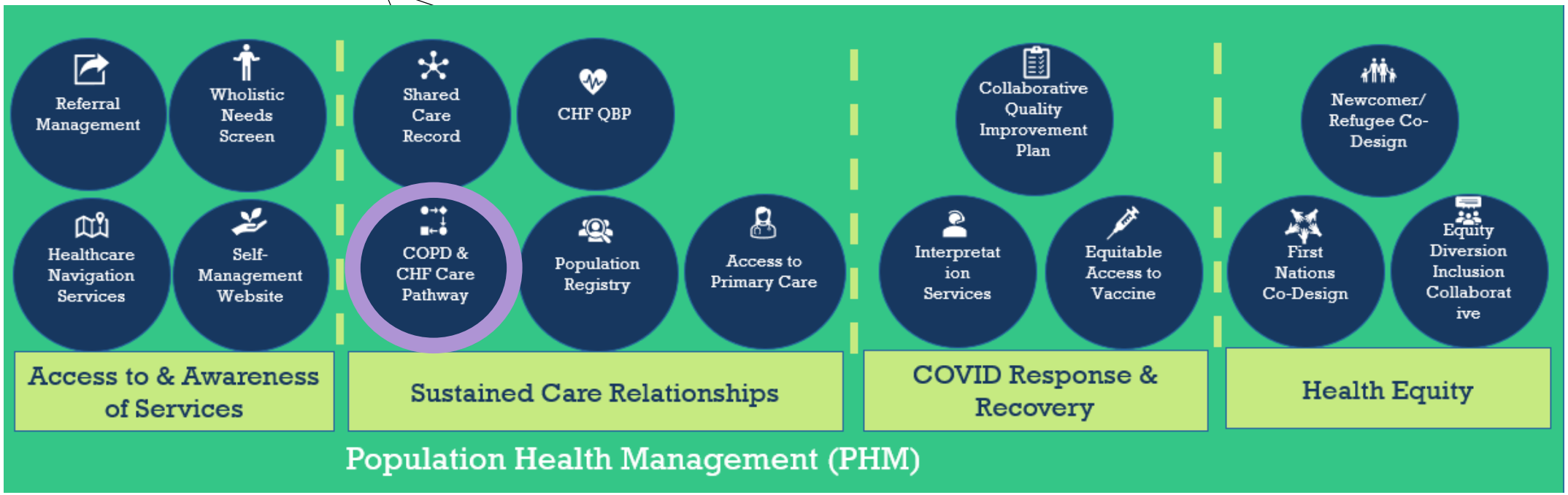
OHTs’ priority populations are:

1. Older adults and/or people with chronic conditions
2. People with mental health and addictions issues
3. People who could benefit from a palliative approach to care
4. People at risk of or affected by COVID-19 or its consequences

BIG THREE ENGAGEMENT

- Patients and caregivers
- Primary Care
- Community

ACTIVE PRIORITY WORK

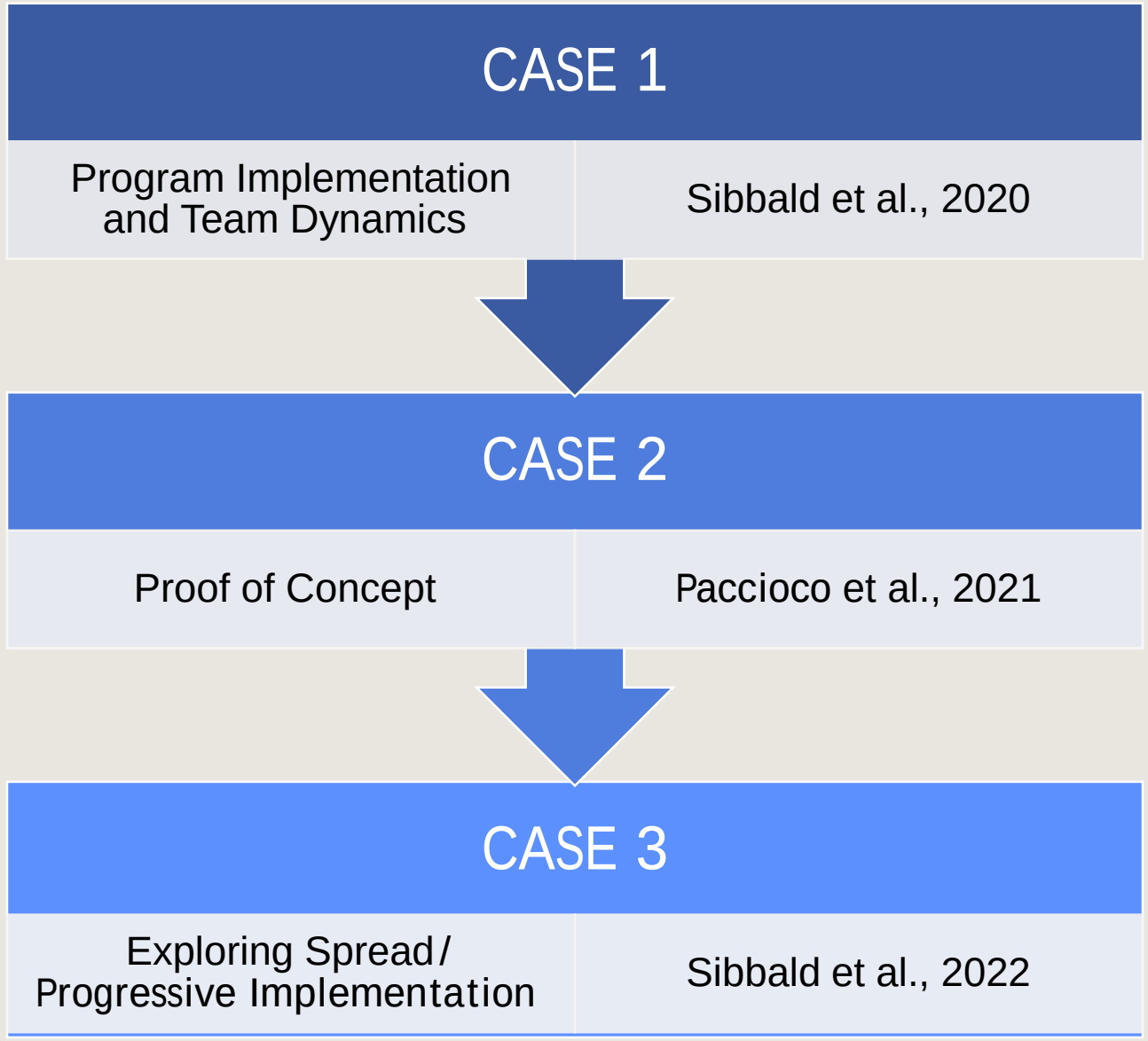


KAREN'S STORY

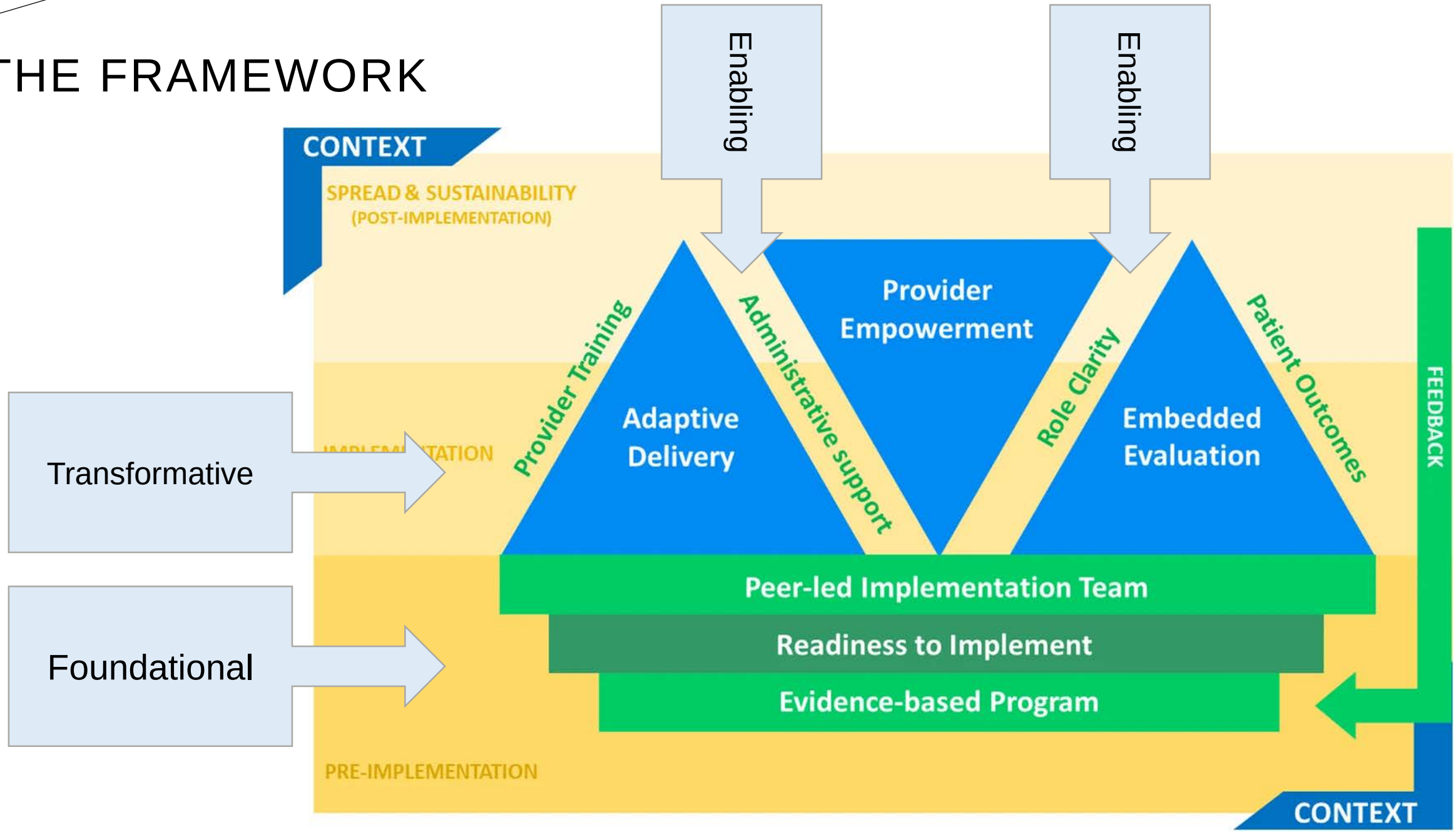
Design and implement health pathways for people living with COPD and/or CHF to support:

- Equitable access to care
- System-wide care pathway design – wholistic and coordinated care
- Capacity Planning – right support at the right time

A COLLECTION OF CASE STUDIES



THE FRAMEWORK

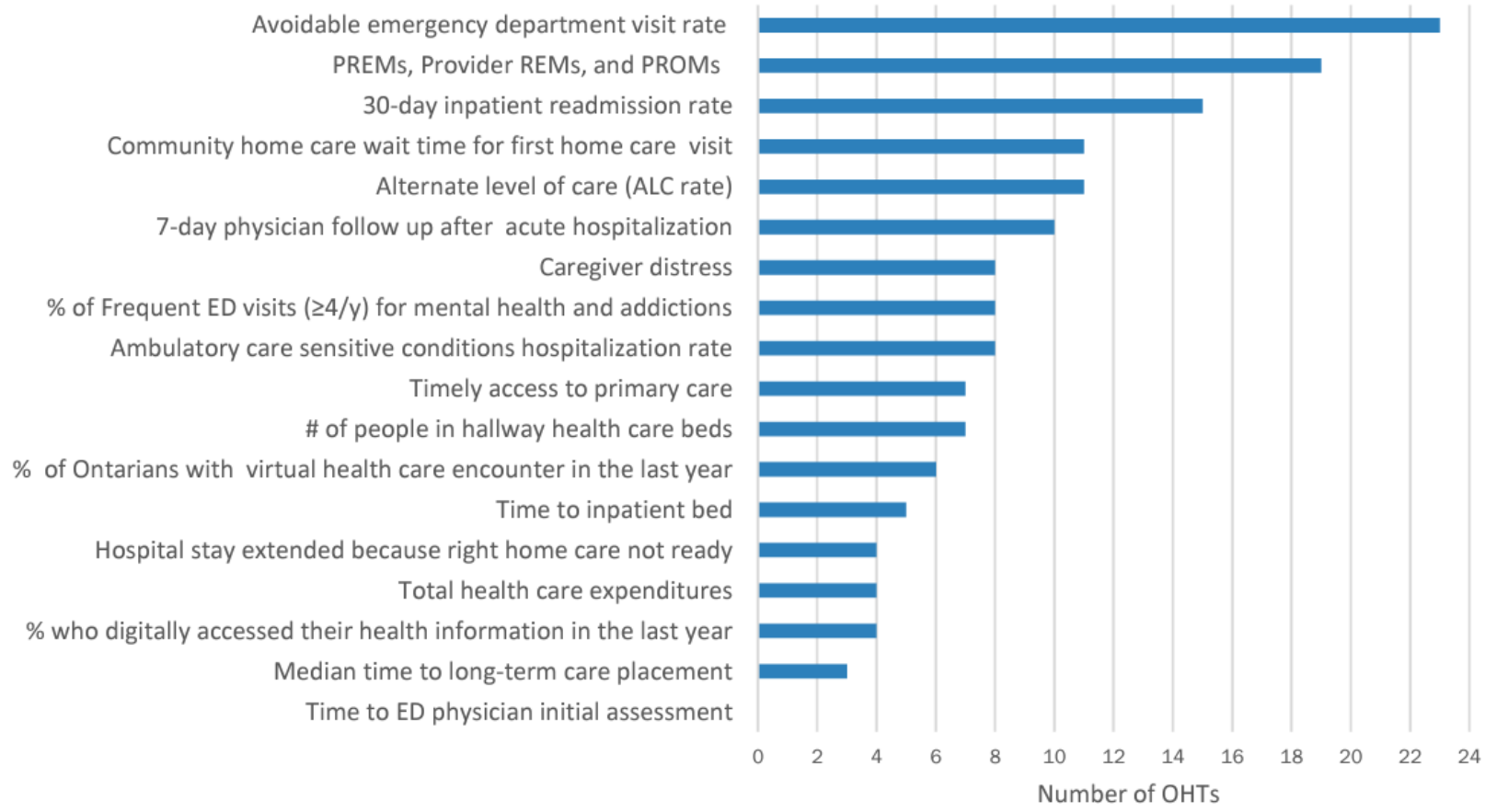


VALIDITY, FEASIBILITY, APPLICABILITY, & SUSTAINABILITY

- OUR NEXT STEP is to explore the feasibility of our framework within a system of integrated care (OHTs)
- We are building evidence on fidelity and adaptations to support program sustainability
  - Within primary care context
  - In consideration of system reform
  - Need to consider organizational capacity
  - Political landscape
- We are also validating framework (academic exercise)

EVALUATING IMPACT

Figure 2: Number of OHTs identifying indicators listed in full application



Top three metrics are:

1. Avoidable emergency department visit rate
2. REMS, Provider REMs, and PROMs
3. 30-day inpatient readmission rate

IMPACT FOR COMMUNITY MEMBERS

"I am proactively engaged by my care team for routine screening and preventative care"

Provided 600 adult bus tickets and 650 children bus tickets to vaccination clinics, primary care, community resources.

"I have 24/7 access to navigation resources to help access appropriate care"

Fit-tested more than 100 community partners with N-95 masks

"I provide feedback on experience and outcomes that is used to improve care delivery"

Partnered with others to vaccinate over 2,400 people through cultural community clinics for COVID-19

"I feel empowered because I have access to my information, care plan and self-care resources and tools"

Led project to create Consolidated Self Management Network website – close to 800 people have registered for a workshop

OHTS CHALLENGES

- Funding, planning, coordinating, delivering, and evaluating integrated health and social services
  - And reporting on all of it
- Difficult to integrate across different levels
  - Changing landscape (surgical innovation)
    - Variety of funding opportunities (mis- or not aligned?)
- Bill 124
- Time.. time.. more time
  - Relationships, evaluation

SO, WHAT CAN AUSTRALIA TAKE FROM THE ONTARIO EXPERIENCE?

- Form alliances, a coalition of the willing
  - Use the existing structures to form inter-organizational partnerships
- High trust (time), low bureaucracy
- Find your target: risk stratification
  - Right care at the right place at the right time
- Platform for change (and sustainability)
  - Gov't required
- Primary care foundation
- [Digital innovation]

GET CLEAR ON THE SOLUTION. AND THE PROBLEM.

Goodwin 2016 - it important that partners in care agree upon the details of their own version rather than pick one of the shelf

“integrated care should be seen as an approach designed to improve care experiences and care quality whilst promoting system sustainability”. Goodwin 2019

- promoting health and wellbeing
- commitment to improving the quality and safety of care services through ongoing and co-productive partnerships.

Fragmentation, adverse impact on care experiences and care outcomes.

people with medically complex or long-term care needs,

QUESTIONS/ DISCUSSION

~ thank you