Brantford Brant Primary Care Town Hall

OCTOBER 28, 2019

GRAND RIVER COMMUNITY HEALTH CENTRE

Agenda

What is an Ontario Health Team?

Patient Story: A Patient-Centred, Integrated System

Current State of Brantford Brant Ontario Health Team

Primary Care and Ontario Health Teams

Patient Story: Transitions in Care

Group Discussion

- Current challenges and opportunities for primary care?
- How can primary care be supported in leading the OHT vision and change?
- What are our next steps? Where do we go from here?

Introduction to Ontario Health Teams

Peter Szota,

Executive Director, Grand River Community Health Centre

Member, Brantford Brant Ontario Health Team Executive Leadership Group

What are Ontario Health Teams?

A new model of integrated care, where groups of providers work together as one single team to care for entire populations

Introduced/enabled in Bill 74: *The People's Health Care Act*, 2019, where they are termed "integrated care delivery systems"

Must include at least three of the following service types:

- Primary care
- Hospital care
- Rehabilitative care
- Home care
- Community support services
- Residential long-term care
- Health promotion
- Disease prevention
- Mental health and addictions

Expected Outcomes of Ontario Health Teams

Ensure a connected patient experience

Provide 24/7 support for patients

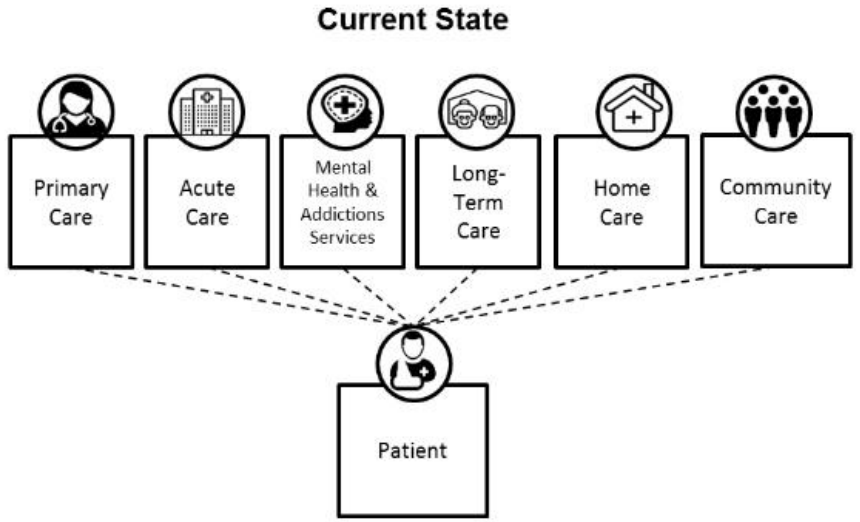
Offer digital access to records and virtual care

Care for a defined patient population

Have a single point of clinical and fiscal accountability

Operate under a single budget

Follow a defined performance model



Patient Story: A Patient-Centred, Integrated System

Dr. David Vincent

Susan and Freddy – After Hours Support

Brantford Brant Ontario Health Team

It's Wednesday at 5:30pm. Susan Krueger returns home from work and her 5 year old son, Freddy has a fever. Freddy has a chronic medical condition. Susan's husband is out of town for work and her closest family lives in Toronto.
The Krueger's family doctor, Dr. Jones is finished for the day. However, Susan knows that Dr. Jones is part of the Brant Ontario Health Team and they provide 24/7 coverage for their patients.

AT HOME
Susan is empowered and supported in gathering information to make a decision.

HOSPITAL OR SPECIALIST CLINIC
Susan and Freddy are immediately (warmly) connected to the most appropriate care setting

PRIMARY CARE FOLLOW UP
Dr. Jones is informed of Freddy's care and able to manage follow up.

- Susan accesses Dr. Jones' office website, which has:
  - Information on after hour care options
  - Self-care advice for common health conditions (or links to this info)
  - Information about other local community services and how to access them
- Susan considers visiting a Brant OHT affiliated walk-in clinic, which has access to Freddy's records
- Susan calls 24/7 Brant OHT coordination service, which is located next to the BCHS ED. An NP is able to access Freddy's health information and after consulting with one of the emergency physicians they decide Freddy needs to be seen by the pediatrician on call.

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Dr. Jones is informed of Freddy's care and able to manage follow up.

- In consultation with the on call pediatrician, Freddy will be seen by the Pediatric Rapid Access Clinic
- Dr. Jones receives messaging directly to their EMR about the call and later that night receives the pediatricians assessment from the Hospital Report Manager
- Follow up visit scheduled with Dr. Jones before Freddy leaves the hospital through an online appointment scheduler
- Antibiotic required which was electronically sent from hospital directly to Freddy's pharmacy and Dr. Jones' EMR record was simultaneously updated once the medication was dispensed at the pharmacy, which is part of the OHT pharmacy network

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PRIMARY CARE FOLLOW UP
Dr. Jones is informed of Freddy's care and able to manage follow up.

- Freddy sees Dr. Jones 4 days later, condition much improved
- Dr. Jones' EMR is updated with all system interactions Freddy has had in past week, including:
  - Call to 24/7 coordinator
  - Consult note from on call pediatrician
  - Assessment from Pediatric Rapid Access Clinic
  - Medication list and dispense report from pharmacy

Current State: Brantford Brant Ontario Health Team

Ben Deignan

Director, Integration and Partnerships, Brant Community Healthcare System

Operations Lead of Brantford Brant Ontario Health Team

Becoming an Ontario Health Team

Key milestones in application process:

1. Self-assessment readiness
2. Validating provider readiness (full application, in development or in discovery)
3. Ontario Health Team Candidates (Ministry has reviewed application and completed site visit)
4. Designated Ontario Health Teams (OHT accountability agreement with Ministry)

31 OHT applicants invited to submit full assessment on Oct. 9

- Some available online: Guelph, Cambridge North Dumfries, North Toronto, Toronto East

41 OHT applicants “in development” including Brantford Brant

Brantford Brant Ontario Health Team

Brantford Brant OHT

12 partners signed self-assessment, submitted to Ministry in May 2019:

- Adult Recreation Therapy Centre
- Alzheimer Society
- Brant Community Healthcare System
- CMHA Brant Haldimand Norfolk
- De dwa dah dehs nye>s Aboriginal Health Access Centre
- Woodview Mental Health and Autism Services
- Family Counselling Centre Brant
- Grand River Community Health Centre
- John Noble Day and Stay Program
- Participation Support Services
- St. Joseph's Lifecare Centre (Stedman hospice, LTC)
- St. Leonard's Community Services

Supported by a number of other local organizations and groups

- Brant Long-Term Care Network (representing 8 Brant LTCHs); City of Brantford

Target populations:

- Mental health and addictions
- Dementia
- Homelessness

! Commitment to working towards collaborative vision, leadership/governance structure, and clinical and fiscal accountability framework

Brantford Brant Attributed Population

Total population (17/18): 143,749

Population characteristics		
	Network	**Ontario**
Average age	41.3	41.0
Median age	41.0	41.0
Number that are seniors (65+)	27,198.0	2,502,986
Percentage that are seniors (65+)	**18.9%**	17.6%
Number that are seniors (75+)	12,212	1,120,986
Percentage that are seniors (75+)	**8.5%**	7.9%
Number that are minors (<18)	28,499.0	2,757,264
Percentage that are minors (<18)	19.8	19.3%
Percentage that are female	50.2	51.0%

Where does the Brantford Brant OHT attributed population live?				
Census Subdivision (CSD)	**CSD Type**	**Attributed population**	**% of total attributed population**	**CSD total attributed population**
Brantford	CY	81,406	56.6%	103,538
Brant	CY	24,096	16.8%	38,056
Norfolk County	CY	6,972	4.9%	67,659
Hamilton	C	5,460	3.8%	579,634
Six Nations (Part) 40	IRI	4,763	3.3%	7,600
Haldimand County	CY	3,230	2.2%	42,219
New Credit (Part) 40A	IRI	2,371	1.6%	8,230

Brantford Brant Ontario Health Team

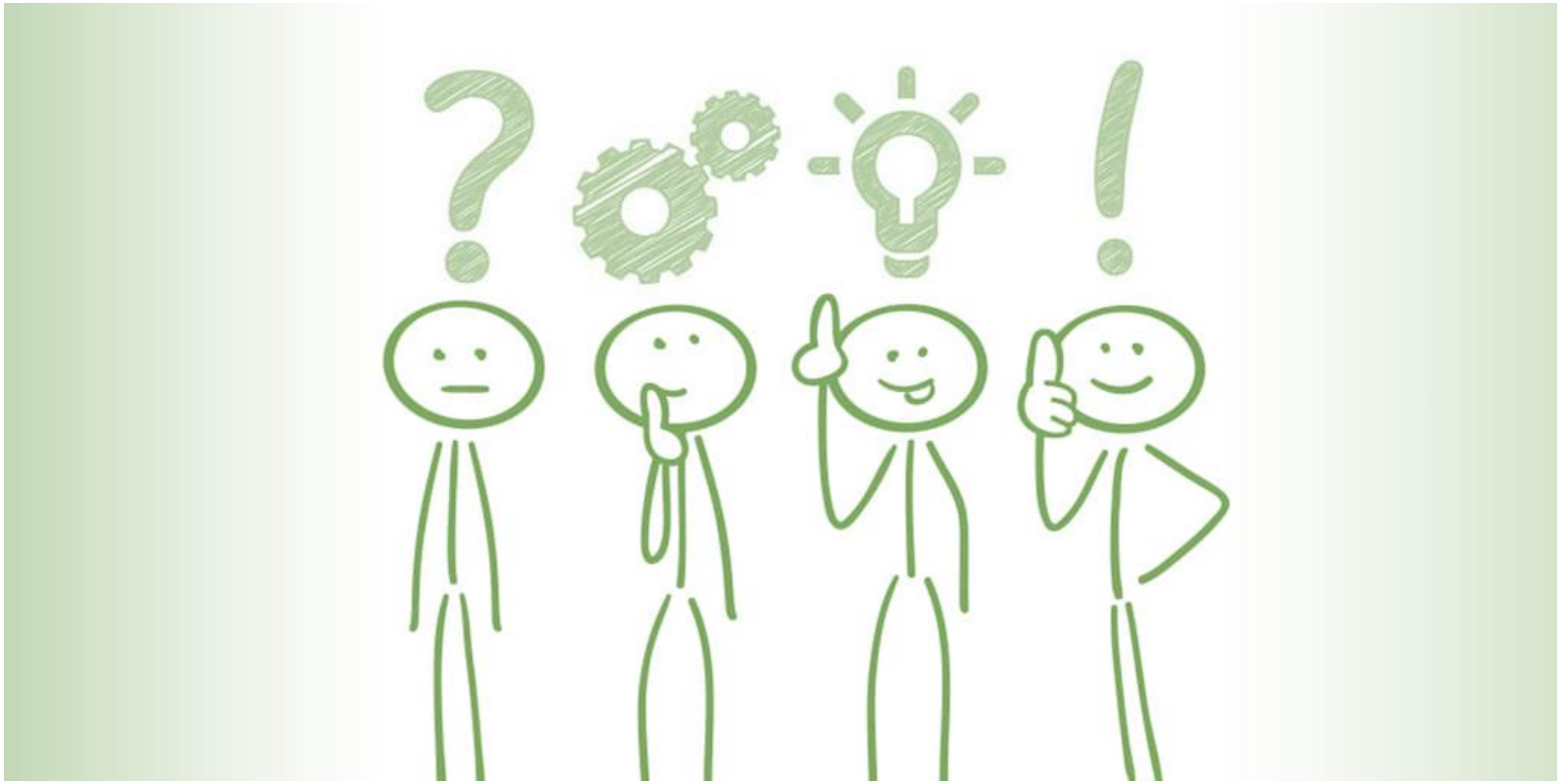
OHT Full Application Document

Completing OHT Full Application document

1. About your population
2. About your team
3. How will you transform care?
4. How will your team work together?
5. How will your team learn and improve?
6. Implementation planning and risk analysis
7. Membership approval

- Appendix A: Home and Community Care
- Appendix B: Digital Health

Questions?



Primary Care and Ontario Health Teams

Dr. Scott Elliott

Position of Primary Care Associations and Colleges

Ontario Medical Association

- Voluntary, physician led, primary care based

Ontario College Family Physicians:

- The health system requires a strong primary care foundation led by family physicians, with specific focus on the Patient's Medical Home model

Association of Family Health Teams of Ontario:

- Multiple FHTs are leading or involved in OHTs proceeding to full application

Nurse Practitioner Association of Ontario:

- No official document, but joint statement with Canadian Nurses Association applauds commitment on community teams and the shared responsibility of delivering patient-focused care

Primary Care Necessary for OHT Strategy

Brantford Brant OHT will not be successful without primary care leadership

Practical perspective:

- Full Application specifically evaluated based on commitment of primary care to collaborating on OHT strategy
- OHTs in first phase had strong primary care engagement (theme)

Conceptual perspective:

- Physician leadership appears to be a key attribute of successful Accountable Care Organizations (ACOs), outperforming those that are organized around a hospital or health system (McWilliams et al. 2018).

Potential Opportunities for Primary Care

Enhanced job satisfaction and quality of work life

More efficient work flows

Improved patient outcomes

Reduced barriers to “system” resources

Compliance with **CPSO** continuity of care expectations

Note: The Ministry has indicated there will be NO change to primary care funding models.

Patient Story: Transitions in Care

Dr. David Vincent

Mrs. Sally Brown

Brantford Brant Ontario Health Team

82 year old female with multiple chronic conditions including CHF and diabetes and has had one previous heart attack. Today, she has a marked change in her breathing and her legs are more swollen.

AT HOME

- Sally calls her Home Care nurse (previously CCAC), who is part of the Brantford Brant Ontario Health Team. This nurse is digitally connected to the team.
- Nurse exam:
  - Legs show 3+ pitting Edema to her knees
  - Heart rate is 110, BP is 100/60, RR 18
  - SaO2 is 90,
  - CVS: In A F 1/6 systolic murmur
  - RS: AE =, bibasilar inspiratory crepe to mid scapula.

CONSULT/TRANSFER TO ED

- Home Care nurse shared this information in real time to MD on-call for the Ontario Health Team
- Decision is made to transfer to ED, where she is assessed and admitted
- During admission, her primary care provider is updated electronically and has the ability to provide relevant health information and help plan for her eventual discharge

DISCHARGE AND FOLLOW UP

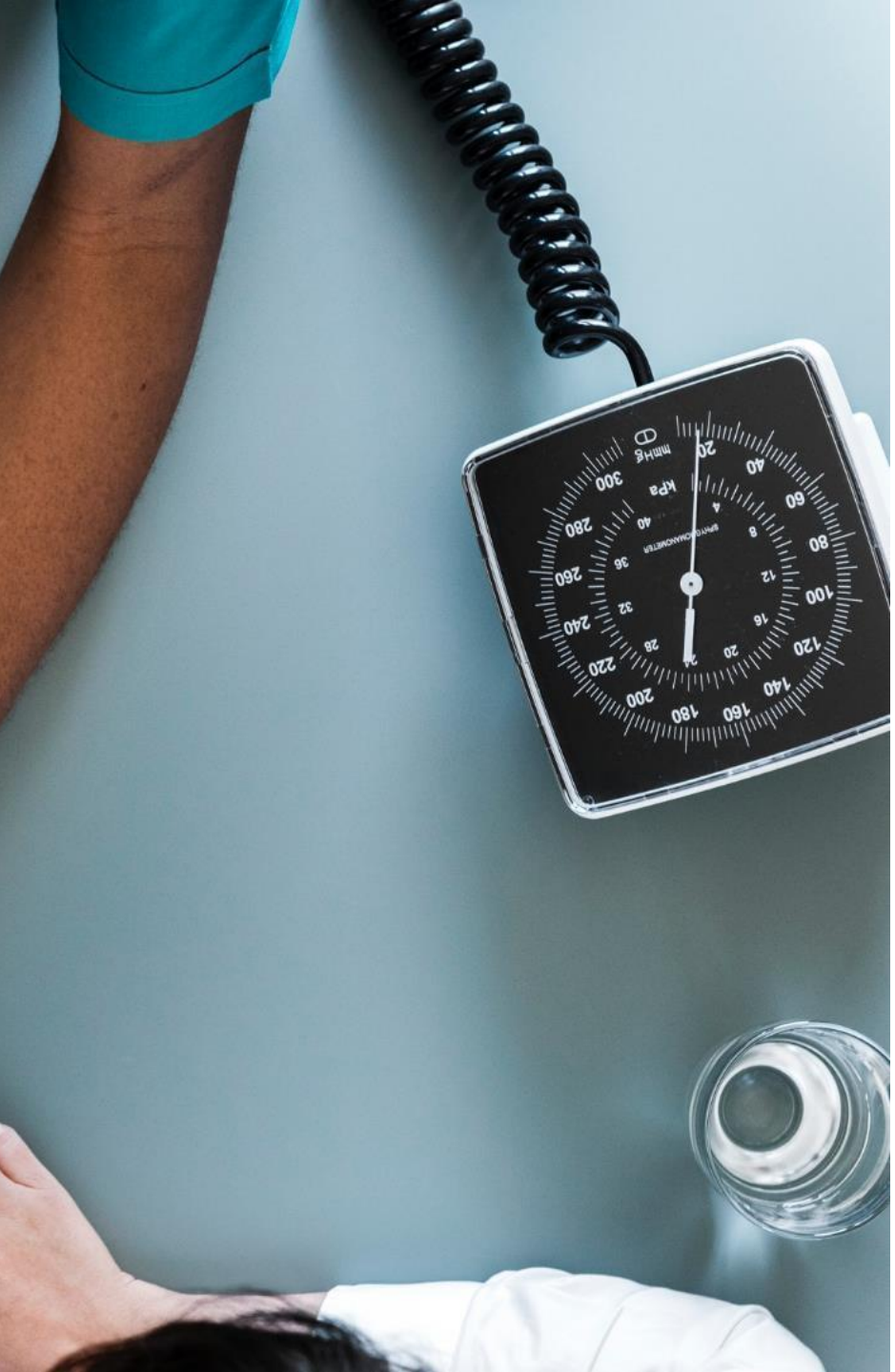
- On day of discharge, medications are reconciled, e-prescribed to pharmacy of Sally's choice
- Pharmacy then automatically updates her current med rec to the family doctors EMR
- Hospital is able to book an appointment with her family doctor BEFORE she leaves the hospital
- Family doctor's EMR is automatically populated with her pending outpatient tests and bookings as well as voice dictated discharge summary

Discussion

1. What are current challenges and opportunities for primary care in Brantford Brant?

2. How can primary care be supported to lead the OHT vision?

3. What are our next steps? Where do we go from here?



Brantford Brant Ontario Health Team

Thank you!

Ben Deignan

519-751-5544 ext. 4820

ben.deignan@bchsys.org