Western Ontario Health Team

Serving the people of Middlesex London

Improving our healthcare experience together - where people are heard, care is connected, and whole health is possible for everyone

Western Ontario Health Team (OHT)

Why do we need to come together as one team?

Patients, clients, care partners, and providers are doing great work across the city of London and the county of Middlesex, within the constraints of the current health care system. Despite everyone's best intentions and efforts, our health care system can feel confusing and disconnected for patients, clients, care partners, and providers. Based on previous work, we know that some services are over-loaded, some programs are difficult to access, some providers feel disconnected, and some people have lost trust in the system's ability to deliver care. As a result, only some people are getting the care they need, in the way they want it, when they need it.

These challenges impact the experiences and health outcomes of patients/clients and care partners, the experiences of healthcare and social service providers, and the efficiency of the system.

The Western Ontario Health Team can help. As one team, we are better together, working toward our common purpose:

The Western Ontario Health Team's key objective is to equitably, and cost-effectively improve patient/client, care partner, and provider experience and

patient/client whole health outcomes through the development of a shared care record, individualized care plans, and sustained care relationships.

Who are we?

We are a dedicated team of local healthcare providers and community members, accountable to the people who access care in Middlesex London and each other, to achieve our shared purpose and work in alignment with our common values.

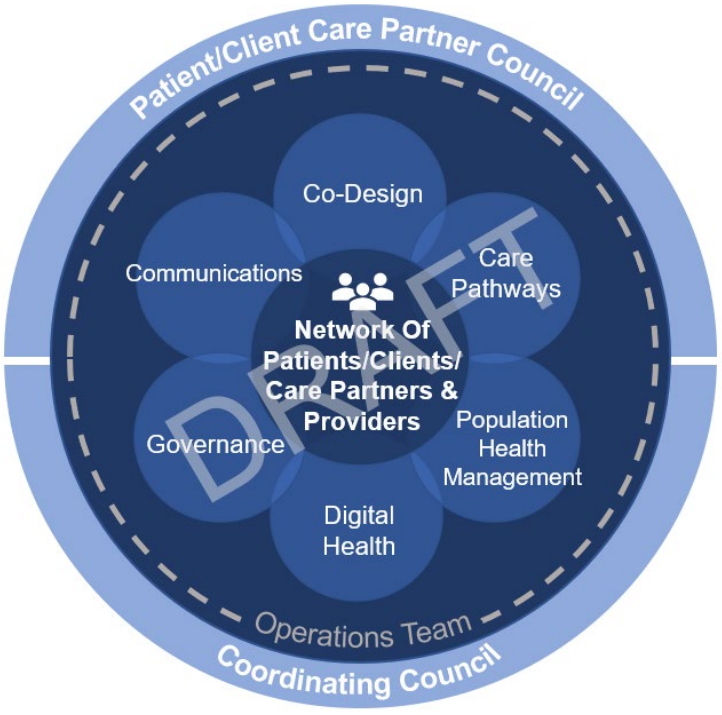
WE ARE COLLABORATIVE

WE ARE TRUSTWORTHY

WE ARE TRANSPARENT

WE VALUE EQUITY

Our structure values patients, clients, and care partners. We consider our local network of patients, clients, care partners, and providers at the centre of everything we do. This is exemplified by the value we place in our Patient/Client and Care Partner Council.



How will we improve care?

We apply a health equity, quality improvement, population health, and co-design approach to everything we do. To better serve everyone, we need to think differently.

At maturity, we will support a population of over 514,000 people with all their primary and secondary healthcare needs.

To start, we will begin by supporting people with advanced Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF). We know that together there are over 40,000 people living with these conditions and over 10,000 with advanced disease. We also know that they are a group of patients with complex needs living in a variety of diverse environments. While we have yet to co-define the specific challenges facing this initial priority population of focus, previous experience tells us that they would benefit from improved care connections.[1,2]

HEALTH EQUITY-DRIVEN QUADRUPLE AIM

The Western Ontario Health Team is committed to a health equity-driven quadruple aim approach to achieve:

- Equitable access to care – everyone can achieve their best possible health potential; one by one, we actively support both the people that we see in our everyday lives (e.g., at the bus stop, at the grocery store) and the people that we do not see in our community (e.g., those who cannot leave their homes, those who are not housed)
- Better population and patient health outcomes – we know our community and we prioritize improvements that optimize the wholistic health and wellbeing of our entire population. No one is left behind.
- Better patient and care partner health system experience – we ask about patient and care partner experience because they will inform our opportunities for improvement, because we believe that improved experiences are a key measure of our success, and because we care

[1] Horgan, S., Kay, K., & Morrison, A. (2020, August). Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs: A Scoping Review. Provincial Geriatrics Leadership Office. https://rgps.on.ca/resources/
[2] Kuluski K, Ho JW, Hans PK, Nelson MLA. Community Care for People with Complex Care Needs: Bridging the Gap between Health and Social Care. International Journal of Integrated Care. 2017;17(4):2. DOI: http://doi.org/10.5334

- Better provider health system experience – we break down barriers and prioritize opportunities that support providers to deliver high-quality care efficiently and effectively; we value the health and wellbeing of providers; and
- Better Value for Per-capita Cost – we are committed to delivering the most appropriate care, at the right time, by the right people, in the right place; we work to sustain a high-quality, public healthcare system

We work with our local French Language partners to ensure equitable access to culturally and linguistically sensitive care.

We are committed to building sustained, cooperative, mutually beneficial, and respectful relationships with local First Nations communities. As we work toward more integrated care and better coordinated care, we are also committed to ensuring ongoing access to culturally appropriate and safe care delivered in First Nations, Inuit, and Metis (FNIM) settings of choice and by providers of choice, as selected by FNIM peoples. We meaningfully partner with Indigenous communities to create better health prospects for current and future generations.

We work with community partners to connect with and support people who experience barriers to care, including immigrants and newcomers, people experiencing poverty, racialized communities, people experiencing homelessness, and people with disabilities – we break down barriers to accessing high quality care.

We recognize and respect the diversity of our community. We take our time, engage in hard work, and resist the status quo, to achieve a culturally appropriate health system that effectively reduces health disparities to become a truly equitable health care system.

We are committed to capturing information on all five aims so we can monitor our progress over time, identify opportunities, and work together to drive change for everyone.

POPULATION HEALTH MANAGEMENT

A population health management program strives to address health needs at all points along the continuum of health and well-being through participation of, engagement with, and targeted interventions for the population. The Western Ontario Health Team, collaborating with patients/clients, care partners, providers, other Ontario Health Teams, Ontario Health West Region and

provincial leadership, is dedicated to using this approach to planning, prioritizing, and implementing change. While we will begin with adults living with advanced Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF), at maturity, we will be continuously improving care with all 514,000+ people in our community.

USING A CO-DESIGN APPROACH

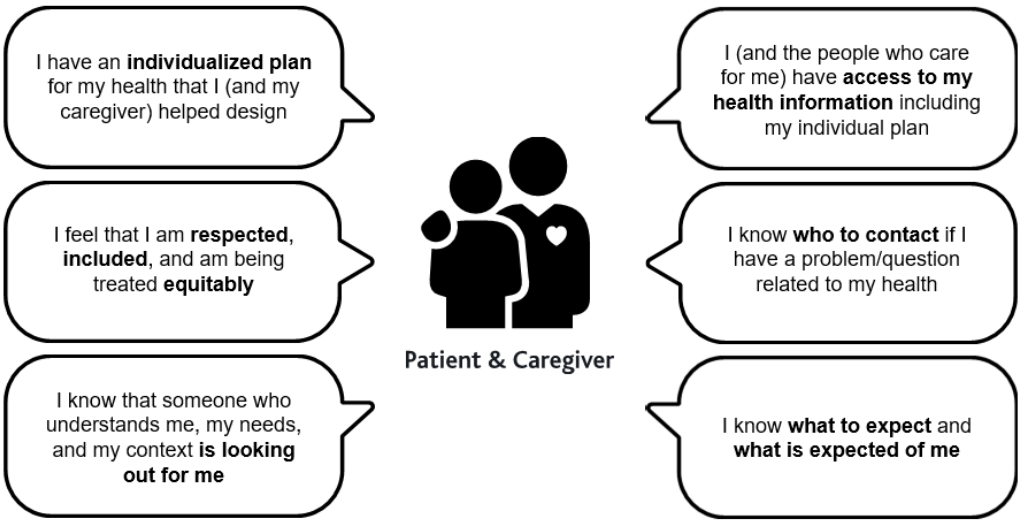
We "walk the walk" when it comes to co-design. We work with patients/clients, care partners, and providers to co-define the problems that we need to focus on and co-design the solutions for improved care. We are committed to, and hold ourselves accountable to, authentically engaging people from various backgrounds and experiences to ensure we are building improvements that serve those who need them most.

What will be different?

Improving our healthcare experience together – where people are heard, care is connected, and whole health is possible for <u>everyone</u>

The Western Ontario Health Team is focused on implementing three key enablers to a population health management approach:

- A sustained care relationship between patients/clients and care partners with the Western OHT – patients/clients and care partners are supported by one team throughout their care journey;
- A shared care record – providers, patients/clients, and care partners can access the information they need, when they need it, to optimize care and experience; and
- A co-created individualized care plan for everyone – patient/clients, care partners, and providers work together to develop a wholistic health plan that is driven by what's most important to the patients/clients, and care partners; patients/clients and care partners understand the care plan


I have an **individualized plan** for my health that I (and my caregiver) helped design
I feel that I am **respected**, **included**, and am being treated **equitably**
I know that someone who understands me, my needs, and my context **is looking out for me**
Patient & Caregiver
I (and the people who care for me) have **access to my health information** including my individual plan
I know **who to contact** if I have a problem/question related to my health
I know **what to expect** and **what is expected of me**

Additional Information

EXPECTATIONS FROM THE MINISTRY BY MARCH 31/22:

- Care has been re-designed for patients in the OHT's priority population(s).
- Every patient in the OHT's priority population(s) experiences coordinated transitions between providers - there are no 'cold hand-offs'.
- Every patient in the OHT's priority population(s) has access to 24/7 coordination and system navigation services.
- The majority of patients in the OHT's priority population(s) who receive a self-management plan understand the plan, and the majority who receive access to health literacy supports use those supports.
- More patients in the OHT's priority population(s) are accessing care virtually and accessing their digital health records.
- Most primary care providers to the OHT's priority population(s) are members of, or partners with, the OHT.
- Information about OHT member service offerings is readily available and accessible to the public, e.g., through a website.
- Progress has been made to reduce inappropriate variation in care and implement clinical standards or best available evidence.

  The OHT's performance has improved on measures of access, transition, coordination of care, and integration.