# Getting to know the Southlake Community Ontario Health Team

# What is an Ontario Health Team?

- New model of care where a ***group of providers*** (e.g. hospitals, home care, primary care, mental health and others) ***voluntarily*** come together and self-organize to ***deliver coordinated continuum of care to a defined population*** or patient segment. Eventually to be funded through ***integrated funding envelope***.
- Likely to be ~70 OHTs across the province at maturity, each accountable for a specific set of patients (based on primary care attachment)
- At maturity, all Ontarians will be part of one OHT
- York Region has the following three OHTs which cover the full geography:
  - Southlake Community OHT
  - Western York Region OHT
  - Eastern York Region North Durham OHT

Source: Ministry OHT Guidance Document released April 3, 2019
http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

# What will OHTs look like at maturity?

Provide a full and coordinated continuum of care for an attributed population within a geographic region

Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey

Be measured, report on and improve performance across a standardized framework linked to the 'Quadruple Aim' (better clinical outcomes, better patient experience, better provider satisfaction, better value)

Operate within a single, clear accountability framework

Be funded through an integrated funding envelope

Reinvest into front line care

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

Source: Ministry OHT Guidance Document released April 3, 2019
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# Southlake Community OHT

## Partners

- Aurora-Newmarket FHT
- Bayshore HealthCare
- CMHA
- CHATS
- Enhanced Care Medical Clinic
- Georgina NP-Led Clinic
- LOFT Community Services
- SE Health
- Southlake
- Southlake Academic FHT
  - BWG FHO
  - Southlake FHO
- York Region – Community and Health Services

## Core Geographies

- Aurora
- Bradford West Gwillimbury
- East Gwillimbury
- Georgina
- Newmarket

## Year 1 Priority Populations

1) Older adults with complex needs and multiple comorbidities
2) Adults with mental health and addiction issues

## Area of Focus (for both priority populations)

1) Improved transitions from hospital to post-acute care
2) Reduced admissions/ED visits by enhancing coordination with homecare, primary care and LTC
3) Primary care, community services and paramedic services focus on 'rising-risk' patient cohort
4) Reduction in process/paperwork/non-clinical workload for primary care physicians
5) Resource shifts from acute to community/primary care

# Overarching OHT Goals

# Addressing the most pressing challenges in the current system

| Current challenges | OHT vision |
| --- | --- |
| **Gaps in care from siloed budgeting, planning, operations and coordination** | Population health management focus (earlier intervention)<br>Improved coordination and less delays |
| **Transitions are often difficult**<br>**Patients repeat their stories** | Warm handoffs & 24/7 navigation<br>Improved access to digital health tools and more virtual care |
| **Current structures prevent collaboration**<br>**Duplication of effort**<br>**Silos contributing to clinician burnout** | Enhanced communication<br>Improved provider confidence re. continuity and transitions<br>Streamlined processes (reduced administrative burden) |
| **Business case for integrated care does not exist in our current volume-based funding world** | Shift to paying value and outcomes not volume (shared risk and value-based procurement)<br>Clear incentives / business case for integrated care at scale and population health management |