

Health System Fundamentals..

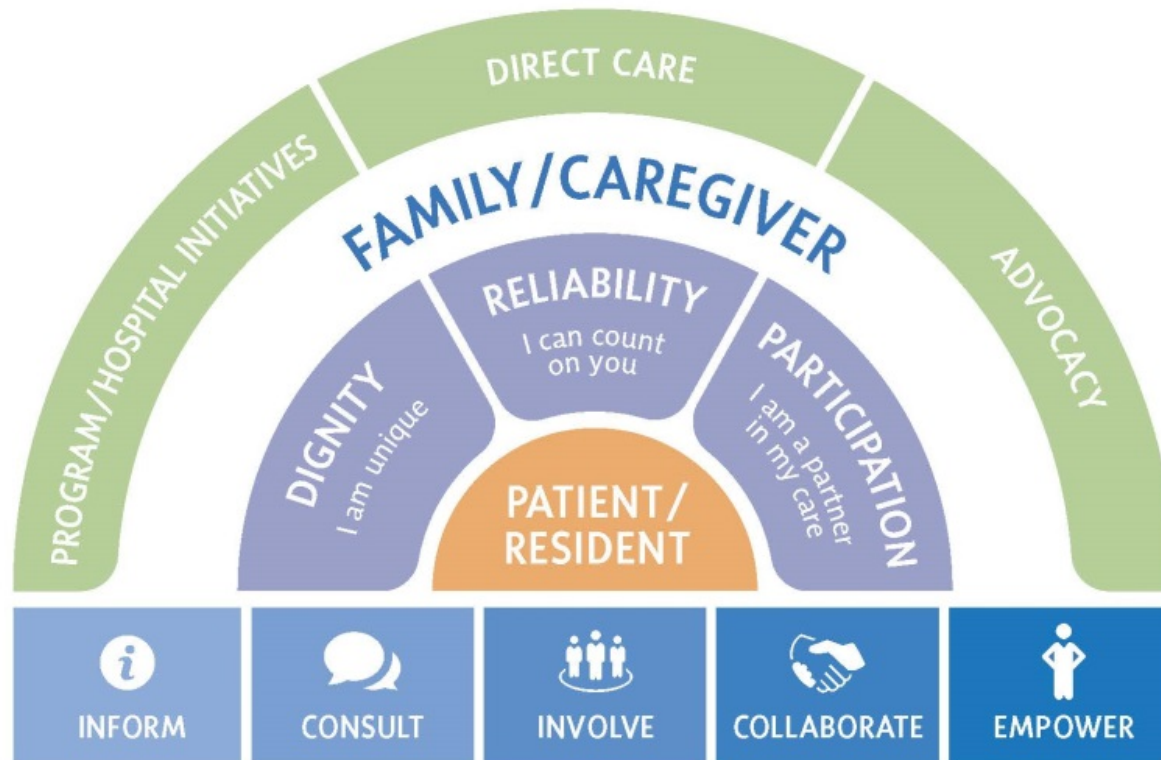
A Primer on Health System Literacy

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Dr. Gillian Kernaghan
President and Chief Executive Officer
St. Joseph's Health Care London

Care Partnership

ST. JOSEPH'S JOURNEY OF CARE WITH
PATIENTS | RESIDENTS | FAMILIES | CAREGIVERS



**What have you done or could do to
more meaningfully engage
patients/family caregivers in
improving their
experience/outcomes?**

What is the LHIN now?



LHIN's Role & Responsibilities

- Delivery of home and community care services (previously CCAC)
- Accountability arrangements and funding of:
 - Public and private hospitals
 - Community support service agencies
 - Community mental health and addictions agencies
 - Community health centres
 - Long-term care homes
 - Primary Care

Note: this responsibility will transfer to the Ontario Health Agency

- The LHIN works closely with - but is not directly responsible for - the funding of physicians, public health, ambulance services, laboratories, and provincial drug programs.

Pace of Change

- New Provincial Government June 29, 2018
- Premier's Council on Improving Health Care June 2018
- First Premier Council Report January 2019
- Ontario Health and OHT's announced February 2019
- LHIN Boards and Provincial Agency Boards end March 31, 2019
- Ontario Health approved in legislation
- Interim CEO appointed April 2019...Matt Anderson appointed January 2020
- Second Premier Council Report June 2019
- Ontario Health Regional offices established Nov 2019
- Integrated into Ontario Health effective Dec 2 2019
 - Cancer Care Ontario
 - Health Quality Ontario
 - eHealth Ontario
 - Health Shared Services Ontario
 - HealthForce Ontario Marketing and Recruitment Agency
- OH and Regional Offices key in COVID response
- Structural model of OH defined in Sept 2020

A Vision for a Coordinated System

Ontario's new health care plan will improve services and patient experience by:

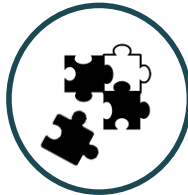
Organizing health care providers to work as one **coordinated team**, focused on **patients** and specific **local** needs. Patients would experience even transitions from one health provider to another (for example, between hospitals and home care providers, with one patient story, one patient record and one care plan).



Providing patients, families and caregivers help in **navigating** the public health care system, 24/7.



Integrating multiple provincial agencies and specialized provincial programs into a **single agency** to provide a central point for performance measurement and quality improvement for the health care system. This will improve clinical guidance, support for providers and better quality care for patients.



Improving access to secure **digital** tools, including online health records and virtual care options for patients – a 21st century approach to health care.

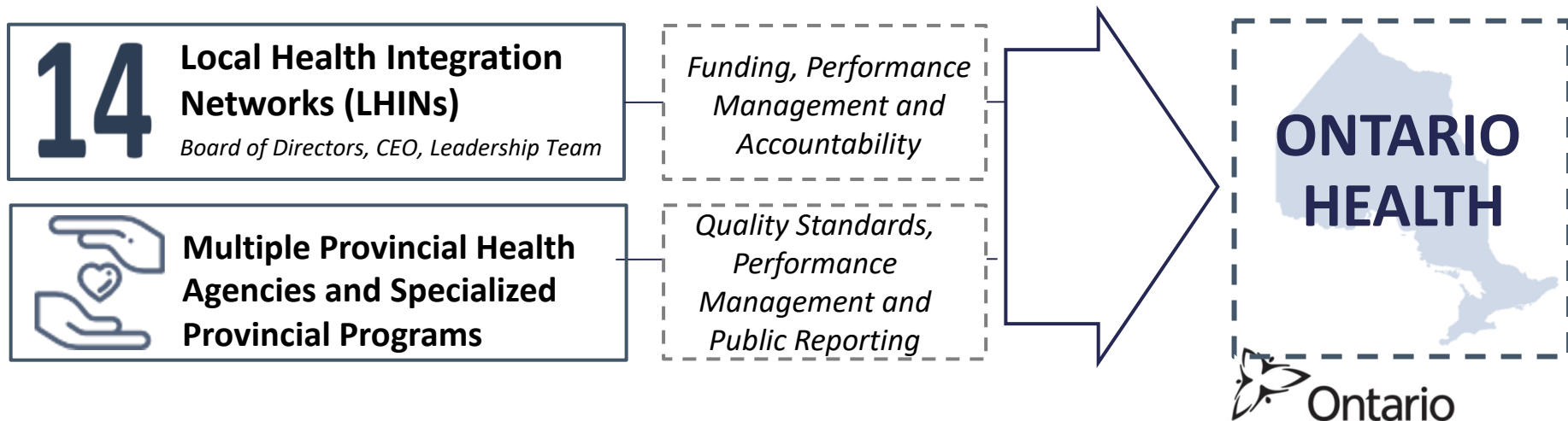


A Single Agency: Ontario Health

Partnering together for a system that is connected and well-run.

Currently, multiple provincial health care agencies and specialized provincial programs provide overlapping, and often confusing, clinical guidance and support. This has resulted in a health care system that is difficult to navigate for both providers and patients.

THE MINISTRY OF HEALTH



Population Health

- "Population health is the health outcomes of a defined group of people, including the distribution of such outcomes within the group (Kindig et al)
- It has been described as consisting of three components. These are "health outcomes, patterns of health determinants, and policies and interventions".



Coordinated Care & Service Delivery: Ontario Health Teams

A system where health care providers partner to coordinate and deliver care.

- ‘Ontario Health Teams’ (OHT) is a new model of integrated care where a group of providers (e.g. hospitals, home care, primary care, mental health and others) are held clinically and fiscally accountable for delivering a coordinated continuum of care to a defined population.
- As part of an Ontario Health Team, patients will receive seamless and coordinated care no matter where they are located or what their health needs are. Ontario Health Teams will ensure patients have a single team of providers for all their care needs and will not experience gaps in service.

At maturity, Ontario Health Teams across the province would provide the following key components:



Cares for a **defined patient population / geography**

Single point of clinical and fiscal accountability; leadership capacity for high-quality care.



Comprehensive continuum of care, including all care settings



Patients will have a **single point of contact**, who will help them navigate the system.



Defined **performance** model that allows for **risk and gain** sharing; performance **publicly reported**



Virtual care in place that gives patients digital choices such as video visits and digital access to patient health records



Communication and **information-sharing** (e.g. shared patient records among all care providers and patients)



One integrated funding envelope, modeled to promote population health, integration and access.



Ontario Health Teams

- Approximately 30 approved in Ontario
- Varied size and complexity
- <http://health.gov.on.ca/en/pro/programs/connectedcare/oht/teams.aspx>



Expected Successes for Year 1

Anticipated Accomplishments:

1. Defined Target Patient Population
2. OHT Communication & Engagement Strategy
3. Patient Engagement Framework
4. Integrated Quality Improvement Plan
5. Harmonized information Plan
6. Strategic Plan for the OHT Leadership, Accountability & Governance

What questions do you have about the system transformation and how could you get engaged in positively influencing the direction of the system?

As you reflect on the pre-readings what leadership attributes do you need to strengthen in this changing system?

Reflection:

What have you learned from a patient or family member that will positively change how you practice