All OHT Webinar Event

June 25, 2024

Ontario Health

Meaghan Cunningham, *Director, OHT Implementation, Ontario Health*

Land Acknowledgement

***Fredrika Scarth**, Vice President, Integrated Care, Ontario Health*

Welcome

Today's Objective

The objective of this event is to:

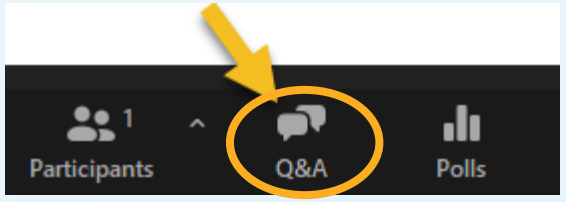
- ✓ Build momentum and support for OHT advancement across all OHTs.
- ✓ Provide updates, information, and direction to all OHTs on priority topics.
- ✓ Support shared learning and knowledge translation.

Today's Agenda

Time	Agenda Topic
8:30 – 8:45 am	Welcome & Land Acknowledgment
8:45 – 9:00 am	Ontario Health Leadership Remarks
9:00 – 10:00 am	Session #1: Primary Care Network/Structures
BREAK 15 Minutes	
10:15- 11:15 am	Session #2: Integrated Clinical Pathways
11:15-11:45 am	Session #3: OHT Updates: • OHT Engagement Framework • OHT Performance Framework
11:45-12:00 pm	Wrap-Up

Webinar Logistics

- This session will be recorded and a link to the recording will be circulated post meeting.
- Questions can be submitted through the Q&A box:



- Any questions that are not answered in today's session will be answered and circulated post-meeting to OH Regions to support conversations with OHTs.

Matthew Anderson, *Chief Executive Officer, Ontario Health*

Dr. Sacha Bhatia, *Senior Vice President, Population Health and Value Based Health Systems, Ontario Health*

Ontario Health Leadership

Dr. Elizabeth Muggah, *Senior Clinical Advisor, Primary Care, Ontario Health*
Dave Pearson, *Director, Primary Care, Ontario Health*
Dr. Kim Morrison, *Executive Lead, Frontenac, Lennox & Addington OHT*
Dr. Sohal Goyal, *Chair, Mississauga Health Primary Care Network*
Dr. Brian McKenna, *Chair, Greater Hamilton Health Network Primary Care Stakeholder Council*

Session 1: Primary Care Networks/ Structures

Objective: To share advice and lessons learned from three leading Primary Care Networks

10:00-10:15 am

15 Minute Break

Lauren Bell, *Director, Integrated Care, Ontario Health*
Abby Leavitt, *Hastings Prince Edward OHT Backbone*
John Crawford, *Patient Experience Advisor, Hastings Prince Edward OHT*
Renee Robinson, *Project Navigator Hastings Prince Edward OHT*
Wendy Smith, *Executive Lead, Transformation and Strategy, Nipissing Wellness OHT*
Madonna Ferrone, *Director of Operations, Best Care*

Session 2: Integrated Clinical Pathways

Objective: Sharing successes, lessons learned, and stories of impact for Integrated Clinical Pathways.

ICP Implementation Approach to Date

The implementation of ICPs is intended to improve outcomes, such as avoidable admission and amputations, and experience of care through integrated care, a greater focus on outpatient management, and by leveraging technology and data. The initial pathway focus is a starting point to enabling enhanced population health through proactive management and prevention.

- ICP planning and implementation began in FY 22/23, starting with HF and LLP as initial clinical priorities
  - Initial demonstration teams are still at early stages of full implementation of the pathway, and are **demonstrating positive local impact** in disease-specific care through their ICPs
- Initial 12 OHTs are now implementing both **HF and COPD ICPs as part of OHT Acceleration**, with pathways launching by Q2 of FY 24/25

	West	Central	Toronto	East	Northwest	Northeast
Initial 12 OHTs	• Burlington OHT • Greater Hamilton Health Network • Middlesex London OHT	• Couchiching OHT • Mississauga OHT	• East Toronto Health Partners • North York Toronto Health Partners	• Durham OHT • Frontenac, Lennox, and Addington OHT	• All Nations Health Partners • Noojmawing Sookatagaing (Healing Working Together) OHT	• Nipissing Wellness OHT
In-flight OHTs	• Huron Perth & Area OHT • Windsor Essex OHT	• Barrie & Area OHT • Central West OHT • Muskoka & Area OHT	• Downtown East Toronto OHT • Mid-West Toronto OHT • North Toronto OHT	• Hastings Prince Edward OHT • Ottawa OHT	• Kiiwetinoong Healing Waters OHT • Rainy River District OHT	• Maamwesying OHT

25 OHTs: 15 HF ICPs | 11 LLP ICPs | 12 COPD ICPs | 1 Indigenous-led team*

Early ICP Implementation Results

Through ongoing implementation, teams have made demonstrable local progress in improving care for patients enrolled in the HF and LLP ICPs. Teams have leveraged seed funding to build collaborative models to provide best-practice care and support improved outcomes that have resulted in reduced admissions and ED avoidance, and timely and appropriate escalations to high-value care.

How HF teams are creating value

Access to Care

- 4,600 patients received best-practice care across 7 OHTs
- Enhanced access to appropriate specialist care

Improvements in Care

- ED avoidance and reduction in admissions for enrolled patients in select OHTs
- PROMs reporting showing progress in reducing symptom burden in select OHTs

Care Coordination

- Expanded access to best-practice interprofessional care
- Improved care coordination and reduced wait times for follow-up care
- Increased patient referrals to specialists when appropriate

How LLP teams are creating value

Prevention and Screening

- Over 2,200 screenings for high-risk, high-needs patients in 9 OHTs
  - Prioritized screenings for Indigenous populations, and unattached populations

Escalation and Coordination

- Timely escalation in care for high-risk populations facing access barriers
- Expanded access to chiropody for populations in OHTs through urgent referrals

Wound Management

- Greater access to chiropody and vascular services to support enhanced management and prevention

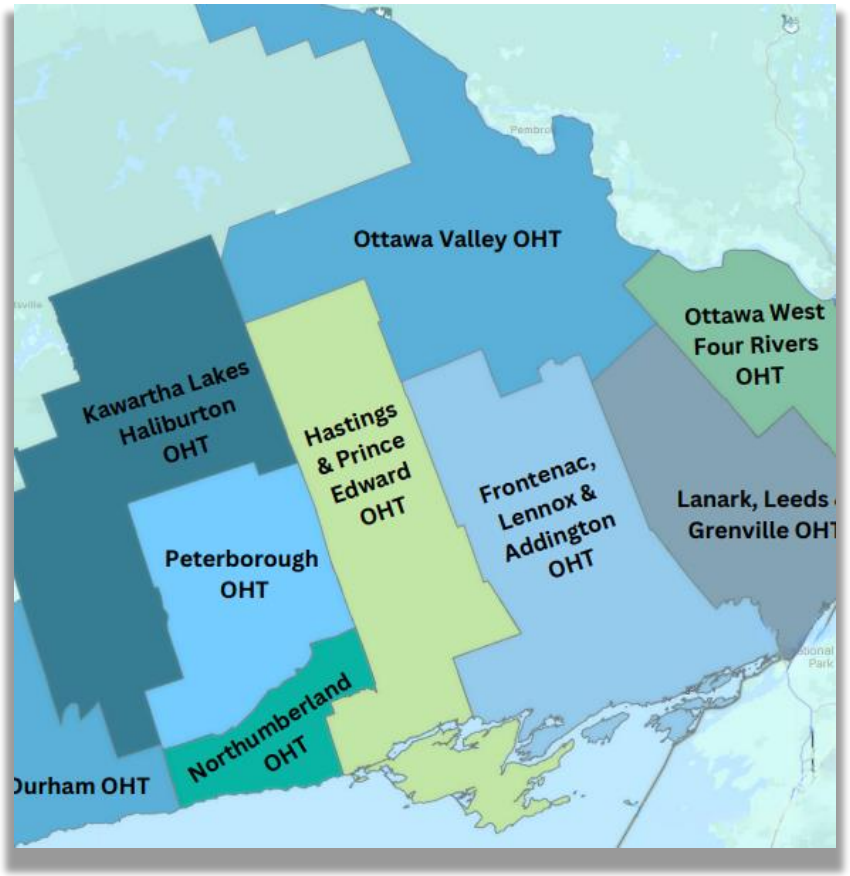
Hastings Prince Edward
Ontario Health Team

Lower-Limb Preservation Demonstration Program

June 25, 2024

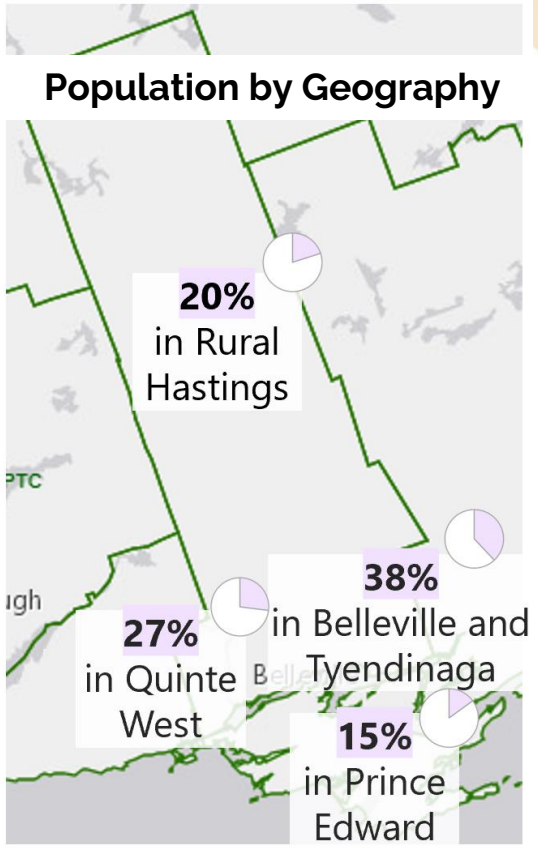
Abby Leavitt, HPE OHT Backbone
John Crawford, Patient Experience Advisor
Renée Robinson, Project Navigator, LLPDP

Meet the Hastings Prince Edward (HPE) OHT



About Us

- Bordered by 5 other OHT's
- Spans 7,066 sq km with a population of 177,060
- Mix of both urban and rural geography
- Large seasonal population



The HPE OHT is a partnership of health and human service care providers from Hastings County, Prince Edward County and the Tyendinaga Mohawk Territory, working in the shared purpose of:

"Caring for our communities together. Partnering for better health and wellness, within, and across our communities."

HPE OHT Partners

HPE OHT Principles for Working Together

Guiding the OHT's actions to implement our shared vision.

Community Focused

Co-design

Distributed Leadership

Diversity, Equity & Inclusion

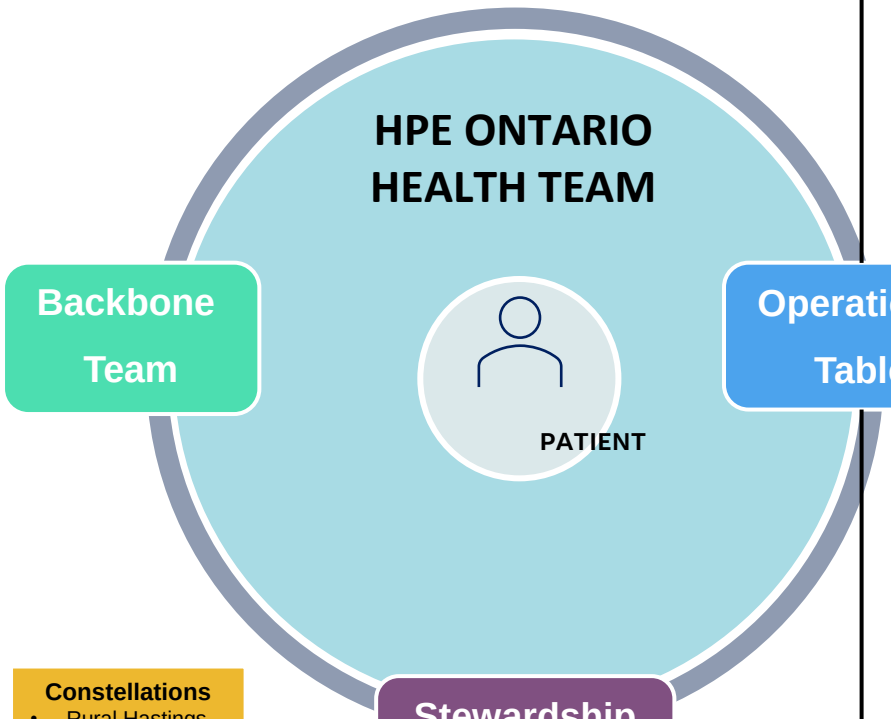
Trust & Transparency

Courage & Innovation

> *"Values are the most basic and fundamental beliefs that guide the way we act and behave. In our OHT, these values will help guide and further develop our relationships and influence how we interact with one another. We look forward to seeing these values in action." – Ed Bentley, PCPC Member*

Example: Testimonial from a Patient, Client and Partner Representative shared on the HPE OHT website

HPE OHT Governance Structure



Constellations
- Rural Hastings
- Quinte West
- Prince Edward County
- Belleville - Tyendinaga

Are responsible for advancing OHT priorities at a local level.

Provides the OHT with direction and advances OHT priorities.

Councils (long-term groups)

Councils are long-term advisory groups

Primary Care Council

The Primary Care Council is comprised of lead physicians or delegates from each of the primary health care organizations in the OHT.

Patient, Client & Partners Council

The Patient, Client and Partners Council plays an integral role as a collaborative partner in helping to ensure that patients, families, and care givers are at the centre of care delivery.

Action Teams (short-term groups)

Action Teams are short-term groups consisting of relevant partners and stakeholders.

Note: This list provide examples of current action teams but is not inclusive of all HPE OHT's Action Teams

- Care in the Community
- Primary Care
- Lung Health
- Health System Responsiveness & Preparedness
- Lower-Limb Preservation

LLP Action Team- HPE OHT Governance Structure

Action Team

Lower-Limb Preservation

Co-leads are a primary care physician champion and a HCCSS champion

Primary Care

- Dr. I Noland, MD Lakeview FHT, Project Co-Chair
- R Robinson, BCFHT, LLP Project Navigator

Home and Community Care Support Services

- L Laing, Director, HCCSS, Project Co- Chair

Hospital (TPA)

- AM MacDonald, Project Manager, Quinte Health
- K Cruess, Operations Director, Quinte Health

HPE OHT

- A Leavitt, Digital Health Project Lead OHT
- J Crawford, Patient Experience Advisor
- A Mask, Senior Population Health & Analytics Consultant, Quinte Health & HPE OHT

Bancroft Community Family Health Team (BCFHT) Pilot Leads

- Dr. C Brown, Physician Advisor
- Dr. A Ferreira, Physician Advisor
- N Moshenko, Chiropodist
- A Holbrook, Data Management Coordinator


John’s Journey

Patient Perspective

The role of the Patient Experience Advisor is a varied one.
Many characteristics should be considered to fulfill this position:

- Good listener
- Able to see beyond their own experience
- Able to see the big picture
- Non-Judgmental
- Ability to maintain confidentiality

One of the other roles is to help board members/decision makers to remember that “people are not numbers” and are frightened by the situation they are in.

They have families who will have questions and concerns and need the same care as the patient.

Advocacy & Awareness

BEST FOOT FORWARD
Saving feet in our community

We Serve
Bancroft Lions Club

We Serve
Madoc Lions Club

Bancroft Community Family Health Team

NEEDS

Diversity, Equity & Inclusion

For patients who cannot afford off-loading devices or shoes and cannot afford to wait for approval

Those who are the most marginalized may still not be eligible for any funding opportunities

VISION

To have a 'virtual warehouse', where providers can assist marginalized individuals to get what they need in a timely manner

"Let's help this person and others who come along in this position."

ACTION

- Engagement with the Lions Club in Bancroft; funding for shoes already received
- Criteria developed to ensure funding goes to the appropriate individuals
- Madoc Lions are also now involved; more meetings with Trenton and Belleville
- Engagement efforts with other service clubs
- Meeting with Trenton Memorial Hospital Foundation for advice and expertise; possible partnership to support fundraising efforts and be holder of the funds


John’s Journey
Moving Forward

About the HPE OHT LLPDP

Opportunity

HPE was selected as a Demonstration Program for the Ontario Health Lower Limb Preservation (LLP) Integrated Clinical Pathway project (March 2023). The LLP Action team identified the Bancroft area as a region in need of integration to improve patient outcomes

Goals

Goal 1: early identification of patients at risk through standardized assessment by all providers; patients at risk are entered into the standardized care pathway as defined by their clinical status (risk level, presence of wounds).

Goal 2: timely access to vascular surgery for high-risk patients; care closest to home; OTN, e-consult options.

LLPDP Reporting

Oct 1, 2023 – Mar 31, 2024

- 89 Navigation Referrals
- 634 Modified Inlow screens completed
- 79 ABPI's
- 30 Wounds identified & seen by Chiropody
- 13 Patients treated with Off-loading
- 10 referrals to Vascular Specialist or testing

Outcomes

Early preventative assessments with a standardized foot screening tool for all health care providers; includes community foot care clinics.

Improve foot wound management with defined referral pathway; includes fast track referral pathway to Chiropody, HCCSS and/or Vascular.

Improve wound closure at 12 and 24 weeks.

Addressing Critical Gaps: Prioritizing Project Objectives to Overcome Barriers

The LLP Action Team worked with system partners to identify gaps and create project priorities and objectives to overcome barriers to care. This led to the development of a model of care and change initiatives for implementation.

High Risk Foot

- **Gaps:** Lack of communication regarding FHT services and chiropody, lack of standard screening tool outside of Primary Care, Lack of care coordination for high-risk patients
- **Project Priorities:** Standardized forms for screening and referrals, navigation role, wrap-around care delivery, patient and provider education

Barriers overcome by:

- More providers trained on foot screening, including dietitians in diabetes centres.
- Pathway for care escalation implemented at Community Support Services supported by foot screening tool.
- Creation of OCEAN referral form with KHSC and PRHC with input from Vascular Surgery (still inactive).

Home and Community Care Support Services (HCCSS)

- **Gaps:** Lack of communication between FHT providers and HCCSS nursing, Access to local ABPI testing
- **Project Priorities:** Improve communication between the FHT and HCCSS service providers, implementation of digital solutions to support integrated care, access to local vascular testing

Barriers overcome by:

- Shared care between HCCSS and Chiropody; making patients aware appointments will be booked with both.
- Optimizing services at best time or location for patient (e.g. ABPI testing)

Care for Unattached Patients

- **Gap:** Lack of process for high-risk patients without primary care provider
- **Project Priorities:** Physician lead for diabetes care, nurse practitioner for acute care needs, collaboration with HCCSS, FHT services

Barriers overcome by:

- Dr. Ferreira providing diabetes care for unattached patients in the DEP, including referrals for vascular imaging or Vascular Surgery.
- NPs providing acute care needs for unattached.

Addressing Critical Gaps: Prioritizing Project Objectives to Overcome Barriers

The LLP Action Team worked with system partners to identify gaps and create project priorities and objectives to overcome barriers to care. This led to the development of a model of care and change initiatives for implementation.

Access to Offloading Equipment and Supplies

- **Gaps:** Lack of local access to offloading devices, lack of equipment for continued footwear modification
- **Project Priorities:** locally available offloading devices for chiropodist fitting, standard HCCSS referrals, equipment and tools for footwear modifications

Barriers overcome by:

- Changes to HCCSS *Referral and Order Requisition for Offloading Devices* form to include Chiropody assessment
- Consignment of off-loading boots to chiropody clinic.
- Purchase of equipment and supplies to modify footwear.
- Partnerships with local service clubs to fund Tier 2 devices.

Ankle Brachial Pressure Index (ABPI) Testing

- **Gaps:** Lack of access to ABPI screening, lack of standards for screening in Primary Care, lack of standards for follow-up testing, toe pressures, or doppler waveforms
- **Project Priorities:** Purchase of ABPI machines, testing in Primary Care, develop standards for re-assessment, access to arterial perfusion testing

Barriers overcome by:

- Creation of a PAD Assessment Pathway, with Vascular Surgery input, to support PCP decision-making.
- Purchase and distribution of 16 ABPI machines and 6 advanced Dopplers throughout HPE.
- Working towards implementing vascular ultrasounds at QH North Hastings Hospital (rural health care)

Metrics for Prevention and Treatment

- **Gaps:** Lack of focused data collection for LLP metrics
- **Project Priorities:** Creation of custom forms by data management coordinator to capture LLP local metrics, OCEAN referral tracking

Barriers overcome by:

- Creation of a digital foot screening tool integrated into EMR; e-Health support for ease of integration for other users.
- HPE standardized metrics implemented at spread sites with support for tracking and reporting.

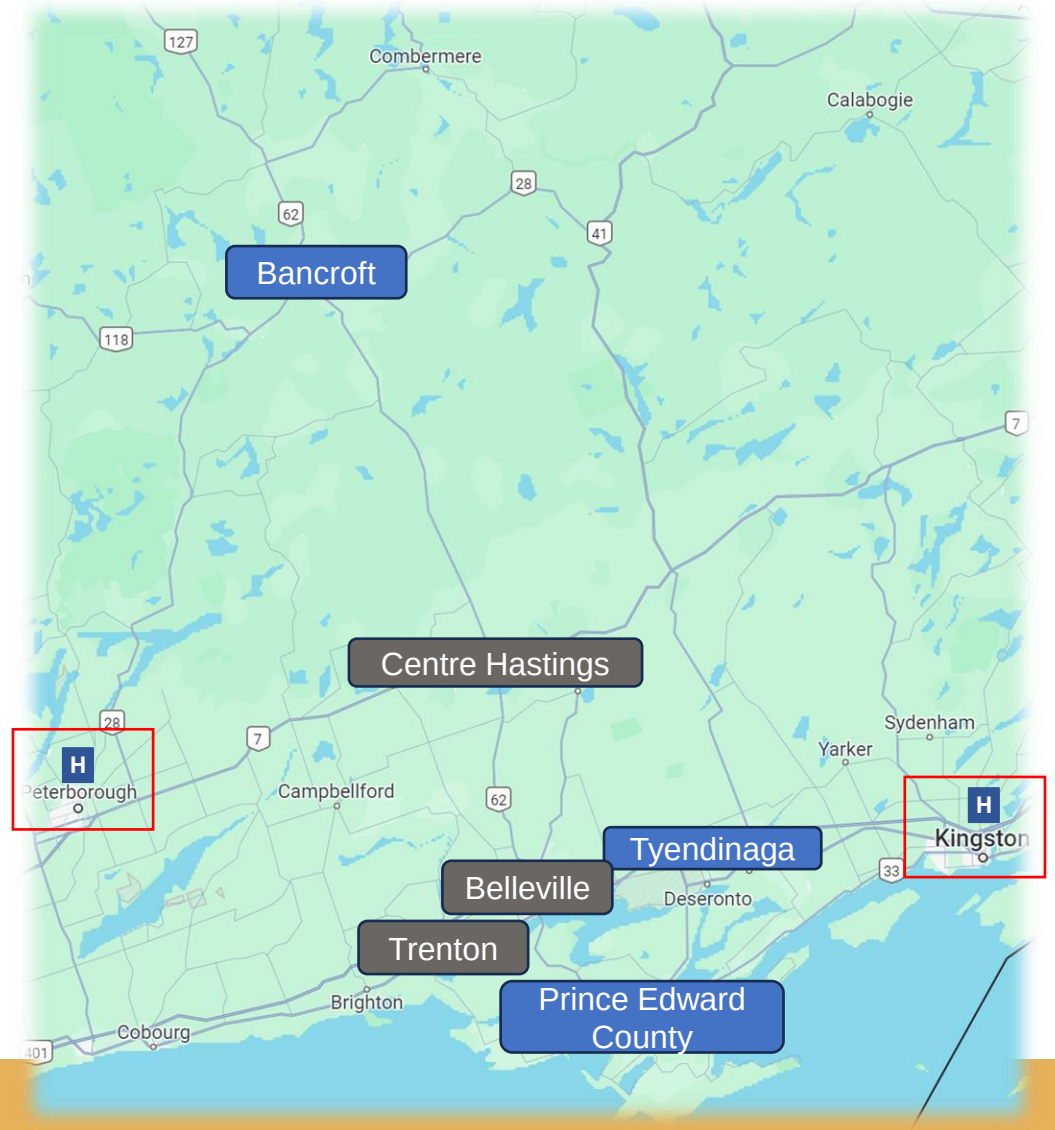
Connecting the Dots...

- Community Focused
- Co-design
- Distributed Leadership
- Diversity, Equity & Inclusion
- Trust & Transparency
- Courage & Innovation

Hastings Prince Edward OHT
Lower Limb Preservation
Demonstration Project

Moving Forward

- The LLPDP is well established in Bancroft, due to the pilot site
- It has spread to Tyendinaga (Mohawks of the Bay of Quinte and the Indigenous Interprofessional Primary Care Team) and Prince Edward County
- Spread is currently underway in Centre Hastings and will then proceed to Belleville and Trenton with the goal of program coverage over the entire OHT
- We continue to work with all OHT partners and existing resources in sustaining the lower limb project in HPE OHT
- The goal remains to provide consistent, high quality, equitable care for those at risk of lower limb amputation in HPE



Équipe Santé Ontario Health Team
Ontario Bimaadzwin Niigaanwiwaad

INTEGRATED CLINICAL PATHWAY FOR HEART FAILURE

Stories of Impact for ALL-OHT Webinar

June 2024

SPEAKER PROFILE

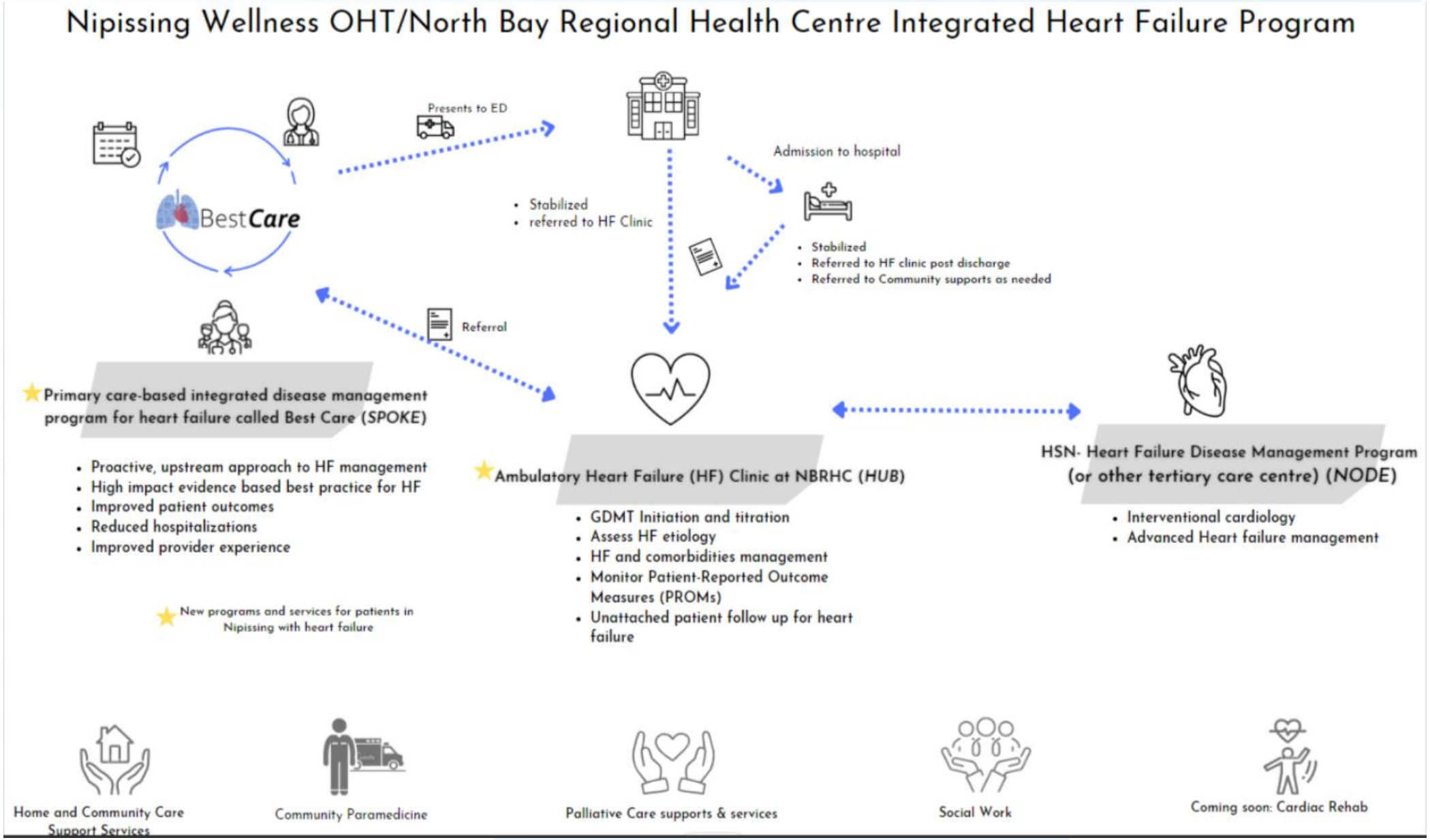
Wendy Smith

Executive Lead
NWOHT

Madonna Ferrone

Director of Operations
ARGI/Best Care

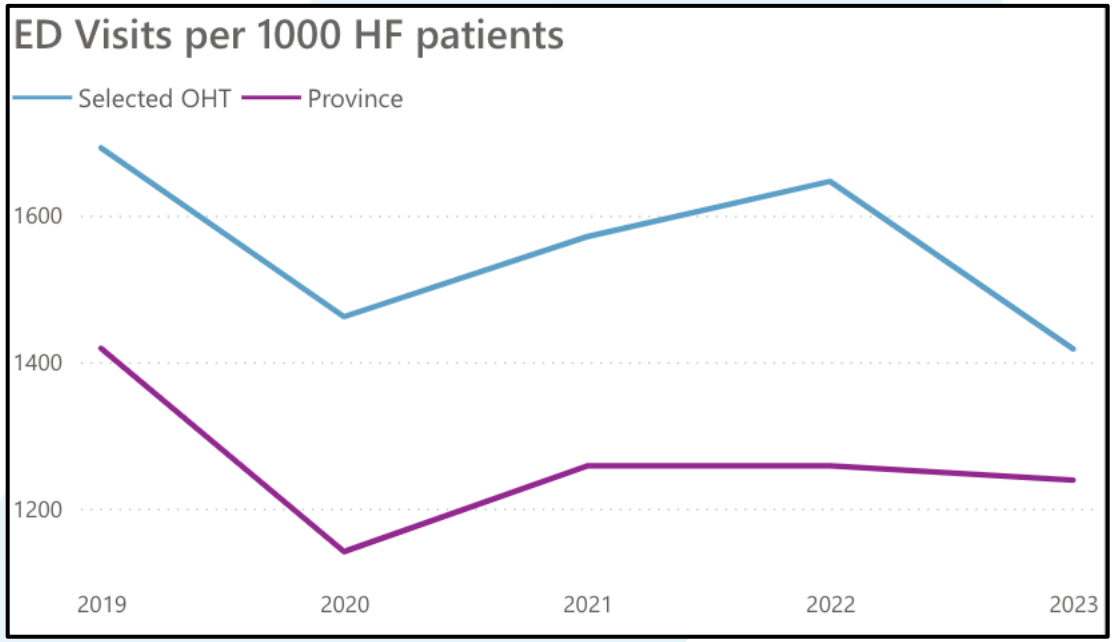
Nipissing Wellness OHT/North Bay Regional Health Centre Integrated Heart Failure Program



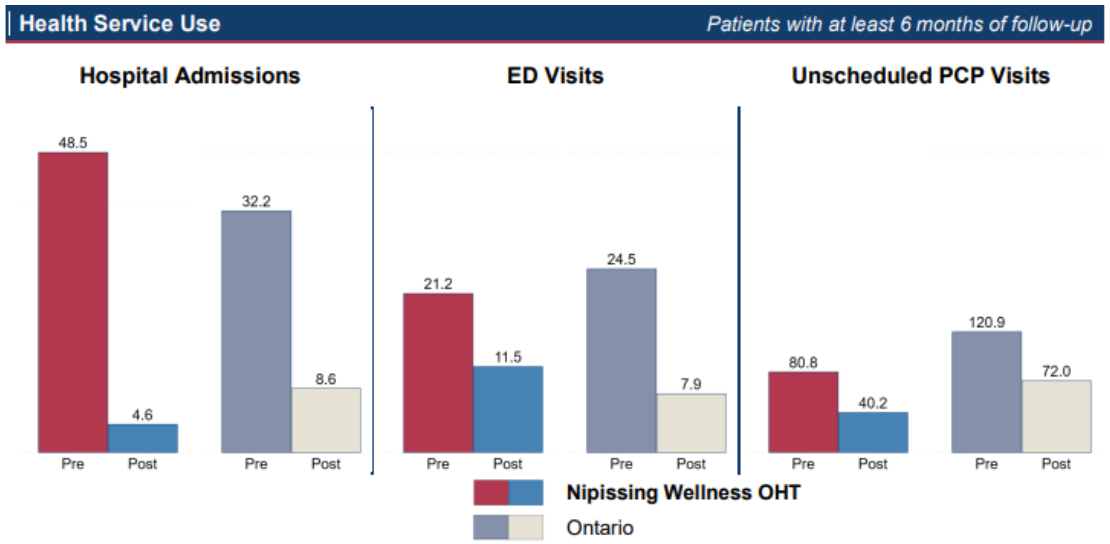
PEOPLE LIVING WITH HEART FAILURE IN NIPISSING

- NWOHTs attributed population includes ~ 3100 patients with a diagnosis of HF ~ 600 of these patients are unattached
- Incidence is 46 per 1000 in NWOHT compared to 37.4 per 1000 in Ontario
- 26% of our attributed population > 65
- Prior to implementation of our ICP local people had no access to LOCAL secondary level care or equitable access to best practice in our district

ED visits for HF in Nipissing Wellness OHT (NWOHT) vs Provincial average



CLINICAL IMPACTS ON HF POPULATION



As of 2024 YTD:

- Quality of life has **improved in 40%** of patients since starting BestCare (based on KCCQ score)
- Hospital admissions have **decreased by 40+%** since starting BestCare
- ED visits have **decreased by 10%** since starting BestCare
- Unscheduled/Urgent Primary Care Provider visits have **decreased by 40%** since starting BestCare

Nipissing Wellness OHT/North Bay Regional Health Centre Integrated Heart Failure Program

Presents to ED

- Stabilized
- referred to HF Clinic

Admission to hospital

- Stabilized
- Referred to HF clinic post discharge
- Referred to Community supports as needed

Referral

★ **Primary care-based integrated disease management program for heart failure called Best Care (*SPOKE*)**

- Proactive, upstream approach to HF management
- High impact evidence based best practice for HF
- Improved patient outcomes
- Reduced hospitalizations
- Improved provider experience

★ New programs and services for patients in Nipissing with heart failure

★ **Ambulatory Heart Failure (HF) Clinic at NBRHC (*HUB*)**

- GDMT Initiation and titration
- Assess HF etiology
- HF and comorbidities management
- Monitor Patient-Reported Outcome Measures (PROMs)
- Unattached patient follow up for heart failure

HSN- Heart Failure Disease Management Program (or other tertiary care centre) (*NODE*)

- Interventional cardiology
- Advanced Heart failure management

Home and Community Care Support Services

Community Paramedicine

Palliative Care supports & services

Social Work

Coming soon: Cardiac Rehab

BESTCARE in Primary Care…

- An effective model of care for chronic disease management that is a repeatable platform for multiple chronic diseases
- An instrument of health system transformation that empowers primary care
- Is an innovative solution created by the physicians of Ontario
- Is trusted by >1,300 primary care physicians in more than 240 clinics, with demonstrated spread and scale
- 100% of providers approached to implement Best Care say YES
- Creates health care teams where no teams exist and enhances care where teams exist.
- Works in all models of primary care
- Resources providers to deliver OH care standards to their most vulnerable patients
- Improves provider experience with health care
- Creates capacity in primary care, the emergency department and in hospital beds
- Is upstream community-based care

PATIENT PERSONA

ICP CoPs – Online Shared Space

COPD Integrated Clinical Pathway CoP

Integrated Heart Failure Care CoP

Integrated Lower-Limb Preservation CoP

A reminder that the Heart Failure, Lower-Limb Preservation and COPD CoPs are open to all OHTs

Click here to join the ICP CoPs

1. Visit the OHT Shared Space and click "SIGN UP" to create your account.

2. Click the "JOIN GROUP" button. You will receive an email notification when you've been accepted into the group.
   Note: You are automatically accepted into the "General Discussion" Group.

3. Don't forget to click on the "Subscribe to Updates" button once you've been accepted into your CoP, to stay updated with all the latest conversations, webinars and resources.

Any questions/concerns? Contact the OH ICP Project Team at **OHTSupport@OntarioHealth.ca**

Integrated Clinical Pathways: Stories of impact video compilation

Meaghan Cunningham, *Director, OHT Implementation*
Ian Cummins, *Director, OHT Strategy*

Session 3: OHT Updates

Objective: Provide an update to OHTs on the OHT Engagement Framework and the OHT Performance Framework.

OHT Engagement Framework

Objectives

- Leverage the benefits of co-design to ensure the framework sets a foundation that drives equity, inclusion, diversity and anti-racism and reflects needs of stakeholders (MOH, OH, OH Regions, and OHTs)
- Clarify roles and define communication pathways
- Build a framework based on accepted guiding principles, that is agile and able to address the varied nature of engagements required across the system
- Build in quality improvement and accountability mechanisms

OHT Engagement Framework Journey

Initial OHT Feedback
- All OHT survey conducted by the field in early Spring 2022
- Survey feedback shared with MOH and OH

Initial Launch
OHT Engagement Framework soft launched via All-OHT Townhall

Evaluation Results
Survey results from the initial evaluation was shared with MOH, OH Provincial and Regional teams, and OHTs.

Framework Development

Framework Refresh

March – April 2022

June 2022

December 2022

July 2023

September 2023

March 2024 & beyond

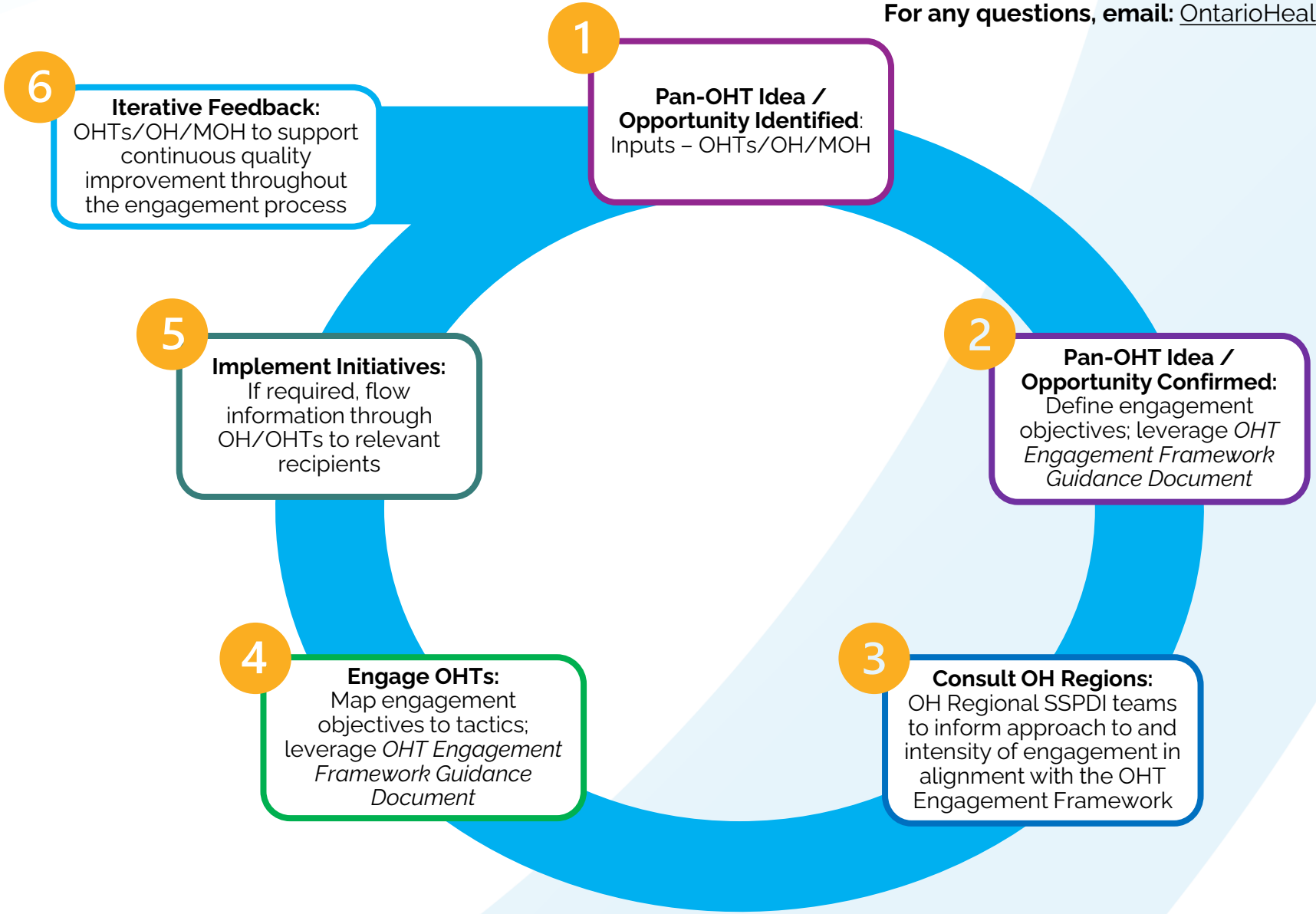
Committee Development
OHT Liaison Committee established

Post-Launch Evaluation
- Six months after the soft launch of the framework, a post-implementation evaluation was started
- An all-OHT survey was developed and conducted by the OHT Liaison Committee from July – September 2023

Refreshed Framework
- Framework & guidance refreshed based on evaluation feedback
- Re-launched framework in March 2024
- Framework socialization & use beyond Q1 FY 24/25

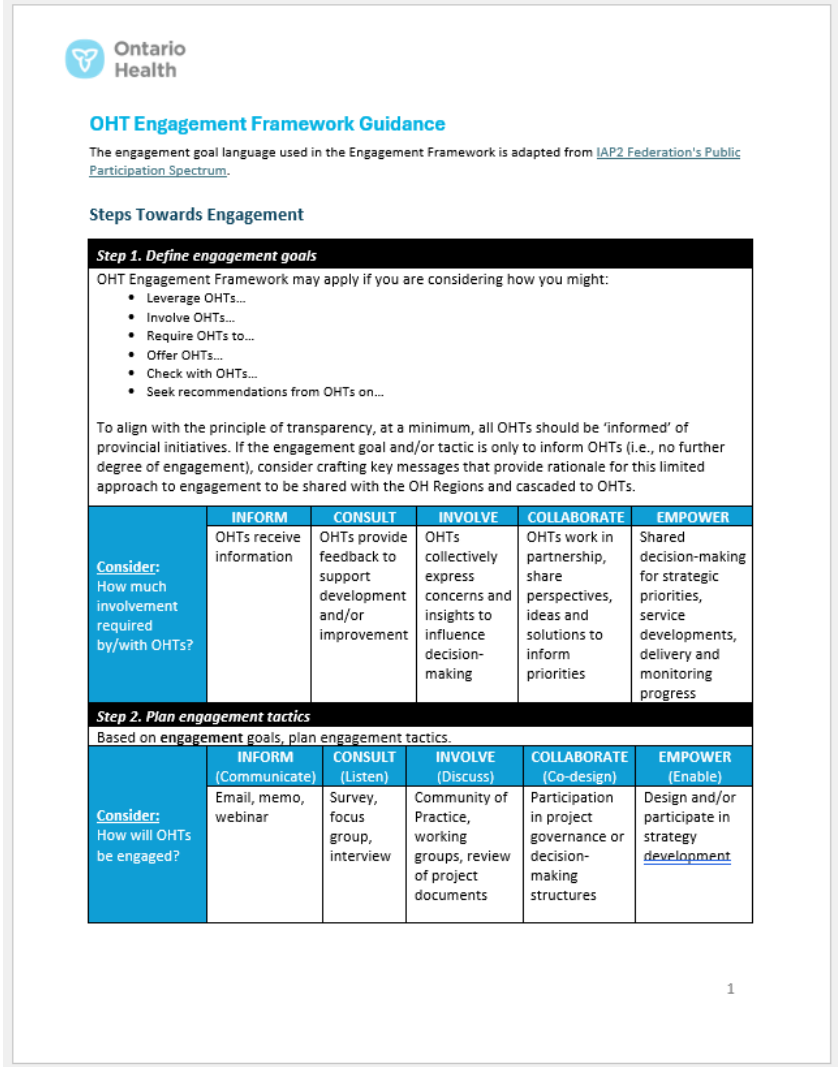
OHT Engagement Framework

For any questions, email: OntarioHealthTeams@ontariohealth.ca



Guidance Document

- The guidance document and summary tool are intended to be used by OH Provincial Teams, OH Regional Teams, and MOH partners to inform the use of the Framework.



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OHT Engagement Framework Guidance

The engagement goal language used in the Engagement Framework is adapted from IAP2 Federation's Public Participation Spectrum.

Steps Towards Engagement

Step 1. Define engagement goals

OHT Engagement Framework may apply if you are considering how you might:

- Leverage OHTs…
- Involve OHTs…
- Require OHTs to…
- Offer OHTs…
- Check with OHTs…
- Seek recommendations from OHTs on…

To align with the principle of transparency, at a minimum, all OHTs should be 'informed' of provincial initiatives. If the engagement goal and/or tactic is only to inform OHTs (i.e., no further degree of engagement), consider crafting key messages that provide rationale for this limited approach to engagement to be shared with the OH Regions and cascaded to OHTs.

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Consider: How much involvement required by/with OHTs?	OHTs receive information	OHTs provide feedback to support development and/or improvement	OHTs collectively express concerns and insights to influence decision-making	OHTs work in partnership, share perspectives, ideas and solutions to inform priorities	Shared decision-making for strategic priorities, service developments, delivery and monitoring progress

Step 2. Plan engagement tactics

Based on **engagement** goals, plan engagement tactics.

	INFORM (Communicate)	CONSULT (Listen)	INVOLVE (Discuss)	COLLABORATE (Co-design)	EMPOWER (Enable)
Consider: How will OHTs be engaged?	Email, memo, webinar	Survey, focus group, interview	Community of Practice, working groups, review of project documents	Participation in project governance or decision-making structures	Design and/or participate in strategy development

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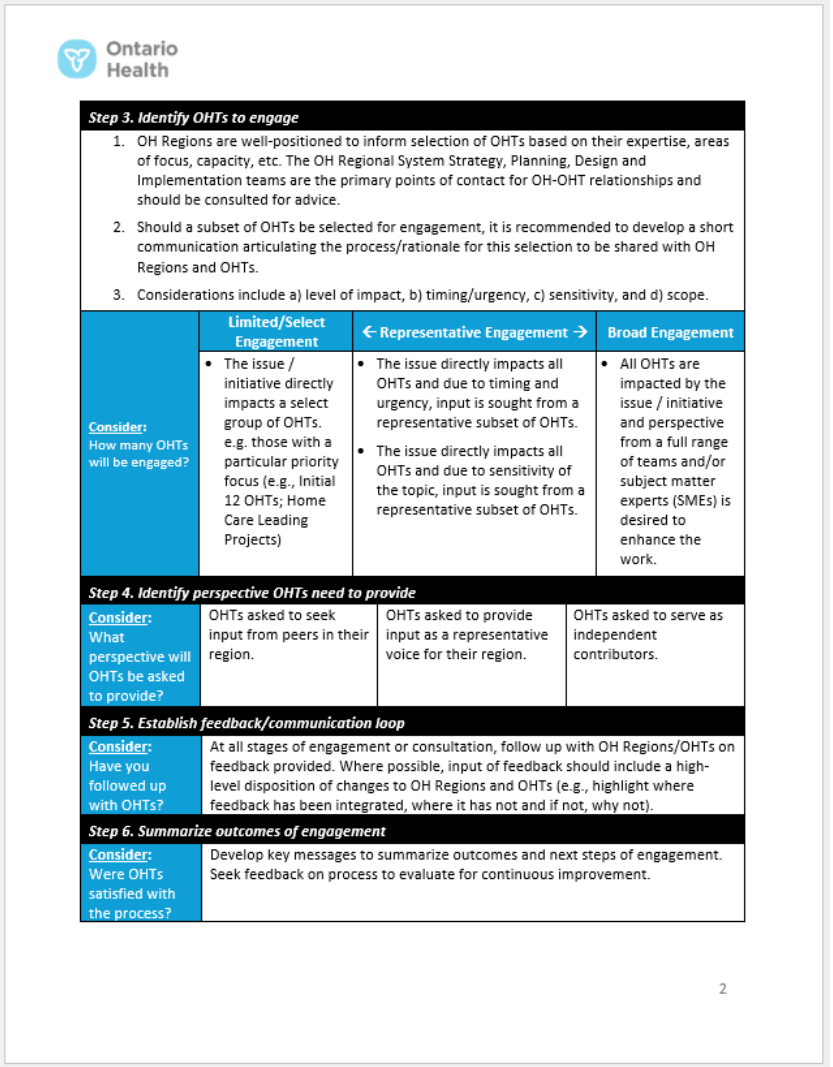

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Step 3. Identify OHTs to engage

1. OH Regions are well-positioned to inform selection of OHTs based on their expertise, areas of focus, capacity, etc. The OH Regional System Strategy, Planning, Design and Implementation teams are the primary points of contact for OH-OHT relationships and should be consulted for advice.
2. Should a subset of OHTs be selected for engagement, it is recommended to develop a short communication articulating the process/rationale for this selection to be shared with OH Regions and OHTs.
3. Considerations include a) level of impact, b) timing/urgency, c) sensitivity, and d) scope.

	Limited/Select Engagement	← Representative Engagement →	Broad Engagement
Consider: How many OHTs will be engaged?	• The issue / initiative directly impacts a select group of OHTs. e.g. those with a particular priority focus (e.g., Initial 12 OHTs; Home Care Leading Projects)	• The issue directly impacts all OHTs and due to timing and urgency, input is sought from a representative subset of OHTs. • The issue directly impacts all OHTs and due to sensitivity of the topic, input is sought from a representative subset of OHTs.	• All OHTs are impacted by the issue / initiative and perspective from a full range of teams and/or subject matter experts (SMEs) is desired to enhance the work.

Step 4. Identify perspective OHTs need to provide

Consider: What perspective will OHTs be asked to provide?	OHTs asked to seek input from peers in their region.	OHTs asked to provide input as a representative voice for their region.	OHTs asked to serve as independent contributors.

Step 5. Establish feedback/communication loop

Consider: Have you followed up with OHTs?	At all stages of engagement or consultation, follow up with OH Regions/OHTs on feedback provided. Where possible, input of feedback should include a high-level disposition of changes to OH Regions and OHTs (e.g., highlight where feedback has been integrated, where it has not and if not, why not).

Step 6. Summarize outcomes of engagement

Consider: Were OHTs satisfied with the process?	Develop key messages to summarize outcomes and next steps of engagement. Seek feedback on process to evaluate for continuous improvement.

2

OHT Performance Framework

Recall

Summary

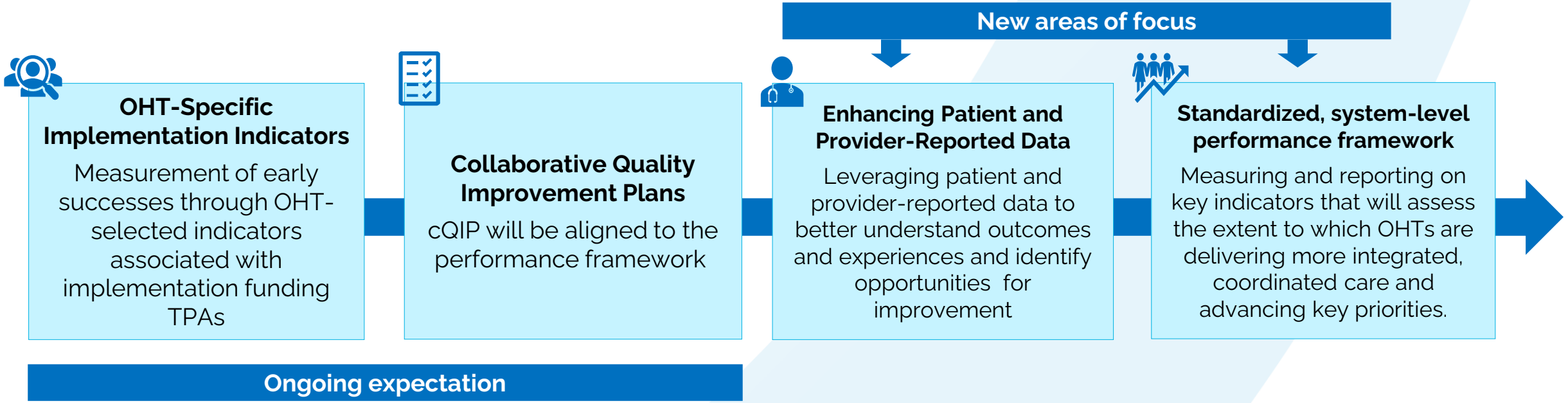
- Since 2019, OHTs have been reporting on local performance measures that reflect local priorities.
- Last year, Ontario Health approved provincial priorities as part of the OHT Acceleration Strategy.
- In October, Ontario Health formed a working group with OHT, patient and scientific advisors to select recommended performance measures for a FY24/25 OHT Balanced Scorecard. These measures have been approved.
- This year, the performance framework will be implemented in partnership with the i12 OHTs with a shared long-term goal of supporting continuous performance improvement.

Today's Objectives:

- Review performance measures and priorities for FY24/25
- Discuss how all OHTs can begin using the performance measures

OHT Performance Framework: An Overview

- The development of a performance framework was an original deliverable in the 2019 OHT guidance. The *Path Forward* (2022) and *OHT Acceleration* (2023) announcements renewed the importance of developing a standardized performance framework with the goal of demonstrating how OHTs are collectively improving patient care.



OHT Performance Measure Selection Process

1

Ontario Health created an OHT Performance working group with scientific advisors, patient advisors and OHT representatives from the acute, primary, home and community care sectors

2

The working group reviewed a short-list of nearly 45 potential performance measures aligned to provincial OHT priorities

3

The working group recommended 18 measures through a modified delphi survey process and consensus-building discussions

Working Group Recommendation

- Working group members reinforced the importance of including a balanced set of health system measures based on administrative, patient experience and provider experience data.
- Based on this feedback, the working group selected a combination of validated and developmental measures for FY24/25.

FY24/25 OHT Balanced Scorecard

8 Validated Measures

Goal: establish a baseline and begin measuring progress

10 Developmental Measures

Goal: pilot test and evaluate for potential inclusion in FY25/26

Validated Measures

The following working group recommended health system measures were approved for FY24/25. These indicators can be reported at an OHT-level and stratified based on equity criteria.

Clinical Priority	Quintuple Aim	Measure	Data Source
Population Health	Improving Population Health	Number of Hospitalizations for Ambulatory Care Sensitive Conditions	OHT Data Dashboard
Transitions in Care	Improving Value	Alternate Level of Care (ALC)	OHT Data Dashboard
Primary Care Access (Attachment)	Improving Population Health	% of patients within the OHTs-attributed population who are attached to a primary care physician	INSPIRE: https://inspire-phc.org/primary-care-data-reports/
HF Integrated Clinical Pathway	Improving Population Health	Admissions per 100 HF patients	OHT Data Dashboard
COPD Integrated Clinical Pathway	Improving Population Health	Admissions per 100 COPD patients	OHT Data Dashboard
Cancer Screening Measures	Improving Population Health	% of cancer screening participation • A summary metric with the option to drill down for individual cancer screening measures (cervical, colorectal and breast)	OHT Data Dashboard

Developmental Measures

The following working group recommended experience and process measures were approved for FY24/25

Clinical Priority	Quintuple Aim	Measure
Care Coordination	Enhancing Patient Experience	**1.** % of patients with information about next steps in care **2.** % of patients engaged in decision-making to the extent preferred **3.** % of patients who have a documented individualized care plan
System Navigation	Enhancing Patient Experience	**4.** % of patients with knowledge of who to contact about questions or concerns pertaining to care
	Improving Provider Experience	**5.** % of providers who feel confident helping patients find and access available health and social services
Integrated Clinical Pathway	Improving Population Health	**6.** % of unique patients enrolled into the initiative (participating in at least 1 stream of care)
Primary Care Network	Provider Experience	**7.** % of primary care providers who report that they have the information that they need about their patients
	Improving Value	**8.** % of Primary Care physicians attributed to the OHT who are PCN members
	Improving Provider Experience	**9.** % of Primary Care providers who rate their involvement with the OHT as high, medium, low vs none
Health Equity and Cultural Safety Measures	Advancing Health Equity/ Enhancing Patient Experience	**10.** % of patients feeling their background and identity is respected by HCPs
Supports for Unattached	Enhancing Patient Experience	*Developmental measure to be developed in consultation with initial 12 OHTs*

Next Steps

- This year, OH will be working with the initial 12 OHTs to design and implement a performance scorecard and review process, establish baseline performance and evaluate the developmental measures. Regular updates will be provided via regional collaboratives.
- OHTs beyond the I12 can optionally begin using the validated performance measures as local OHT measures. OHT-level data for the validated measures will be made available through the OHT Data Dashboards and INSPIRE reports. Ontario Health will not use or report on this data to assess performance.
- While OHTs can also optionally use some or all of the developmental measures, they should be aware that they may be refined or adapted as they are being tested by the i12 OHTs.
- We encourage all OHTs to continue sharing outcomes and lessons learned related to performance measurement through TPA reporting.

Next Steps

- In July, Ontario Health will distribute an information package to all OHTs with more information about all of the measures presented today in addition to an FAQ document

Meaghan Cunningham, *Director, OHT Implementation*

Closing Remarks

Key Messages

- Thank you for your participation in today's webinar and your continued commitment to promoting an integrated care system.
- All participants will receive a copy of the presented slides and a recording of the session.
- Translated materials will be circulated when available.
- Thank you for the questions posed at registration and during the webinar. We will work towards providing answers via the OH Regional teams in a timely manner.

Survey!

- When the webinar ends, a survey will appear with an opportunity for you to input your review of today and suggestions for future events. We appreciate your time and feedback to help us learn.

Thank you