RISE
Rapid-Improvement Support and Exchange

Ontario Health
Quality

Health system partner(s)

RISE brief 21: Ontario Health (Quality) and how it can support OHTs as a health-system partner
(Last updated 26 March 2020)

Overview

Approved Ontario Health Teams (OHTs) now face the exciting challenges of:
1) 'moving the needle' on quadruple-aim metrics for their year 1 priority populations, which in turn is a key step towards OHTs scaling up a population-health management approach for their entire attributed population; and
2) 'moving the needle' on key OHT building block-related goals for year 1 (e.g.., seamless transitions and virtual care encounters), which in turn is a key step towards putting in place the eight OHT building blocks for their entire attributed population.

To do so, OHTs can draw on the assets and resources that have been developed over the years by key health-system partners. One such partner is Ontario Health, which has a variety of resources for OHTs. This brief shares resources developed by the Quality Business Unit of Ontario Health, formerly Health Quality Ontario. Ontario Health (Quality) has more than a decade of experience in supporting quality improvement across healthcare sectors, conditions and populations, as well as in developing assets and resources that can now be drawn upon by OHTs. The following assets and resources are already available through the HQOntario.ca website, with other business units to follow.

Assets and resources for prioritized year 1 priority populations

Ontario Health (Quality)'s assets and resources can help teams in moving the needle on quadruple-aim metrics for their four frequently selected year 1 priority populations (Table 1).

Table 1: Assets and resources related to year 1 priority populations

Year 1 priority population	Assets and resources
People with mental health and addictions issues	• Quality standards o Anxiety disorders (with more focus on care for adults in community and primary care) o Major depression (care for adults and adolescents) o Obsessive-compulsive disorder (draft) o Opioid use disorder (opioid addiction) o Schizophrenia (care for adults in the community) o Schizophrenia (care for adults in hospital) o Unhealthy alcohol use and alcohol use disorder • Community of practice o Community mental health • Health technology assessment products o Cognitive behavioural therapy for psychosis o Internet-delivered cognitive behavioural therapy for major depression and anxiety disorders o Mental health evidence bundle [Canadian Agency for Drugs and Technologies in Health, from here on referred to as CADTH] o Pharmacogenomic testing for selection of psychotropic drugs

	○ Repetitive transcranial magnetic stimulation (rTMS) for people with treatment-resistant depression
Older adults with greater needs, including 'at risk,' comorbidities/chronic conditions, complexity, frailty, and high service users	• Quality standards ○ Behavioural symptoms of dementia (care for patients in hospital and residents in long-term care) ○ Chronic pain (care for adults, adolescents and children; draft) ▪ Opioid prescribiing for chronic pain (care for people 15 years of age and older) ○ Dementia (care for people living in the community) ○ Diabetic foot ulcers (care for patients in all settings) ○ Hip fracture (care for people with fragility fracture) ○ Low-back pain (care for adults with acute low-back pain) ○ Osteoarthritis (care for adults with osteoarthritis of the knee, hip or hand) ○ Pressure injuries (care for patients in all settings) ○ Venous leg ulcers (care for patients in all settings) • Health technology assessment products ○ Pain management evidence bundle [CADTH] ○ Structured education and neuromuscular exercise program for hip and/or knee osteoarthritis
People at the end of life and/or needing palliative care	• Quality standard ○ Palliative care (care for adults with a progressive, life-limiting illness) • Community of practice ○ Palliative care implementation support group
People with chronic conditions, including chronic heart failure, chronic obstructive pulmonary disease (COPD), dementia (which could also be grouped with mental health), diabetes and those with complex-care needs	• Quality standard ○ COPD (care in the community for adults with chronic obstructive pulmonary disease) ○ Dementia (care for people living in the community) ▪ Behavioural symptoms of dementia (care for patients in hospitals and residents in long-term care homes) ○ Diabetic foot ulcers ○ Diabetes in pregnancy ○ Diabetes Type 1 (draft) ○ Diabetes Type 2 (prediabetes and Type 2; draft) ○ Heart failure ○ Transition from hospital to home • Health technology assessment products ○ Long-term care evidence bundle [CADTH] ○ Additional specific health technology assessments for various chronic conditions

Assets and resources for putting in place the OHT building blocks

Ontario Health (Quality)'s assets and resources can also help teams in putting in place the eight OHT building blocks and to move the needle on key building block-related goals (Table 2).

Table 2: Assets and resources related to the OHT building blocks

Building block (and its relevance to teams)	Assets and resources
Building block #1: Defined patient population (who is covered, and what does 'covered' mean?): 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. *Year 1 expectations*: Patient access and service delivery target met. Number of patients with sustained care relationship reported.	• Not applicable

Building block (and its relevance to teams)	Assets and resources
Plan in place for expanding target population. *At maturity*: Teams will be responsible for the health outcomes of the population within a geographic area that is defined based on local factors and how patients typically access care.	
Building block #2: In-scope services (what is covered?): 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 the full continuum of care and include or expand primary care services. *Year 1 expectations*: Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary-care coverage for a significant portion of the population. *At maturity*: 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.	• Not applicable
Building block #3: Patient partnership and community engagement (how are patients engaged?) Demonstrated history of meaningful patient, family and caregiver engagement, and support from First Nations communities where applicable. Plan in place to include patients, families and caregivers 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. *Year 1 expectations*: Patient declaration of values is in place. Patients, families and caregivers are included in governance structure(s) and patient leadership established. Patient-engagement framework, patient-relations process, and community-engagement plan are in place. *At maturity*: 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 service.	• Patient-partnering framework – A guide for planning for, implementing and evaluating patient-partnering activities • Resources for patients, families and caregivers – A collection of resources to support partnering with healthcare providers and organizations • Resources for healthcare providers – A collection of resources to support patient partnering in the treatment process, in implementing an organizational partnering process, and in other processes • Patient, family and public advisors network – Network of individuals with experience participating in discussion forums, sitting on committees, sharing one-on-one feedback, and informing and helping to build resources and tools for patient partnering o Note that this network was meant to support Ontario Health (Quality) work, but network members could also be a resource to other parts of the healthcare system
Building block #4: Patient care and experience (how are patient experiences and outcomes measured and supported?): 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. *Year 1 expectations*: 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. *At maturity*: 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.	• Quality standards – outline what high-quality care looks like for conditions or topics where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive, with each quality standard package of resources including: o A quality standard containing five to 15 evidence-informed, measurable quality statements focused on high-priority, achievable areas for quality improvement in Ontario (with each quality statement accompanied by associated quality indicators to help healthcare providers and organizations with their improvement efforts) o A patient guide so patients, families and caregivers know what to discuss about their care with their healthcare provider o A case-for-improvement slide deck outlining why the quality standard was created and the data behind it o If applicable, a quality-indicator data table with results at the provincial, regional, and provider level, where possible, as well as across available equity stratifications o A measurement guide intended for healthcare professionals to support adoption of the quality standard

Building block (and its relevance to teams)	Assets and resources
	○ Recommendations for adoption at the system, regional and practice levels to help healthcare providers and organizations adopt the standards. ○ A 'getting started guide' with practical tools for quality improvement • Quality standards playbook for transitions between hospital and home, which is targeted specifically at OHTs • Quorum – An online community to support quality-improvement work
Building block #5: Digital health (how are data and digital solutions harnessed?): 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. *Year 1 expectations*: 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. *At maturity*: Teams will use digital-health solutions to support effective healthcare delivery, ongoing quality and performance improvement, and better patient experience.	• Not applicable
Building block #6: Leadership, accountability and governance (how are governance and delivery arrangements aligned, and how are providers engaged?): 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 the team, reflecting a central brand, and where applicable, putting in place formal agreements between team members. *Year 1 expectations*: 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. *At maturity*: 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.	• Not applicable
Building block #7: Funding and incentive structure (how are financial arrangements aligned?): 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 fundholder, and reinvesting savings to improve patient care. *Year 1 expectations:* Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data. *At maturity:* Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.	• Networks of healthcare providers engaged in supporting the successful implementation of integration initiatives: ○ bundled care and funding ○ Health Links • Other supports to, as well as lessons learned from, past integrated-care initiatives (e.g., bundled care, Health Links, integrated-funding models, rural health hubs) ○ Note that Ontario Health (Quality) is continuing to draw on these experiences in supporting OHTs and will be contributing to a RISE brief about lessons learned from these initiatives
Building block #8: Performance measurement, quality improvement, and continuous learning (how is rapid learning and improvement supported?): Demonstrated	• Public reporting of system performance and health outcomes – Both 'static' and interactive reports, including a yearly

Building block (and its relevance to teams)	Assets and resources

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.
Year 1 expectations: Integrated quality-improvement plan in place for the following fiscal year. Progress made to reduce variation and implement clinical standards and best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative.
At maturity: 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 OHTs are providing integrated care, and performance will be reported.
	report (Measuring Up) and specialized reports (including on wait times)
	• Resources for measuring care experiences
	• Indicator library – Searchable library of information about quality indicators reported by Ontario Health (Quality)
	• Quality improvement plans (QIP) – Structured approach to setting and tracking quality-improvement goals to improve integrated care and engaging boards and leaders
	  o As part of QIP supports, teams have access to the publicly available plans of other organizations and other resources related to integrated care (also see Quorum for indicators and change ideas)
	  o Note that Ontario Health (Quality) is developing further guidance to support OHTs as they start to plan improvements to integrated care across the entire team
	• Quality rounds – Monthly accredited educational talks about quality-improvement projects
	• Quality-improvement webinars – Archive of previously recorded webinars addressing quality-improvement topics
	• E-learning modules – Online educational modules to help primary-care practices see patients on the day they call in or on a day of their choosing
	• IDEAS Foundations of Quality Improvement Program – The IDEAS Foundations program is being offered by specific partner organizations across the province, and those interested in the introductory quality-improvement course (for healthcare providers and managers who are participating or would like to participate in quality-improvement projects) can contact ideas@hqontario.ca
	• Individualized 'audit and feedback' reports to participating:
	  o primary-care practices
	  o specialty-care settings
	  ▪ hospitals
	  ▪ general medicine
	  ▪ orthopaedic surgery
	  o long-term care homes
	• Report summarizing key lessons learned over the past five years about spreading and scaling innovations
	  o This report can be a helpful asset to OHTs as they scale and spread their year 1 implementation successes with both priority populations (to their full attributed population) and OHT building block-related goals (to all OHT building blocks)
	  o In this report, the Adopting Research to Improve Care (ARTIC) program is summarized: what it is; how it started; its emphasis on an evidence-based implementation approach to the projects it supported; its impacts on care, patients and their families; and our collective learnings on how interventions can best be spread to improve care on a large scale
	• Health technology assessments – Assessments of new and existing healthcare services and medical devices, where topics can be submitted online, which recommend to the Ministry of Health whether these services and devices should be publicly funded; assessments can also be used to inform

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	decisions about procurement and interventions to be implemented o Note that Ontario Health (Quality) also liaises with CADTH, which provides additional evidence resources including: ▪ assessments of services and devices, as well as drugs and diagnostic tests ▪ rapid-response service when a full health technology assessment is not needed. ▪ 'horizon scans' about new and emerging technologies'environmental scans' about the national and international landscape (e.g., practices, processes and protocols) in which a technology will be used • Networks of healthcare providers engaged in quality improvement for specific: o sectors ▪ primary care ▪ specialty care – diagnostic imaging, emergency medicine, general medicine, and surgery o conditions ▪ pain management - as physicians continue to work collaboratively in their respective OHTs with a team of health professionals to deliver comprehensive and coordinated patient care, they have opportunities to learn more about their practice and opioid prescribing patterns using supports from the Ontario Pain Management Resources o treatments and tests o unnecessary treatments and tests (Choosing Wisely)

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RISE prepares both its own resources (like this RISE brief) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results, and conclusions are those of RISE and are independent of the ministry. No endorsement by the ministry is intended or should be inferred.

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