

Ontario Health Teams Central Evaluation

Formative Evaluation: Insights from Case Studies of the Early Experience of Developing OHTs

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Background

Ontario Health Teams (OHTs) were introduced in 2019 as a new way of integrating care delivery. They were developed to enable patients, families, and health care providers work together to create a coordinated continuum of care that is better connected to patients in their local communities. OHTs involve a cross-sectoral group of providers and organizations, and at maturity will be clinically and fiscally accountable for a defined geographic population¹. In Fall 2019, 30 teams were invited by Ontario's Ministry of Health (MOH) to submit full applications to apply to become OHT candidates. This report is a preliminary snapshot of interviews conducted with OHT participants. Our goal was to develop an understanding of what was important to participants when developing an OHT. In this report, we will present preliminary results on the strengths and challenges participants experienced, and the strategies they deployed, as participants began the work of developing OHTs.

Methods

A stratified random sampling approach was used to select 12 OHT applicants as case studies representative of geography (urban-suburban/rural-small community) and sector (hospital/community)². The number of participant organizations ranged across OHTs from 43 to seven. Stratifying OHTs by signatory lead (hospital/community) as identified in OHT applications allowed for the inclusion of teams with potentially different organizational resources, sectoral emphases and leadership styles. One hundred and nine interviews were conducted across 11 OHTs³ between January and March 2020; with approximately ten interviews conducted with each OHT. Participants were identified with the help of lead OHT contacts. They included leaders, providers, and patient family advisors across participating organizations who had been instrumental in shaping their OHT. Interviews were conducted by telephone (with a few over Zoom videoconferencing) by a team of five qualitative researchers. Interviews were recorded, transcribed, summarized, and thematically coded. Results are presented here in aggregate across case studies, rather than by participant type or individual OHT, as we aimed to identify trends and themes across participants and OHTs. Full coding and analysis using NVivo of transcribed interviews is currently underway.

¹ Ontario Ministry of Health. 2019. Ontario Health Teams: Guidance for Health Care Providers and Organizations. URL: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

² Of the 12 applicant OHTs, three were not selected to move forward to a candidate OHT by the MOH.

³ Interviews are yet to be conducted with one OHT due to early logistical considerations, and later accessibility concerns caused by the COVID-19 outbreak.

Key Findings

We identified five key components of OHT development that resonated across participants: 1) Building on existing relationships and scaling-up programs, 2) Interorganizational collaboration, 3) Primary care engagement, 4) Patient and family engagement, and 5) policy, resources and direction. These five key components were cited as strengths when present, challenges when absent, or the aim of strategic interventions and future plans.

1. Building on existing relationships and scaling-up existing programs

All OHTs included some organizations that had already worked together, many on previous healthcare integration initiatives. The OHT approach was therefore often in alignment with the strategic plans of member organizations, and the OHT felt like a “logical extension” (01_5) and a “natural evolution” (20_2) of what was already in place. Most participants therefore welcomed the OHT model, describing it as “long overdue” (27_2) and “absolutely the right thing to do” (23_10).

When selecting Year 1 target populations, participants talked about leveraging established community connections, digital health innovations, patient and family advisory councils, previously identified priority populations, and methodological tools for population selection. Taking an inventory of existing programs helped participants identify which initiatives could be spread and scaled across their OHT. A participant described the efficiency borne out familiarity with fellow team members:

... we already had a model in place here with many collaborators around a table. [...] And so working through the trials and tribulations of getting people to take off their own organizational hat and look through a different lens for the common good of an integrated service delivery model is something that was already worked through over several years. So it doesn't become the lynchpin of dysfunction, if you will, for this particular purpose because it's already in our rear view mirror... [24_6]

The Local Health Integration Networks' (LHIN) presence at certain OHT tables was also seen as a benefit. The LHIN was credited with providing guidance and impetus for OHT formation in these OHTs, and its continued engagement in the OHT was seen as the result of a “solid relationship” built over many years (24_1).

Belief in the OHT model

While existing familiarity and trust amongst OHT team members provided the “relationship glue” (28_2) that bound organizations together, it was often accompanied by a shared sense of goodwill and willingness to make a difference. Across OHTs, participants spoke of putting in many hours of work off the side of their desks because they believed in the model. There was a shared belief in the OHT model of care itself – a model that went beyond a traditional biomedical paradigm of providing care, to including a focus on health and wellness, preventative care, the social determinants of health, and an equity lens for the vulnerable.

Participants spoke of the commitment of many, from a community leader who drove many hours through snow to attend meetings, to a physician who hosted dinners at his home to foster engagement amongst colleagues.

2. Interorganizational collaboration

While a history of collaboration and trusting relationships helped partners come together, transcending familiar organizational interests in favour of systemic ones was a new task for many, and one that required constant work. A history of distrust and disenfranchisement of some sectors, and lingering distrust

of the hospital by some community and primary care groups challenged partners' ability to work together in a few OHTs.

Co-leadership for interorganizational collaboration

Most OHTs started with the hospital putting out a broad call for interested organizations. Yet, the hospital, in some OHTs, was described as having a “purposeful quiet voice,” wary of the perception that they would be seen as “running the show” (24_2). Indeed, some primary care and home and community care (HCC) providers were worried about sectoral dominance, with the hospital ‘taking over’ the OHT. This concern was often catalyzed by organizational and regional histories, organizational size, and budgetary differences that allowed the hospital to make more substantial (though fiscally proportionate) contributions towards OHT development. Participants across OHTs agreed on the importance of having a co-led initiative that was not dominated by the hospital.

Participants felt the hospital fulfilled an important coordination role, as it was typically the only partner with the resources and capacity to rent meeting space, provide catering, and fund key administrative positions. While this work of coordination – sometimes interpreted as a form of leadership – was appreciated, both hospital and community participants were sensitive about the optics of the process: “People want the hospital to lead, but they don’t want hospitals to say they’re leading” (07_8). Hospitals’ ability to include other sectoral voices, and their willingness to transform from historically dominant players to equal partners were therefore seen as key facilitators of collaboration.

... the co-chairs in our [OHT] are not hospital-based. And I think that was done very purposeful to show the commitment to community [...] oftentimes we were sidelined as far as some of these huge systems. And certainly, in the community, you always seem to be the poor cousin to acute care. [...] I think those small steps of acknowledgement do start to change a bit in the thinking and the culture. [28_2]

In this context, the commitment of leaders across sectors was important, as was its display. At one OHT, for example, community care providers collectively paid for a dinner for all partner organizations to celebrate their acceptance as a candidate OHT. Hospital leaders played a particularly important role in setting a tone of inclusivity and equal collaboration. A few participants noted that their OHTs were shaped by these individuals’ commitment to transformation; transformation that required the hospital not just to include but even privilege the community sector:

[Hospital leader] truly understood that in order to run the hospital well, he needed a well invested community around him. [...] You know, I'd never heard a hospital CEO, in my time, stand in front of a room and say he was 100 percent committed to making this submission about community-based investment. [20_6]

Governance for interorganizational collaboration

Creating representative and equitable governance models for meaningfully shared decision-making was challenging due to significant fiscal disparities and varied income sources across OHT partners. Thoughtful governance models could therefore help structurally facilitate collaboration. Examples of governance structures included an oversight committee co-chaired by non-hospital-based partners, committees co-chaired by both hospital and community care representatives, partners from different organizations taking turns co-chairing meetings, and disallowing a partner from being out-voted on an issue under consideration that primarily affected their own sector. While many OHTs saw themselves as arriving at decisions by shared decision-making and consensus, primary care and HCC were allowed a larger proportion of votes in certain governance models. While this allowed for the inclusion of perspectives from a variety of primary care models, it was also informed by the historical power and privilege of the medical profession, as a physician reflexively observed:

...we have an awful lot of power and an awful lot of influence. [...] So in this case it was, you need primary care, you need doctors to be involved with this because if the doctors aren't involved, you're sunk. So do what we say. [01_5]

Fears of hospital dominance were openly discussed at some OHTs, as was the concern of other (often smaller) organizations losing control over local fund management when funded through a shared funding bundle. Other issues discussed included the management of competing interests (e.g. for-profit and not-for profit organizations) and arriving at common linguistic terms (e.g. patients versus clients).

Other Strategies

In addition to encouraging co-leadership and thoughtful governance models, OHT participants employed a range of strategies aimed at further fostering meaningful collaboration. They included encouraging participants to speak their mind openly, thoughtfully broaching contentious topics, and drawing up and sharing organizational biographies to garner an understanding of partner organizations.

Frequent in-person meetings attended by stakeholders across sectors that allowed a shared understanding of goals was also seen as important. To facilitate this,

Listening was seen as more important than talking, and participants who took the time to “understand where the other person comes from” (28_5) were valued.

organizational mission statements were aligned with an integrated community focus at one OHT. At another OHT, designated sectoral representatives were tasked with disseminating information back to specific groups. Yet another OHT occasionally brought together stakeholders across tables to discuss how different projects shared a common vision. This enabled “learning in parallel,” where participants made discoveries about each other’s sectors such as the fact that “the gaps for seniors were quite similar to the gaps for children and their families” (20_6). Some OHTs used external facilitators or consultants to help develop terms of reference, conflict resolution procedures, and voting models, as well as to moderate difficult conversations. External facilitators were sometimes themselves familiar and trusted individuals, chosen for their perceived experience and connections.

OHTs with a dedicated individual for OHT development (such as a project coordinator) saw this person as an indispensable resource. This role was funded through pooled resources, or more commonly, by the hospital. Participants’ openness to certain partners contributing less than others due to financial constraints also enabled not-for-profit and smaller organizations to stay involved. A few went further, suggesting that smaller community organizations supported by donations should be financially supported to allow them to participate in OHT work.

3. Primary Care Engagement

Primary care was identified by participants as a “big area of opportunity” (16_9) for improving communication and connection across the OHT. Given its emphasis in the MOH’s original conceptualization of the OHT model, primary care engagement was seen as critical to OHT development. Many primary care leaders, as well as some of their hospital-based counterparts (who were also involved in cultivating broad physician engagement), were enthusiastic about the OHT initiative. They helped develop engagement strategies to keep primary care physicians informed about the OHT model, from hosting open houses and best practice clinic days, to holding telephone consultations and putting together tailored fact sheets. Some OHTs set up physician councils so that physicians could decide on what issues were important to them, communicate them to the OHT, and represent and be accountable to the broad range of primary care physicians in the area. Primary care physicians across participating organizations were broadly on board with the objectives of the OHT. In rural contexts, many primary care physicians were also attached to hospitals, fostering a sense of cross-sectoral familiarity and trust.

Key Challenges

While primary care physicians who were involved in the OHT in a leadership capacity recognized the need for such an initiative, they were also cognizant of its demands. These demands led to difficulties engaging primary care due to a confluence of cultural, professional, and logistical concerns. Approaching family physicians itself was described as challenging in some regions because of the large number of solo family doctors. OHTs with more physician remuneration models based on rosters and capitation rather than fee-for-service, and those with fewer solo practitioners therefore often found it easier to garner primary care engagement.

Participants described creating primary care ‘outreach’ networks, going door to door out in the community, and providing workshops and webinars to better engage these individuals. Furthermore, some primary care providers and nurse practitioners who harboured historical perceptions of being sidelined continued to experience a sense of disenfranchisement. Participants from many OHTs therefore found it difficult to garner primary care engagement, especially at the onset of the OHT initiative.

Some physicians described challenges in explaining and understanding the “so what factor” (20_2) - the purpose of the OHT, and the impact it would have on patient care.

For their part, primary care practitioners worried that the OHT work was taking them away from providing direct patient care, while also resulting in them losing income, something with which their salaried colleagues did not have to contend:

I’m now losing remuneration to go to a meeting where I’m volunteering. But everyone else around the table is being paid at an hourly wage. [...] If I get an email today that says, oh, next week at 10:00 we’re going to be meeting, it’s like, well, that’s great, I’m in the operating room. What do you want me to do here? [...] And if I’m not going, you guys are potentially going to make decisions that are without the representation you need. [01_1]

The expectation of volunteerism at the expense of both patients and income resulted in some primary care physicians objecting to the “cavalier attitude” of the MOH in “trying to build a new system on the backs of already stressed family doctors” (24_7) without requisite support:

I’m trying to get off the train, to be honest, because it seems like there’s a lot of demands on my time now. [...] What I’m trying to do is not maybe be on as many action tables and not maybe go to every committee meeting that I could attend, and not go to all-day sessions that the Ministry puts together. [...] To do what? To sit around and smooch with other people and get their fantastic ideas? [...] Well, that’s just a burden. You’re not supporting me. You’re actually taking me out of my normal comfort zone and seeing my patients and taking care of people. [24_7]

In a few OHTs, participants explained how these frustrations led to a few primary care individuals and organizations stepping back from the OHT initiative. OHTs developed a range of strategies to help address these concerns. When primary care physicians at one OHT felt bombarded with demands on their time, steering committee meetings were scheduled less frequently, evening meetings were considered, and a middle table was set up between steering and action committees to filter and respond to time sensitive MOH and OHT demands. Video conferencing options were also made available. Some OHTs explained how they made a concerted effort to conserve physician time by limiting their involvement to clinically relevant meetings and spreading attendance across tables.

4. Patient and Family Engagement

Health professionals (leaders and clinicians) saw great value in the inclusion of patient and family advisors, who themselves valued being included in OHTs. Yet, there were qualitative differences in how the two groups thought about this engagement.

The Health Professional Perspective

Across OHTs, health professionals saw the collaboration of patient and family advisors as a key component of OHT development. They were seen as OHT co-designers, as they participated in visioning sessions, offered ideas, and helped identify gaps.

The presence of patient and family advisors at committee meetings and working groups encouraged participants to leave their sectoral hats behind and work back from the principle of “if it’s good for the patients [...], that’s the right thing to do” (20_1).

Patient and family advisors were often viewed as the flag around which heterogeneous participants across sectors could rally.

... having patients and families in every conversation also helps us stay true to the cause and I think it does help people just check their behaviours a little bit to say, you know, what I’m about to say, is this coming from a place of altruism and what’s best for people or is this coming from a place of protectionism. [06_1]

Patient and family participation at OHT tables therefore served as a constant reminder of the purpose of the OHT in structural and everyday ways. As one participant noted, “they steer us, they ground us” (20_5). For instance, patient-family advisory councils were set up at many OHTs, one of which purposefully renamed itself the “Community Wellness Council” in recognition of a focus on early identification and wellness (24). Patient stories played a central role at many OHTs, with one OHT always beginning meetings with “a patient story, a doctor story, a system story” (15_6). Another provided patients and caregivers with acronyms lists before meetings, training on the healthcare system, and accountability agreements to help them understand their roles and the roles of others, in an effort to put them on an “equal footing with clinicians” (16_5). Some felt that a stipend or honorarium should be provided for patients and caregivers as an acknowledgement of their contribution of time and expertise to the OHT. At a minimum, participants thought that patient and family advisors should be compensated for any respite care and parking fees incurred as a result of their participation.

The Patient and Family Advisor Perspective

For their part, patient and family advisors appreciated the efforts made to include them in OHT development but felt they had more to give. Half had heard about the OHT initiative through their work as advocates in other organizational initiatives, and the rest had been specifically invited to join by OHT leaders. One participant described feeling appreciated by an OHT’s nurse practitioner group’s engagement efforts, while another valued the personal invitation to join made by an organization’s CEO. Feeling valued – something that typically coincided with the perception of having made a difference – was of critical importance to patient and family advisors. Patient and family advisors spoke of feeling valued when they had the opportunity to contribute to decision-making as “equal partners” (25_3), and when their suggestions were taken a step further and tangibly acted upon. They described how they appreciated being able to shape the “navigator concept” (07_3), being invited as part of their OHT delegation to share their story at a MOH event, and being meaningfully included on their OHT’s governance structure:

... each one of us was given an individual vote, not one vote for [all] patient caregivers. So, when they look at us at the table, as steering committee, we were part of the 17 or 18 and we carried three of those votes as we decided on what work we wanted to focus on. And that’s an important thing, it’s not one isolated vote with thoughts or opinions. We represent a very broad-based group of people in the community.” [20_7]

Despite their appreciation at being included and the efforts noted above, many patient and family advisors felt that engagements efforts had been lacklustre and wished they could contribute more meaningfully to their OHTs. The lack of meaningful engagement was experienced in different ways across OHTs. One patient and family advisor spoke of “feedback fatigue” – something they worked hard to avoid by guiding their OHT towards incorporating patient voices in active ways (27_9). Another described their disappointment at being left out of key meetings and discussions and having to force their way in by request rather than invitation. This led them to question the value of engagement: “why engage? [...], I don’t like wasting my time” (28_4). Yet another patient and family advisor spoke of their disappointment when their suggestion that their OHT should be promoted on social media was not taken seriously. Others spoke of how providers were invited to bring other groups and organizations to OHT meetings, while patient and family advisors were not, leaving them feeling like a minority tasked with the burden of representing a heterogeneous majority of voices. In this case, they took it upon themselves to create an informal network of OHT patient and family advisors, through which they informed each other about OHT matters. Many echoed the need for greater patient and family advisor representation. As one noted, “I can speak to my road, because that’s the road I travelled,” but the greater the range of patient and family advisor voices included, the more complete the map (07_3). A few also suggested that compensating patient and family advisors for their time would allow greater participation from marginalized groups.

5. Policy, Resources and Direction

Across OHTs, many participants felt that there was a lack of resources and direction from the Ministry of Health to guide the operationalization of this new model of care. While a few participants appreciated the ‘low rules environment’ underpinning OHT formation, a majority yearned for greater direction from the MOH.

A sense of precariousness and uncertainty was compounded by two key issues: uncertainty about the future of HCC given the dissolution of LHINs, and uncertainty about digital plans, given the potential amendment of Personal Health Information Protection Act (PHIPA) legislation.

Participants felt that they lacked a “blueprint...framework...foundation” (06_9) for the new model of care.

Home and Community Care

The future state of HCC was largely unknown, given the dissolution of LHINs and lack of clarity over if and how HCC would transition into the OHT domain. The resulting uncertainty was a “distractor” that added “a layer of uneasiness,” (24_6) and made it difficult to design the care coordinator role; seen as an integral part of the new model. Participants also worried about potential conflicts of interest that could arise when allocating HCC contracts to organizations that might be voting members of an OHT governance team. Additionally, there were concerns about disparities relating to human resources, unions, and wages for providers in the same role across different sectors.

Digital Health Solutions

Developing secure digital health solutions that facilitated communication between sectors and provided patients with virtual care options and access to their own health information, was seen by many participants as a key to the success of integrated care. However, significant challenges had to be addressed. Many participants explained how information sharing both within and across sectors was difficult because providers often used different and sometimes incompatible electronic health records, or even paper-based systems. Participants feared their attempts to develop local-level digital solutions would result in a panoply of systems that would not communicate. There was, therefore, a sense of trepidation about moving forward with digital solutions, a concern expressed by participants from OHTs with robust and shared e-health records too. A perceived lack of direction from the MOH was compounded by a dearth of resources for many. The lack of funding besetting OHTs in general therefore affected their ability to develop digital health solutions too. This was a significant challenge particularly for smaller community and primary

care organizations that often had no dedicated funding for digital or Information Technology. Furthermore, there was uncertainty around how PHIPA legislation would be changing in the months ahead. Participants described how this legislation complicated information sharing, given differences in which providers and organizations were deemed health information custodians with access to patients' personal health information. Some participants therefore decided to wait for direction from the MOH before moving ahead with firm digital health plans, so that they would not have to redesign systems at a future date.

Other Concerns

The sense of uncertainty experienced by OHT participants was further compounded by a range of concerns. Many felt that they lacked clarity on the operationalization of the funding model and year 1 accountability agreements. They were uncertain if savings could be retained and reallocated rather than returned to the MOH. Some noted that current Multi Sector Service Accountability Agreement (MSAA) targets would challenge their ability to allocate resources towards the OHT. There was also some uncertainty about the reliability of the attribution model data, leading to concerns about whether outcome measures for the population served could be accurately captured. A few OHTs also felt that the indicators of interest to the MOH were too acute care focused. Some were confused about the start date for implementation. Participants were also concerned that the OHT would create a plan only to have it derailed by new guidance provided later by the MOH. As one participant noted:

... we're crying for leadership and direction, and we would love [...] a singular direction and a requirement relative to where time, money, resources and energy went in IT platforms, etc. [...] More tools to help people support the work we're doing [...]. On the governance side, [say] here's two or three models that we would like you to use. [...] As opposed to, you know, 25 and 50 and 75, whatever we end up, people all going out and engaging lawyers and spending hours and hours and hours and hours and hours exploring different models and workshopping things, and ultimately all ending up at the same three or four places. [15_1]

The perceived lack of direction from the MOH was especially prevalent for the OHTs not selected to move forward as candidates during the first round. In these OHTs (and even amongst those selected in some cases), there was frustration around a perceived arbitrariness and lack of transparency in the process used to select candidate OHTs.

Most participants firmly believed that this level of system redesign would require substantial initial investment. This was noticeably lacking to the many participants across OHTs who described having to "work off the side of their desks" (16_4). They felt the MOH expected OHT participants to redesign healthcare while simultaneously maintaining their day jobs and quality patient care.

Conclusion

Despite their unique contexts and histories, OHTs shared many underlying strengths and challenges, and their participants deployed strategies that even if different, aimed to accomplish similar objectives. The OHT initiative was welcomed, as many believed that the new model would benefit patients and enable much needed collaboration across sectors. Participants reported that they were previously engaged in work that was aligned with the objectives of the OHT model. In addition to a history of collaboration, participants identified a range of strategies that helped them continue to work together, from co-leadership approaches to adopting governance approaches that were sensitive to organizational and sectoral needs.

While many lauded the objectives of the new model and saw a real need for its implementation, participants were beset by a sense of its fragility. As one noted, “so many things could derail this” (06_1). While patients and caregivers were seen as providing the impetus for OHT development, many patient and family advisors themselves felt undervalued or underrepresented. Some OHTs also had to contend with cultural histories of acute care dominance and the disenfranchisement of certain sectors, leading to disillusion and skepticism from certain participants.

A lack of funding and direction from the MOH were key concerns. These in turn informed other concerns such as difficulties developing digital health solutions and designing care coordination functions. Reluctant primary care engagement was particularly challenging to overcome, given the structural changes that were required to enable physicians to feel that participating in OHT development was not at the expense of patients and pay. Yet, while participants were concerned that the lack of guidance, resources, and policy facilitators might slow down OHTs, many vowed to push forward regardless and continue the work of OHT development. For many, it seemed, OHTs held the promise of breaking “the physical and conceptual walls between us” (20_3). At this early stage of development, the OHT model had become the peg upon which the hopes of many for system reform precariously hung.

Addendum

At the time of writing, OHTs have been redirected toward responding to the COVID-19 pandemic. It will be revealing to understand how partnership networks, resources, and planning for OHT development supports this pandemic response, and also how the diversion resulting from pandemic management may affect the focus and direction of OHTs moving forward. The development of local systems and relationships is an essential component of person-centred population health management, including the capability of partners in local health systems to lean in to support one another. Sustaining the gains from early OHT development will require continued attention paid to those aspects of OHTs that were seen to be most important as reported in this summary, and in accompanying reports based on surveys undertaken at the formative stage of OHTs.