Key Messages

1. We are developing a new way of organizing and delivering care that is centred on patients, families and caregivers.
2. In the Guelph area, we are building on what we already do well - collaborating to meet the needs of patients.
3. Together, we will be able to achieve much more than we could separately.
4. All of us are committed to strengthening our local health system and available services, improve client experiences and ultimately, make the community healthier. While OHTs are being developed, community members can be assured their existing health services will remain available and accessible.

Overview

The Guelph and Area Ontario Health Team (OHT) was one 158 Ontario teams that submitted an application to the Ministry of Health for consideration. Of those submissions, 31, including Guelph, were invited to the next step and submit a full application by Oct. 9. So far, 14 healthcare organizations* in Guelph and surrounding area have become core members of the new *Guelph and Area Ontario Health Team* (Guelph and Area OHT).

In developing our submission, numerous engagement sessions have been held over the past number of months involving patients, families, persons with lived experience, clinicians and other health care providers. From those meetings, the first two local priority populations were identified - palliative care and mental health & addictions.

Palliative Care

Background

With an aging population, it is anticipated that there will be a 52% increase in deaths over the next 10 years in our region. In order to meet the needs of these patients, families and their caregivers, the uelph and Area OHT will require greater capacity to provide community-based, integrated palliative care services. During the engagement sessions, we heard families and caregivers wanted to be included as partners in the care plan but not leading the plan and should always know the next step in their treatment and/or care.

From front-line staff need role clarity, team awareness and shared understanding related to the patient journey. Palliative care providers need more information and training. They also want time to have discussions that are culturally sensitive about serious illness and the end-of-life stage.

Finally, the Guelph and Area OHT must ensure communication is clear and informative about the disease trajectory from diagnosis to treatment(s), to the palliative approach to care, through to end-of- life care. Care must be based in the community, not the hospital and the OHT must ensure trained professionals engage in serious illness conversations as soon as a life-limiting illness is diagnosed.

Year 1 targets for Palliative Care

- Trial existing and emerging triage mechanisms to support fewer patients to the Emergency Department in the last 30 days of their life

- Develop a consistent mechanism for identifying patients with life limiting illness by March 31, 2020.

- Identify those who are involved in serious illness conversations and support them to develop the skills and provide the necessary resources by March 31, 2020

- By December 31, 2019 seriously ill patients, family and other caregivers will have access to 24/7 support via a "*serious illness call line.*"

- Add/update a (new) social engagement component in the patient's care plan by September 2020 which would be provided by volunteers

Mental Health & Addictions

Background

The needs of patients struggling with mental health and/or addiction (MH&A) are often complex. It is both overwhelming and difficult for these individuals to access appropriate and timely support(s) in our current system. As a result, many individuals struggling with complex MH&A fall through the cracks and do not receive the level of care they require and at times, do not receive any care at all. The Guelph and Area OHT is committed to developing one integrated MH&A service that has the capacity to meet the unique and complex needs of all Guelph and Area OHT residents with MH&A in a timely and patient-centered manner.

Extensive engagement sessions have taken place over the past three months involving those with MH&A lived experience, their peers, peer workers, family member(s), caregivers, outreach workers, front-line staff, management and directors from various MH&A organizations, first responders, physicians and nursing staff.

Three of the key change ideas that have evolved from engagements include:

- Develop a MH&A service that is integrated with primary care to support primary care providers to effectively address the needs of their patients with MH&A issues, while enabling cross-sector learning and an increasing capacity for both physicians and front-line/peer workers to more effectively support individuals with MH&A Develop a centralized, low-barrier, interdisciplinary hub capable of providing timely and flexible access to rapid assessments and wrap-around care to meet the needs of vulnerable individuals experiencing complex MH&A
- Expand mobile teams and services to better reach and meet the needs of vulnerable individuals experiencing complex MH&A

Year 1 targets for MH&A

- Patients will have fewer repeat visits to the emergency department for mental health and/or addictions issues
- There will be fewer 911 and police calls for MH&A related issues

- There will be fewer instances of self-harm including suicide/overdose
- Patients won't wait as long to access the MH&A support they require
- Patients will report improved quality of care
- More patients with MH&A issues will report their family practice feels safe, welcoming, free of stigma

Conclusion

Across both palliative care and MH&A, the need for timely and coordination communication was identified. Specifically, discharge processes always including communication with primary care provider and sharing of the patient's care plan amongst members of the care team.

Now that these Year 1 key change ideas and plans have been developed for palliative care and mental health & addictions. Next steps include co-design of other elements of care, including care coordination, system navigation, supported transitions, virtual care digital access to health information and digitally enabled information sharing to enable the year 1 priorities.

Finally, governors from each partner organization are meeting at the end of September to continue the process to develop an integrated governance structure for the Guelph and Area OHT.

If you have any questions, concerns or comments OR if you would like to contribute to the Guelph & Area Ontario Health Team, please contact Emmi Perkins (emmi.perkins@lhins.on.ca)

*** Guelph and Area OHT members:**

Canadian Mental Health Association WW
eHealth Centre for Excellence
Guelph Family Health Team
Hospice Wellington
Sanguen Health
Stonehenge Therapeutic Community
Traverse Independence
East Wellington Family Health Team
Guelph Community Health Centre
Guelph General Hospital
Mango Tree Family Health Team
St. Joseph's Health Centre Guelph
The Elliott Community
WWLHIN Home and Community Care

APPENDIX: Ontario Health Team Model

- An Ontario Health Team (OHT) is a group of providers that are clinically and fiscally accountable for delivering a full continuum of care to an attributed population within a specific geographic area. Eventually all health service providers in Ontario will be a part of an OHT.

- A key focus of the OHT model is improving the patient experience. Patients will experience improved access to care (e.g., virtual care, text, online bookings), improved transitions and coordination of care, and 24/7 coordination and system navigation. Patients will retain full choice in who they see for their care.

- While health services are at the core of an OHT, they will also include close collaboration with human and social services.

- Year one priorities were identified by the Guelph-Puslinch Leadership Council after engaging patients and providers in a collective data review and priority setting discussion. They include:

  1. Developing integrated service teams to support complex and vulnerable clients struggling with Addictions & Mental Health in the community to divert unnecessary ED visits, reduce the length of stay in the ED and also avoid costly repeat ED visits and,
  2. Strengthening integrated community and hospital palliative care teams with a focus on reducing ED visits in the last 30 days of life.

- OHTs will determine their own governance structures that must include strong clinician and patient representation. There is currently no expectation that organizations in an OHT will change their legal structure. When an OHT reaches "maturity", a stage at which all the milestones and capacities of an OHT have been achieved, the members must designate a single fund holder.

- The Ministry has indicated that OHT's can accommodate existing physician remuneration models.

- The second *Premier's Council Report on Improving Healthcare and Ending Hallway Medicine* which included 10 core recommendations to government is key designing the emerging OHT model and priorities. (To read the full report, click here)

Patients of early Ontario Health Teams will begin to experience better coordinated, integrated health care that is easier to navigate. For providers, OHTs foster local collaboration and enables greater communication and coordination. Providers will be supported to work as one coordinated team - focusing on patients and specific local needs, so people can more easily navigate the system and experience easy and coordinated transitions from one health care provider to another. These teams will have flexibility to redesign how they deliver care to meet the needs of their patients in the most effective way.