RISE population-health management webinar:

A deep dive into designing care models for your priority populations

May 6, 2021

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Ontario Palliative Care Network, Provincial Clinical Co-Lead

This session helps support OHTs in achieving the following OHT TPA milestones:

- Re-designing care for patients in your priority population(s)
- Helping every patient in your priority population(s) to experience coordinated transitions between providers

Welcome!

In the chat box, please select "everyone" tell us your name and your organization/OHT

Zoom Meeting

Leslie McGeoch

Unmute Stop Video Security Participants Chat Share Screen Reactions More End

Chat

To: Everyone File

Type message here...

Chat

Send to: Everyone

Hello

Send

You can also follow us on twitter @ OHTrise to learn about upcoming events and to post about population-health management!

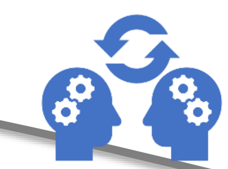
Land acknowledgement

“As we meet here today, we are in solidarity with Indigenous Peoples of Turtle Island and would like to begin by acknowledging that the land on which we gather is part of the Treaty Lands and Territory of the Mississaugas of the Credit, and before, the traditional territory of the Haudenosaunee, Huron and Wendat. We also acknowledge the many First Nations, Inuit, Métis and other global Indigenous Peoples who now call this area their home. We are grateful for the opportunity to be working on this land”.

Today's journey
Designing care models

Segmentation

Recap of core concepts on how to move from segmentation to care model design



Hear from **the Mental Health and Addictions Centre of Excellence** about common approaches and resources for concomitant care models

Hear from the **Ontario Palliative Care Network** about common approaches and resources for concomitant care models

Redesigning care models and testing changes

Core concepts: What co-design looks like

Beginning with initial population segment(s) of priority population

- **Scenario 1:** Change **requires building a new system** to improve care
- **Scenario 2:** Change can be accomplished **within existing system structure**
- **Scenario 3:** Change requires **redesign of existing system**

Expanding co-design to new segment(s)

- Action Teams/Work Groups **develop interim measures** to see if changes are an improvement
- Testing ensures no failures when moving to implementation.
- **Membership of team may change** as Care Model co-design evolves.

- Individual changes **ready for implementation.**
- Testing avoids failures when implementing. Membership of team may change to members with implementation expertise

Changing care for whole priority population

- System **monitoring and evaluating** with **continuous quality improvement** lens.
- This functionality built into OHT infrastructure.

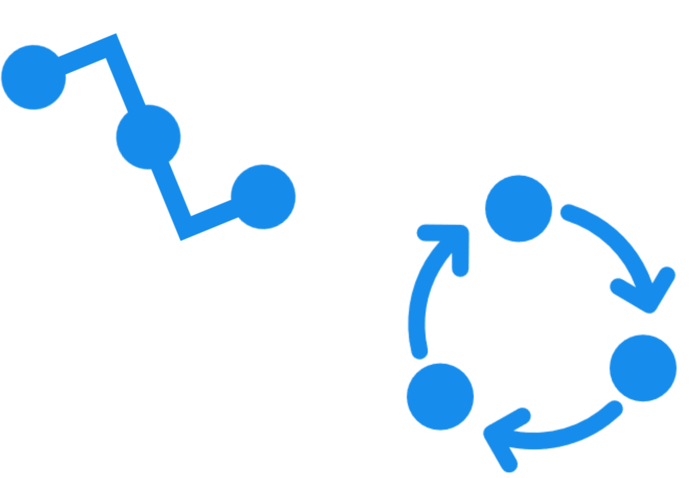
Continuous testing of changes until system is impacting population health as planned

ALL redesign needs to apply an equity lens

Core concepts: the difference between care pathways and care models

Care pathways

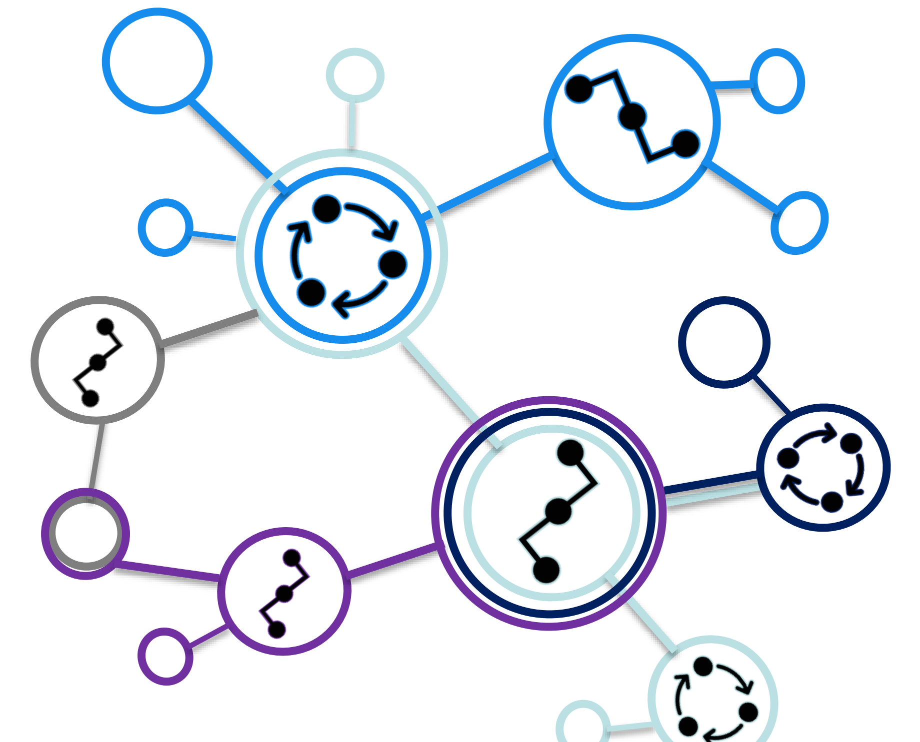
Care Pathways refer to **steps taken to deliver a care process**

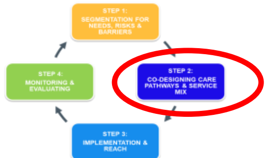


versus

Care models

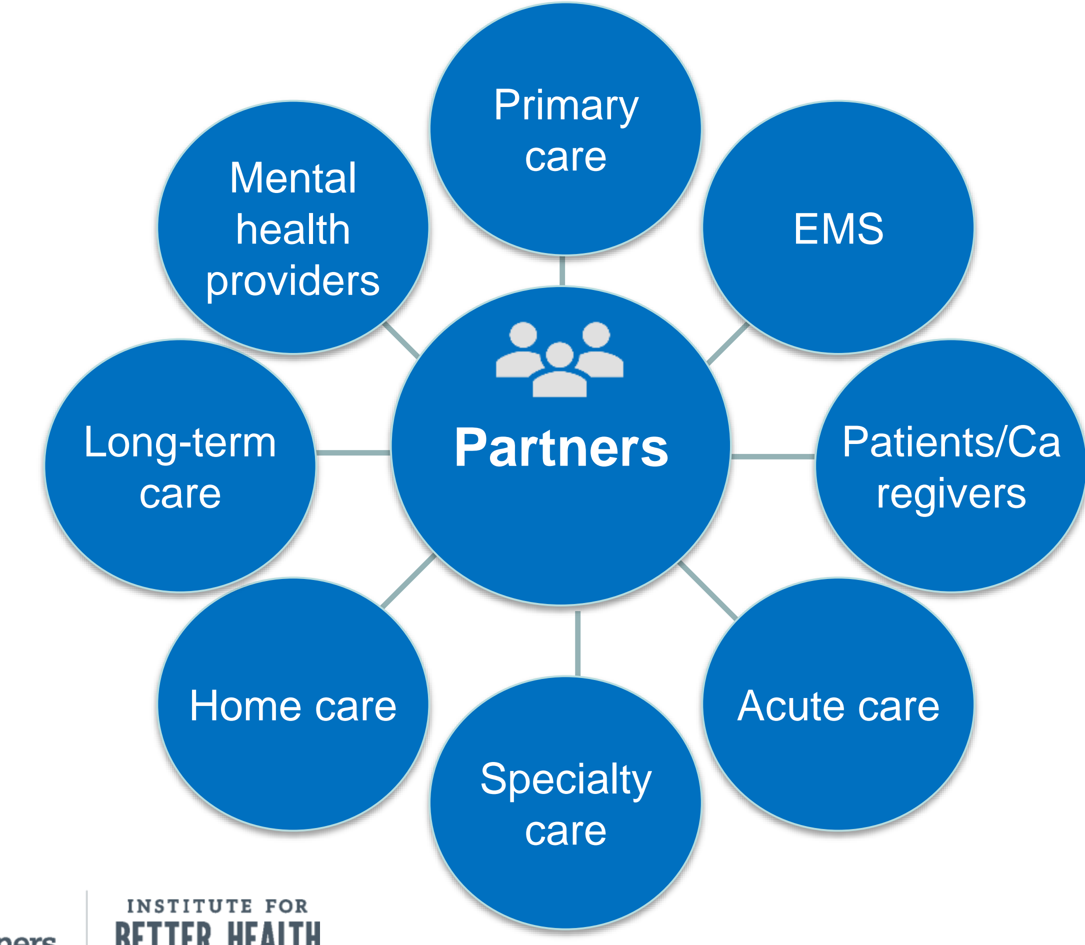
Care Models are **systems of care** with multiple pathways and processes inside





Core concepts: System Redesign Concepts to be Considered

- **Delivery System Redesign**
  - Care access
  - Care coordination
  - Care management
  - Care navigation
- **Clinical Decision Supports**
- **Information Technology Support**
- **Self-management Support**
- **Community Resources**



McMaster University HEALTH FORUM

INSTITUTE FOR BETTER HEALTH

Improving Population Outcomes in Mental Health and Addictions

RISE OHT WEBINAR

MICHELLE ROSSI & DR. PAUL KURDYAK | MAY 6, 2021

Establishing a MHACOE in OH

MHACOE will serve as:

- *Foundation on which the Roadmap to Wellness will be built*
- *Central point of oversight and accountability*

April 2019
Connecting Care Act creates Ontario Health

May 2019
New legislation to support MHA care announced

December 2019
Transfer order issued for first cluster of health agencies into Ontario Health CCO, HQO, EHO, HFO, HSSO

February 2020
Mental Health and Addictions Centre of Excellence Act proclaimed

Mandates OH to establish a MHACOE to:

- *Operationalize the strategy*
- *Develop clinical, quality, service standards; monitor performance metrics; provide resources and support incl. to OHTs*

March 2020
Roadmap to Wellness launched

April 2020
OTN transfer into Ontario Health

April 2021
LHIN (non home care) functions and TGLN transfer into Ontario Health

Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

With a focus on addressing anti-Indigenous and anti-Black racism

11 Areas of Action

Collect Equity Data
Set up systems and supports to collect, analyze, and use equity data to report findings and inform future decisions

Embed in Strategic Plan
Ensure efforts to address equity, inclusion, diversity, anti-Indigenous and anti-Black racism are at the highest priority for the organization

Partner to Advance Indigenous Health Equity
Recognize that strong relationships with Indigenous leadership and communities - founded on respect, reciprocity, and open communication — are critical in ensuring that the new health care system in Ontario reflects and addresses the needs of Indigenous peoples.

Invest in Implementation
Apply the financial and people resources needed for success and ongoing sustainability

Identify Clear Accountability
Establish and assign "who" is responsible for "what"

Represent & Reflect Ontarians
Strive for all levels of the organization to reflect the communities served

Include & Engage Key Voices
Listen to the staff and communities and include their ideas and feedback into the design, delivery & evaluation of programs and services

Address Racism Focus on Anti-Indigenous & Anti-Black Racism
Identify and address discriminatory practices and procedures in all forms and all levels using targeted approaches

Reduce Disparities
Use data and best practices to establish standards, identify disparities & implement corrective action through a focus on access, experience & outcomes for the population

Contribute to Population Health
Work with other arms of government and agencies in planning services to improve the health of the population

Report & Evaluate to Drive Improvement
Publish Framework metrics publicly with all reports including an equity analysis

Represent & Reflect Ontarians

Include & Engage Key Voices

Identify Clear Accountability

Collect Equity Data

Embed in Strategic Plan

Address Racism
Focus on Anti-Indigenous & Anti-Black Racism

Invest in Implementation

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Partner to Advance Indigenous Health Equity

Reduce Disparities

Contribute to Population Health

For more information, go to: www.ontariohealth.ca

Ontario Health

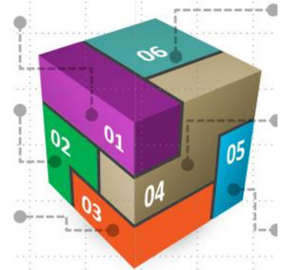
What would a mental health system in Ontario look like?

- If cancer care can be revolutionized, why can’t mental health care?
- Clinical leadership
- Regionalized centralized access
- Centralized data analytics
- Iterative learning to align patient needs (both diagnostic group and illness severity) with appropriate evidence-based service
- Outcome monitoring to ensure patients get what they need and/or stop getting what they don’t need
- Appropriate alignment of accountabilities and incentives with performance, focus on culture of improvement
- Start building the system in a focused way; target high priority, high impact areas of care
- Understand the patient/client experience; pursue the quadruple aim

Early priorities

Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System
Ontario

1. Establish a Mental Health and Addictions Centre of Excellence within OH, lessons learned from other provincial programs
2. Expand access to publicly funded psychotherapy across Ontario
3. Advance data and digital infrastructure to support better system planning, understanding of demand and utilization, outcomes, cost, health system performance monitoring and program management, and quality improvement
4. Core services/Identify high-prevalence, high-priority populations and advance improvement in associated clinical services



Understand gaps in care and case for improvement; link to existing evidence-based quality initiatives and clinical leadership; quality standards; health technology assessment; capacity planning; measurement and reporting….applying a provincial program model

Core Services Framework

Developing a core services framework to identify gaps and set standards for service delivery

Core Services Framework

	Population MHA Needs	Core Service Categories	Proposed Core Services
Lowest Volume, Highest Cost — 5	Severe or Complex Need	Highly specialized, intensive	• Emergency & In-Patient Psychiatric Services • Forensic Services • Psychotherapy Services • Withdrawal Management • Peer Support • Family Support
4	Moderate to Severe Need	Intensive and Specialized	• Assertive Community Treatment • Early Psychosis intervention • Child Youth Intensive Treatment • Specialized Consultation, Assessment & Treatment • Addictions Treatment • Withdrawal Management • Case Management • Crisis Response • Court Supports/Diversion • Supportive Housing • Counselling and Therapy (incl. Psychotherapy) • Peer and Family Support
3	Moderate Need	Targeted to moderate MHA needs	• Addictions Treatment • Supported Employment • Court Supports/Diversion • Supportive Housing • Case Management • Withdrawal Management • Crisis Response and Support • Counselling and Therapy (incl. Psychotherapy) • Peer and Family Support • Brief Intervention • Specialized Consultation, Assessment & Treatment
2	Low Need	Early intervention & self-management	• Peer Support • Family Supports • Counselling and Therapy (incl. Psychotherapy) • Brief Intervention • Targeted Prevention
Highest Volume, Lowest Cost — 1	General Population	Population-based health promotion & prevention	• Prevention and Promotion

Service Locations
Over time, ranges of services that could be aligned with Ontario Health Teams (OHTs)

- Primary Care (levels 1–5)
- Hospitals (level 5)
- Hospitals & Community MHA Agencies (levels 3–4)
- Community MHA Agencies & Public Health, Schools (levels 1–2)
- Virtual Care (levels 1–5)

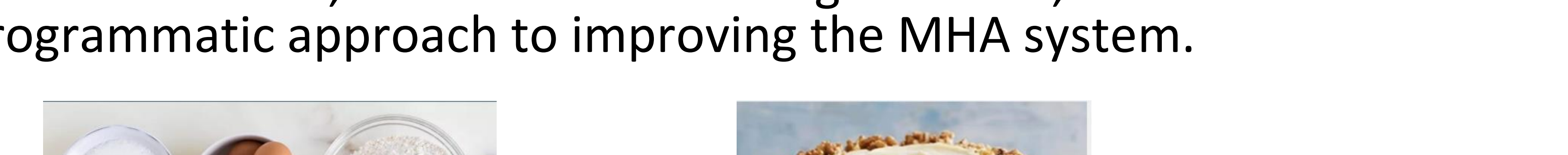
Core services will be defined and validated with input and collaboration from system partners, clinical researchers, people with lived experience and families.

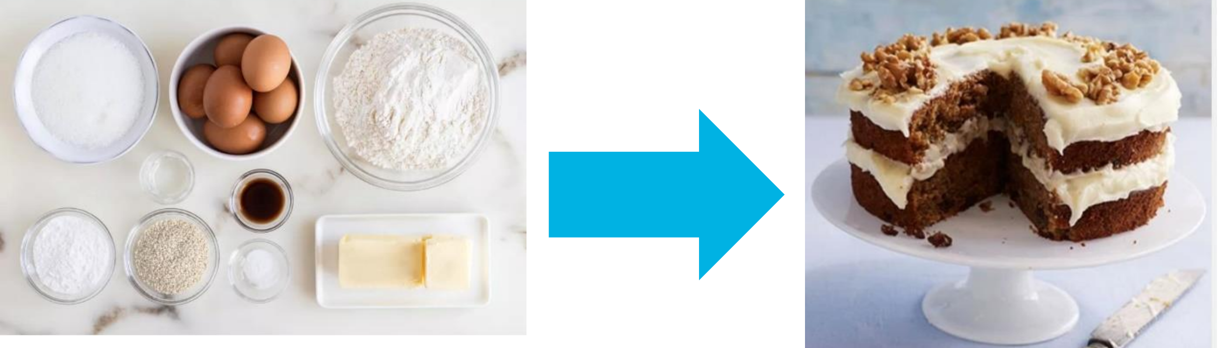
Source: Adapted from work by the National Needs Based Planning Project (Rush, 2017)

Levers of performance & improvement

- Clinical leadership and stakeholder engagement
- Evidence (clinical standards and guidance, evaluation, qualitative insights)
- Data and digital infrastructure/information systems
- Effective program monitoring and performance management
- Mental Health and Addiction system measurement and reporting
- Integration and Coordination (access and system navigation)

These levers are essential to, and form the building blocks of, the Mental Health and Addiction's programmatic approach to improving the MHA system.

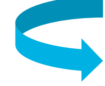




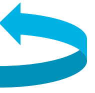
Tackling high priority, high prevalence clinical domains

1) Better understand the needs of the population (including unique sub-groups);

2) Determine the types of services available and resources invested to respond to population need, and what is required;



3) Know whether or not efforts to respond to need are achieving the intended outcomes;



4) Develop an evidence-based program to deliver improvement

5) Align investments with evidence to fill gaps, and accountabilities with performance to deliver better outcomes.

6) Monitor, learn, improve.

Big dot indicators reveal variation, but what you are you going to do?

- Mental Health and Addictions is extremely diverse
  - Spans a lifetime and differs based on age
  - A large number of different disorders mapping onto different populations
  - Evidence-based interventions differ based on type of disorder
  - Each disorder has its own severity/complexity spectrum
- **A population-based and programmatic approach is more important than the population of interest**

The Case For Depression – the burning platform

- Highly prevalent
- Highly burdensome
- Poorly detected (50% are undiagnosed)
- Significant variation in treatment quality and poor access to specialty care
- Untreated depression causes significant disability AND has adverse impacts on medical comorbidity outcomes when comorbid

The Case For Depression – The Opportunity

- In many US jurisdictions, routine integration of depression case detection and management
- In Ontario, scale and spread of a provincial CBT program for mild to moderate depression

Selecting initial high priority, high prevalence clinical domains for focused improvement and provincial oversight

Underway for patients with anxiety and depression through the newly funded provincial Ontario Structured Psychotherapy Program.

Centralized access

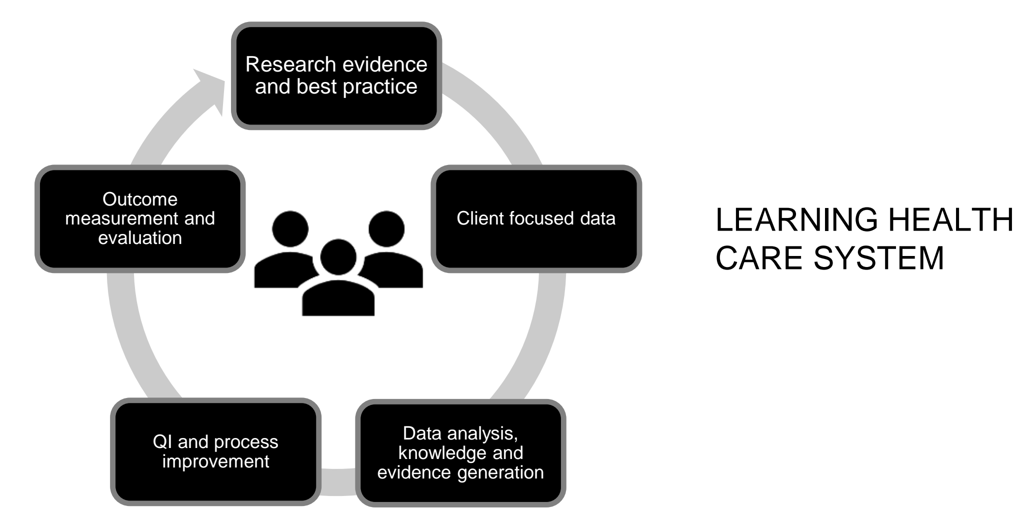
Delivered by a regional network with planning and administration led by a hub and patients accessing services in local service delivery sites

Standardized clinical training and program guidance

Ongoing clinical consultation

Standardized data collection at all sites from intake, assessment, through treatment. Clients stepped up or down as required.

Outcome driven with regular reporting at the hub level of recovery rates (target 40%) and reliable improvement rates (target 60%)



LEARNING HEALTH CARE SYSTEM

Questions and Answers

STEP 1:
SEGMENTATION FOR NEEDS, RISKS & BARRIERS

STEP 2:
CO-DESIGNING CARE PATHWAYS & SERVICE MIX

STEP 3:
IMPLEMENTATION & REACH

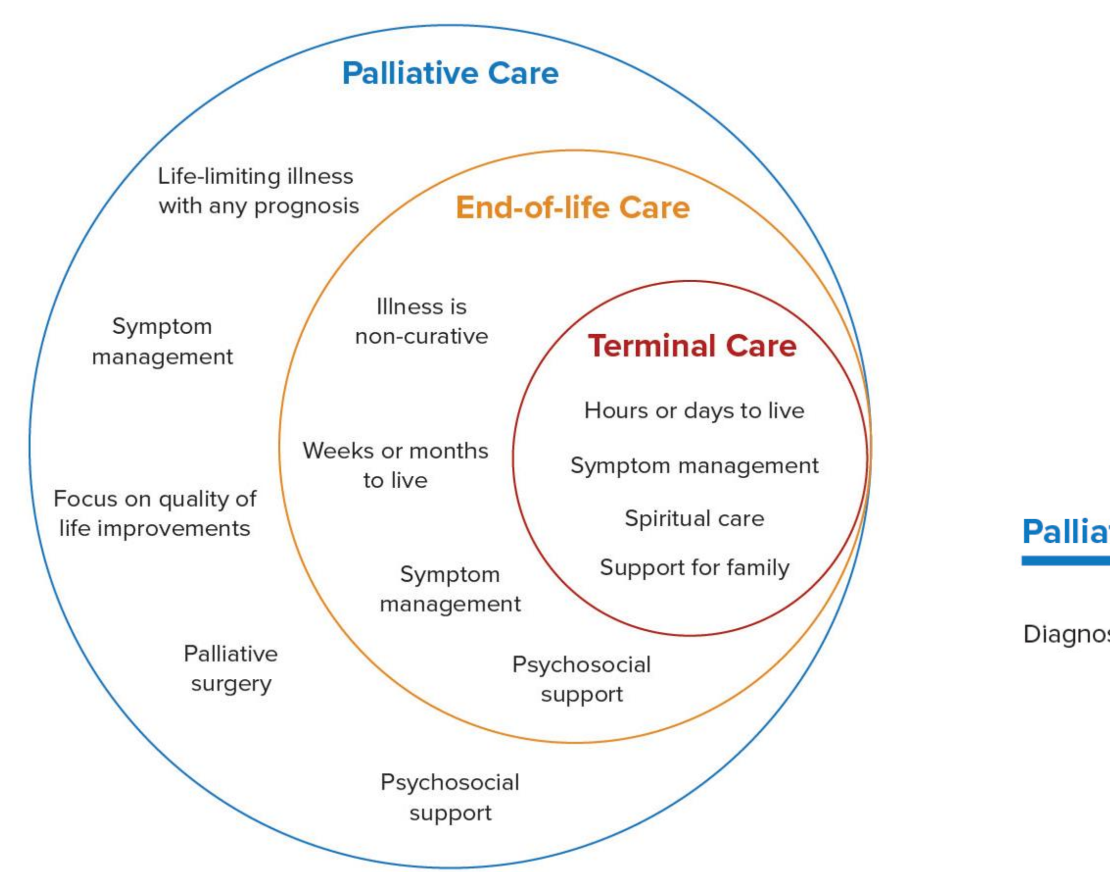
STEP 4:
MONITORING & EVALUATING

Ontario
Palliative Care
Network

Available Tools to Support Co-designing A Model of Care for People Who Would Benefit From Palliative Care

Ms. Susan Blacker, MSW, RSW
Provincial Clinical Co-Lead, OPCN

Clarifying Palliative and End-of-Life Care



From: Palliative Care in ON: Everything you need to know, Guides, 2019, Closing the Gap Healthcare, Accessed at: https://www.closingthegap.ca/palliative-care-in-ontario-everything-you-need-to-know/
To learn more about the difference between Palliative Care and EOL Care, see: tip_feb_2021_palliativeapproach_eol.pdf (hpcconnection.ca)

Connecting the Dots Between Segmentation & Care Model Design

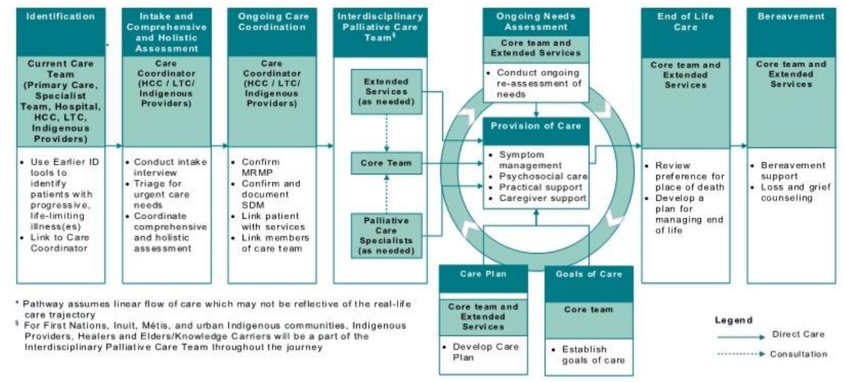
Begin with ONE population segment(s) of your priority population → Understand the segment → Characterize patient needs → Design care models/ programs/pathways → Monitor care and outcomes

Priority population:
Those who could benefit from palliative care

- ❑ leverage one of the recommended tools to support earlier identification

The OPCN has already done the work to design the model of care.
Work with your Regional Palliative Care Network to:

- ❑ Apply the recommendations in the Health Services Delivery Framework to guide service delivery planning for your OHT
- ❑ Leverage the patient pathway to identify the community resources, and cross sectoral partnerships that may be needed to address identified palliative care needs



The Quality Standard for Palliative Care describes what high-quality care should look like

- ❑ Leverage the indicators to assess whether your OHT has achieved quality care

Local Support through Regional Palliative Care Networks* (RPCN)

There are 14 RPCNs located across the province:

- led by a Network Director, and two Clinical Co-Leads
- provide the structure and leadership to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care.

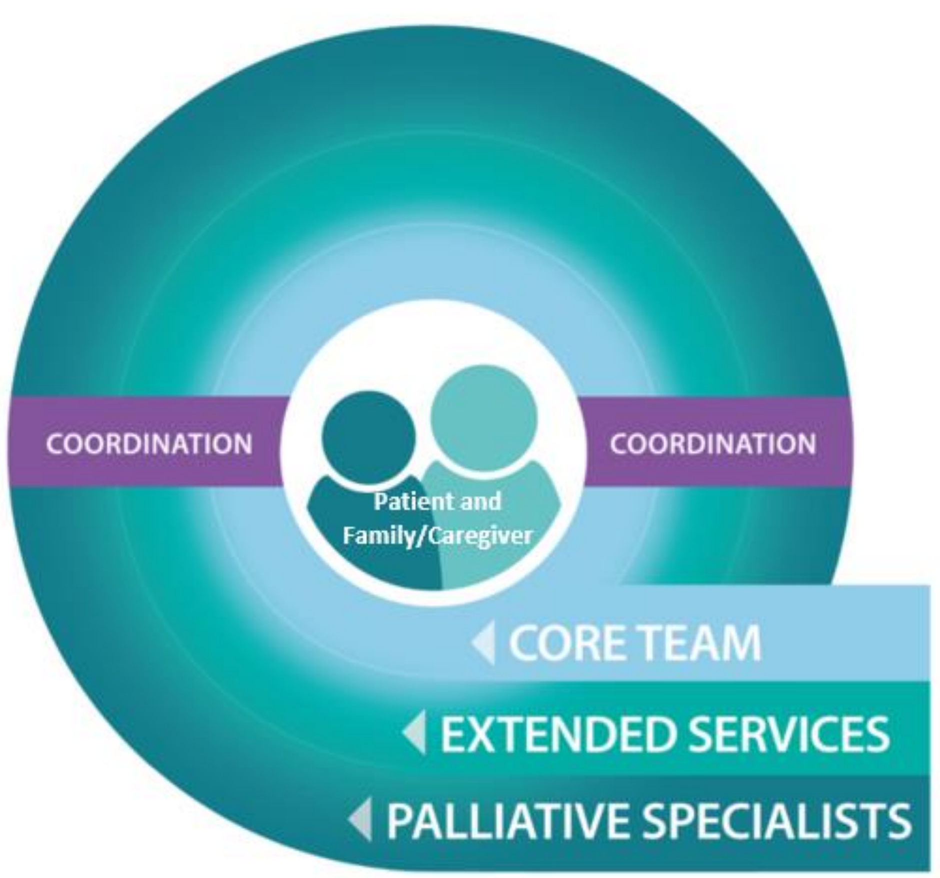
The existing local leadership, expertise and relationships within RPCNs can:

- Provide a critical mechanism to support OHTs in planning and implementation.
- Facilitate access to local data
- Ensure alignment with provincial direction
- Help minimize duplication and maximize efforts to improve outcomes for individuals with palliative care needs

Ontario
Palliative Care
Network

How to Organize Care to Achieve High-Quality Palliative Care

The Palliative Care Health Services Delivery Framework



The model of care describes "team" from a patient (or family/caregiver) perspective along with how they want to receive care

The Interdisciplinary palliative care team:

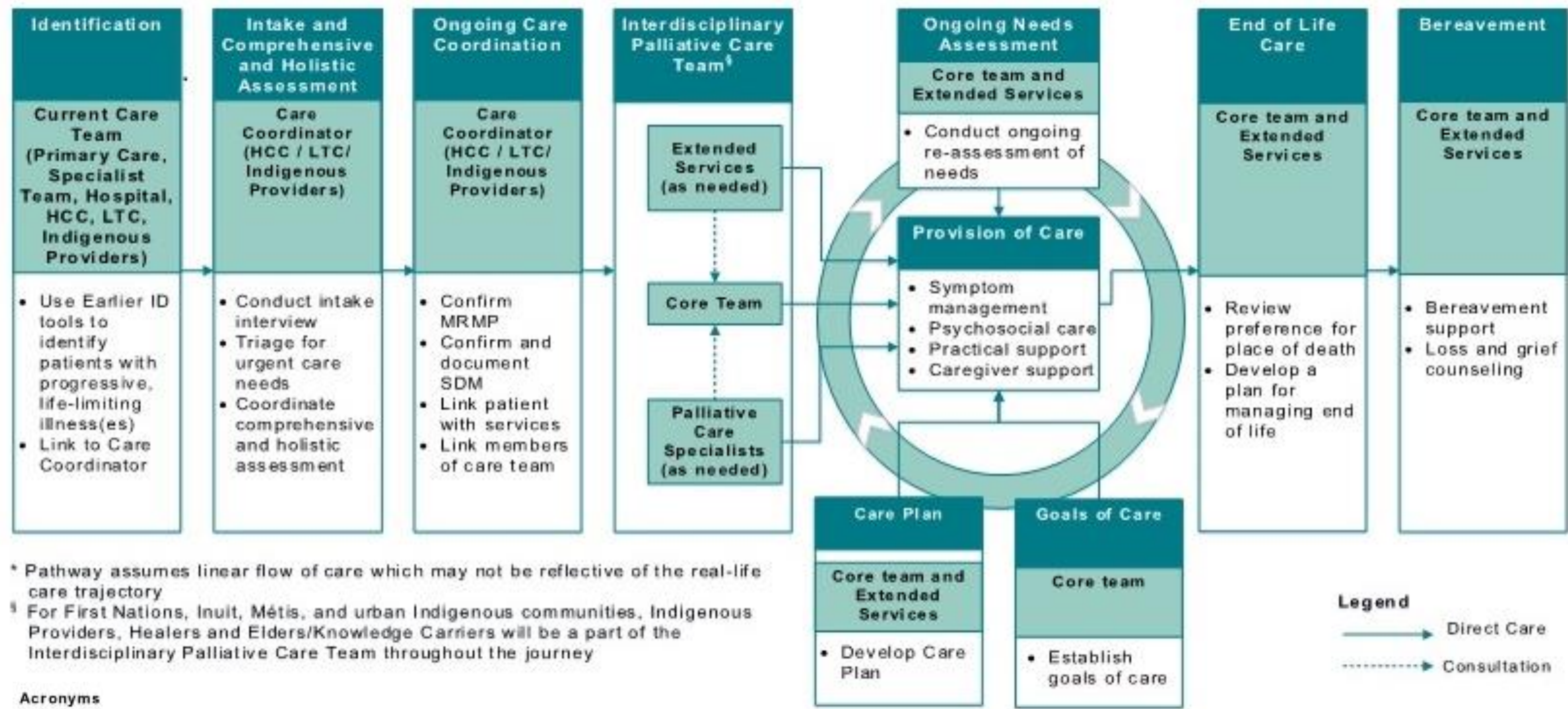
- **Core Team** - physician or nurse practitioner and a designated care coordinator and, often, a nurse
- **Extended Services** - Interdisciplinary providers as needed
- **Palliative care specialist(s) -** for consult with team members and providing direct patient care as needed

The Delivery Framework also recommends that providers have access to palliative care expertise 24/7 to support decision-making and clinical practice.

Ontario
Palliative Care
Network

Delivery Framework Patient Pathway

2. CO-DESIGNING CARE PATHWAYS, SERVICES, & MANAGEMENT



Delivery Framework Recommendations

2. CO-DESIGNING CARE PATHWAYS, SERVICES, & MANAGEMENT

Recommendation 1: The patient who would benefit from palliative care will be identified early in their illness.

Recommendation 2: At any point from when the patient's illness is identified through end-of-life and bereavement, there will always be a designated care coordinator.

Recommendation 3: All patients and family/caregivers will have 24/7 access to an interdisciplinary palliative care team.

Recommendation 4: The Core Team will collaborate with the patient (or the Substitute Decision-Maker) and their family/caregivers to regularly assess their needs, and to develop and document a care plan that is based on the patient's wishes, values and beliefs, and their identified goals of care, and to obtain consent for the plan.

Recommendation 5: The patient will have 24/7 access to pain and symptom management from the Core Team or the on-call providers. This may occur in-person or via telemedicine (e.g., telephone support, virtual care, etc.).

Recommendation 6: The patient and their family will have access to emotional, psychological and spiritual care to address their needs in a culturally safe manner.

Recommendation 7: The patient and their family/caregivers will have access to practical and social supports that addresses their needs in a culturally safe manner.

Source: Palliative Care Health Services Delivery Framework

Delivery Framework Recommendations

2. CO-DESIGNING CARE PATHWAYS, SERVICES, & MANAGEMENT

Recommendation 8: Planning for end-of-life care will begin as early as possible and when it is acceptable to the patient and their family/caregivers.

Recommendation 9: The family/caregivers of the patient with a life-limiting illness will be supported throughout the person's illness trajectory, at the end of life, and through death and bereavement.

Recommendation 10: The palliative care needs of the patient living in a long-term care home will be supported by the home in which they reside.

Recommendation 11: The First Nation, Inuit, Métis or urban Indigenous patient and their family/caregivers will receive palliative care that utilizes a grassroots, participatory and collaborative approach and incorporates cultural knowledge into all aspects of care.

Recommendation 12: French language services will be highly visible and easily accessible to the patient and family/caregivers. Healthcare providers must offer these services, guided by the Active Offer Principle, without waiting to be asked.

Recommendation 13: The palliative care needs of the patient who is homeless or vulnerably housed will be identified as early as possible and care will be provided wherever the patient is.

Source: Palliative Care Health Services Delivery Framework

How to Get Started: Suggested Next Steps to Support You

- ❑ **Engage your local Regional Palliative Care Network (RPCN) in your service delivery planning**
  - ❑ email info@ontariopalliativecarenetwork.ca to request their contact information

- ❑ **Leverage existing OPCN tools/resources to support your planning and integration efforts**
  - ❑ Tools to Support Earlier Identification to facilitate segmenting the population
  - ❑ Palliative Care Health Services Delivery Framework provides recommendations to guide service delivery planning
  - ❑ Palliative Care Health Services Delivery Framework includes a patient pathway
  - ❑ Quality Standard for Palliative Care includes indicators to assess whether you have achieved high-quality care
  - ❑ Palliative Care Competency Framework outlines the knowledge, attributes and skills providers need to deliver high-quality palliative care in Ontario.

For questions, or more information please reach out to:
Deanna Bryant deanna.bryant@ontariohealth.ca
Or
Tara Walton Tara.Walton@ontariohealth.ca

Ontario
Palliative Care
Network

Questions and Answers

STEP 1:
SEGMENTATION FOR NEEDS, RISKS & BARRIERS

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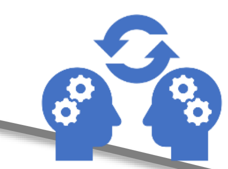
Today's journey
Designing care models

Segmentation

Recap of core concepts on how to move from segmentation to care model design



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Redesigning care models and testing changes

RISE population-health management upcoming events

Webinars

RISE PHM core concepts webinar #4 (June 17th, noon-1pm): will help OHTs think about how to understand and address health inequities across their population and learn how to map their resources to support this work. This session will feature Sophia Ikura from Health Commons Solutions Labs.

- To register and for additional details click HERE or visit https://www.mcmasterforum.org/rise/join-events

Coaching
(Cohort 1 and 2 OHTs)

If you are a cohort 1 or 2 OHT priority population working group or population-health management lead and do not have a population-health management coach but would like one, please contact Leslie McGeoch (Leslie.McGeoch@thp.ca)

Collaboratives
(Cohort 1 and 2 OHTs)

Virtual collaborative session #3 (June 1, 11:30-1pm):

- **What will it help me do?** it will help you think about how to build care models which meet the needs of all segments of your priority population, learn from other OHTs on how they are implementing PHM and learn from the Provincial Geriatrics Leadership of Ontario on resources available to support OHTs in this work.
- If you are a priority population working group or population-health management lead and would like to attend, please contact Leslie McGeoch (Leslie.McGeoch@thp.ca) or your coach

Online collaborative discussion space (available anytime):

1. Visit the OHT Collaboratives platform and click the “Sign Up” button.
2. Join the collaborative of your choice (or join all 3!) by clicking on the “Join Group” button:
   - Older Adults and Chronic Diseases Collaborative
   - Mental Health and Addictions Collaborative
   - Palliative Care Collaborative
3. Click “Subscribe to Updates” to stay up to date on events and resources

Population-health management (PHM) resources

RISE resources:

- Resources by priority population
- **Overview of PHM including application to COVID management** webinar, deck and one page summary
- **Redesigning care models through co-design** webinar, deck and one page summary
- **Additional webinars on PHM:** Spring 2020 and Fall 2019

Segmentation and evaluation resources

- HSPN

Resources by priority population

- **Older adults with greater needs**
  - Provincial Geriatrics Leadership Ontario (PGLO):
- **Palliative approach to care**
  - Ontario Palliative Care Network (OPCN) including the Palliative Care Health Services Delivery Framework
- **Mental health and addictions**
  - Centre for Mental Health and Addictions Provincial System Support Program: including the Ontario structured psychotherapy program
  - Mental Health and Addictions Centre of Excellence

THANK YOU!

APPENDICES

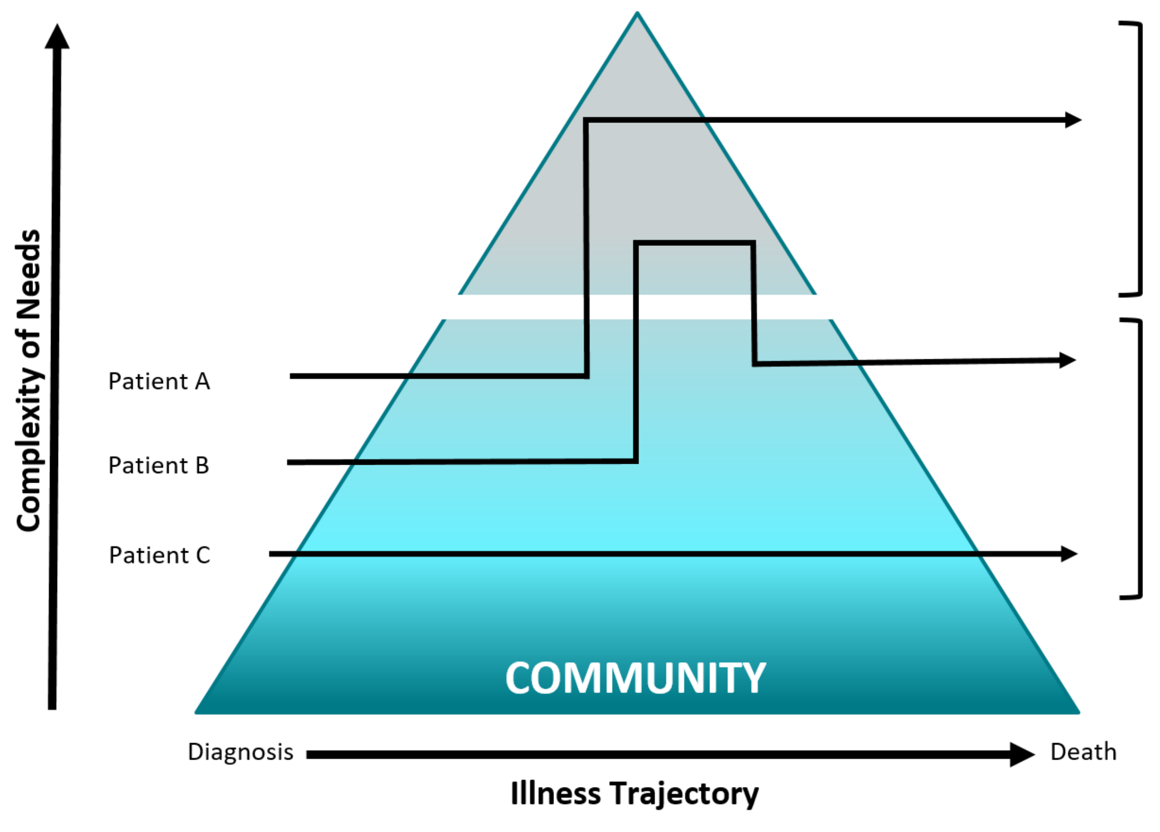
- Additional information and resources from OPCN

Why is Palliative Care Integration Important for OHTs?

- Palliative care is appropriate for any individual with a life-limiting illness
- A palliative approach to care can be introduced as early as diagnosis and should be integrated throughout the illness trajectory.
- Patients and families who would benefit from a palliative approach to care may be identified in any care setting, including hospitals, primary care, and community care.
- Having access to palliative care at home is not only what Ontarians prefer, but is known to reduce hospitalizations and emergency department visits

Palliative care is an essential component of care delivery in community. All OHTs should consider how they can effectively integrate palliative care into their service delivery planning to better meet patients' needs.

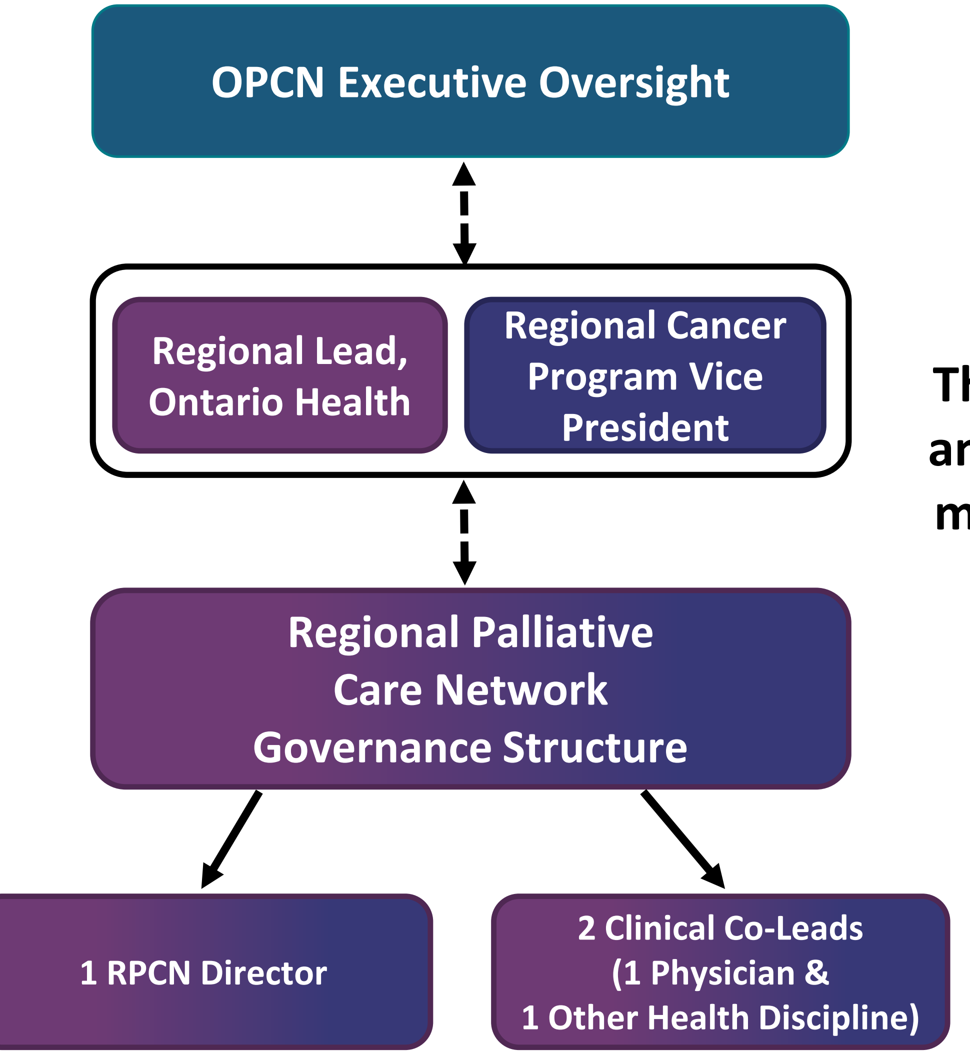
Who Provides Palliative Care?



- **Complex palliative care needs may require transfer to specialist palliative care teams** (Patient A)
- **Some palliative care needs may require consultation and clinician to clinician support (shared care) by specialist palliative care teams** (Patient B)
- **Most palliative care needs can be addressed through primary-level palliative care (A palliative approach to care)** (Patient C)
  - Primary Care Clinicians
  - Non-Palliative Specialist Clinicians

Ontario Palliative Care Network

Local Support through the Regional Palliative Care Networks* (RPCN)



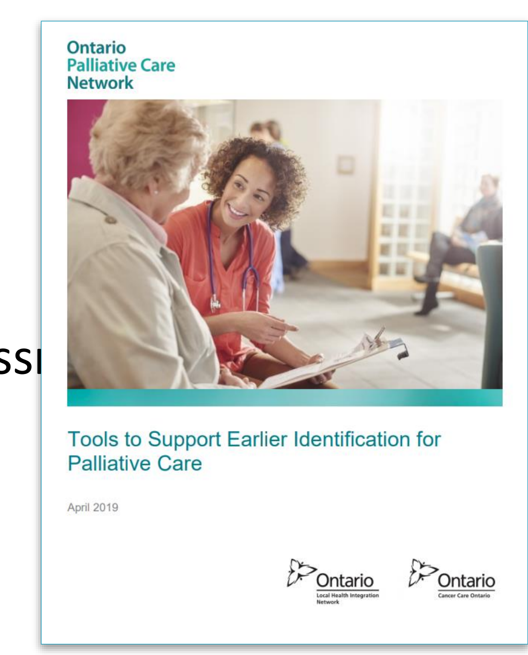
The existing local leadership, expertise and relationships, can provide a critical mechanism for enabling regional/local transition into OHTs.

Ontario Palliative Care Network

How to Identify Individuals Who Would Benefit from PC?

Tools to Support Earlier Identification for Palliative Care

- Early identification of palliative care needs results in better overall outcomes.
- Early identification in palliative care aligns with a population health approach.
- The OPCN resource outlines tools and processes that lead to identification and assess
- The Early ID tools can be integrated into all settings of care.
- The Early ID tools can be integrated into digital platforms that support patient care.



Link to Resource:
https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/OPCNToolsToSupportEarlierIdentificationForPC.pdf

What Does High-Quality Palliative Care Look Like?

The Quality Standard for Palliative Care

- Outlines 13 Quality Statements that describe what high-quality palliative care should look like.
- Applicable to care for people in all settings, including home and community, hospice, hospital, and long-term care.
- Provides quality indicators to evaluate how well performance is aligned with the standard
- Includes a Patient Reference Guide, Recommendations for Adoption and indicators to help assess quality of care

Link to Resource: https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care

The Palliative Care Health Services Delivery Framework

An innovative model of care to enable adults with a life-limiting illness who are living at home or in community settings, and their family/caregivers, to remain at home as long as possible.

- Seamless 24/7 access to high quality person-centred care and supports.
- An Interdisciplinary Care Team having access to relevant and up-to-date patient information.
- Engaging patients/caregivers as active members of the care team, with care decisions aligned to the patient's specific goals and wishes.
- Tailored recommendations for Francophones, First Nation, Inuit, Métis and urban Indigenous peoples, homeless and vulnerably housed populations, and people living in long-term care homes.