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RESEARCH NOTE

#PARG 2020-08RN

Description and Observations of the Transition to a Model of Ontario Health Teams

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It is of general consensus that Ontario's health care system has noted integration challenges (Devlin, 2019a, 2019b). As per the Ministry of Health (2019d), "over time the province's health system has become fractured and disconnected, and as a result patients have been left to suffer on wait lists and navigate the system on their own". To address these concerns, the government has proposed a new model of coordination and desires that "health care providers will be accountable for the patients they serve and will partner to effectively coordinate their care" (Ministry of Health, 2019d).

The purpose of this research note is to describe the transition to a new model of service delivery and organisational governance called Ontario Health Teams (OHT), and to discuss some observations resulting from this transition.

This note is part of a sequence of three research notes. The first note (#PARG 2020-06RN) provides a typology and a list of organisations within Ontario's health care system. The note represents the system as it has existed before implementation of 2019 reforms. The second note (#PARG 2020-07RN) provides an overview of the transition to a single Ontario Health agency. This third note (#PARG 2020-08RN) examines the organisational transition to Ontario Health Teams.

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Source of issues leading to integration concerns

In other provinces, regional health authorities fund programs and services directly. However, LHINs in Ontario have generally funded other independent (often nonprofit) organisations (Moat, Mattison and Lavis, 2016; Office of the Auditor General of Ontario, 2015). Some of the organisations operating within Ontario's health care system are quite disconnected, such as primary care (offered by physicians in medical professional corporations) and acute care settings (offered by hospitals), which can be a source of patient dissatisfaction and system level inefficiencies and ineffectiveness (Martin, 2017). Physicians, both in primary care and specialty care, have a considerable degree of autonomy within the health care system; even though physicians, hospitals, and the remainder of employees within the hospital are all publicly paid (Fierlbeck, 2011; Martin, 2017).

As for hospitals, their Boards of directors have remained intact throughout provincial legislative reforms which have given them some independence from government authorities. Board membership of these organisations is usually anchored within the communities (and is often high profile as larger organisations) (Moat et al., 2016). These volunteer boards have their own interests which may differ from those of LHINs and the Ministries of Health (MoH) and Long Term Care (MoLTC). This has not been the case in other provinces where regional health authorities have replaced hospital Boards of directors.

Fragmentation of Ontario's health care system is therefore a concern (Lavis, 2016) as patients and families deal with a cumbersome system that is difficult to navigate (Devlin, 2019b; Donner, 2015). Health care management is further complicated by the need to integrate services between organisations to increase patient satisfaction and reduce patient safety risks (McNeil, 2015). Hospitals (and other health service providers) also rely on a network of relationships to achieve their objectives. These interdependent relationships between the nonprofit, for-profit, government sectors become fundamental to their operations (Abzug, 1999). For instance, hospitals rely on partner agencies to meet one of their important objectives of ensuring efficient patient flow from acute care to the next level of care, whether it be rehabilitative care, home care, palliative care, etc. As an example of this lack of integration, hospitals face a limited supply of long-term care homes and other settings to which they can discharge patients safely who no longer need acute care (Lavis and Hammill, 2016). When this or other discharge problems occur, these patients are commonly called 'alternative-level-of-care' (ALC) patients. ALC patients can lead to hospital overcapacity, which then leads to "hallway medicine", a practice the provincial government has vowed to eliminate (Devlin, 2019a, 2019b), and is an ongoing process.

As a result of these challenges, greater integration of services is demanded by citizens (and by extension governments), which require the elimination of silos that exist between organisations (Office of the Auditor General of Ontario, 2015). This creates a pressing need to integrate health care services along the continuum of care (Fierlbeck,

2011) in order to increase patient satisfaction, reduce safety risks and increase financial efficiencies. This can be achieved either by coordinating services, or through outright amalgamation. It should be noted that health care has too often suffered from the pendulum swing between decentralization and centralization of control as a means of achieving, among other things, greater integration (Axelsson, 2000).

Ontario Health Teams

The provincial government has continued to address integration concerns by enacting legislation under *The People's Health Care Act, 2019* (Government of Ontario, 2019) that introduces the concept of Ontario Health Teams (OHT) and authorizes their funding. These changes are driven by a bottom-up desire from patients (and by extension citizens) for more care coordination and a top-down desire from government funders for financial efficiencies. It is assumed, or perhaps hoped, that a model of OHT will achieve both. It should be noted that network governance models in health care are not new, and has recently been initiated throughout England (Hammond, Speed, Allen, McDermott, Coleman and Checkland, 2019).

The objective of OHT is to "provide a new way of organizing and delivering care that is more connected to patients in their local communities. Under Ontario Health Teams, health care providers (including hospitals, doctors and home and community care providers) work as one coordinated team - no matter where they provide care." (Ministry of Health, 2019a). OHT are to be financially accountable to Ontario Health.

OHT model

OHT are a model of governance for the delivery of health care and are designed to coordinate care among organisations to offer integrated services (Ministry of Health and Long-Term Care, 2019). Health care integration "is challenging when each provider functions independently and is funded without common accountabilities and performance metrics" (Ministry of Health and Long-Term Care, 2019, p.4). OHT are designed to address these concerns and are defined as "groups of providers and organisations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population" (Ministry of Health and Long-Term Care, 2019, p.2).

The intended benefit of this approach is that "patients are likely to expect to receive more coordinated, seamless and comprehensive care from an OHT" (AFHTO, 2019, p.8). These teams may include, but are not limited to acute care, primary care, long-term care, home care, community care, palliative care, and mental health and addictions services. Since 2017, home and community care services were provided by LHINs (see description in note #PARG 2020-07RN), which are currently under the direction of Ontario Health (Ministry of Health, 2019e). There are plans to move home and community care services to OHT. These OHT are likely to be phased in over a

number of years. The pace of this change will depend on numerous factors, including the structure of government incentives (i.e. financial arrangements) and the willingness of partner agencies to collaborate. Components of an OHT are shown in Table 1. Table 2 summarizes the seven focal health care services under OHT and combines them with organisations from Figure 1 in PARG note #PARG2020-06RN.

Table 1 – Components of an OHT model

1. Patient Care and Experience
2. Patient Partnership & Community Engagement
3. Defined Patient Population
4. In-Scope Services
5. Leadership, Accountability, & Governance
6. Performance Measurement, Quality Improvement, & Continuous Learning
7. Funding and Incentive Structure
8. Digital Health

Source: Ministry of Health and Long-Term Care (2019, p.16-17)

Table 2 - Summary of health care services in OHT

Services	**Organisation**
Acute care	Hospitals
Primary care	Medicine professional corporations, other health professional corporations
Mental health or addictions	Other primary care organisations (e.g. local branches of CMHA)
Home care	Home and community care services
Community care	Community support service agencies, community health centres
Long-term care	Long-term care homes, retirement homes
Palliative care	Other primary care organisations (e.g. hospices)

Source: AFHTO (2019, p.2)

Characteristics of OHT

Characteristics of a mature OHT include the following 8 items (Ministry of Health and Long-Term Care, 2019, p.15):

- "Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.
- Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers, and the communities they serve.
- Teams will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care.

- Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.
- Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls.
- Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be reported.
- Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.
- Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience."

Eligibility

To begin the process of creating OHT, in April 2019 the MoH asked groups of health care providers to submit a self-assessment, of which there were 158 submissions across the province (AFHTO, 2019). From this pool of submissions, in August 2019 the MoH invited 31 teams to submit full applications (Ministry of Health, 2019b) and in December 2019, the MoH selected and approved the first 24 OHT (Ministry of Health, 2019a). The list of the first cohort of 24 OHT is provided in Appendix A. The other invited teams are working on revising their applications. A new round of OHT will begin with invitations for full applications in 2020.

As of now, OHT are designed as collaborations rather than separate legal entities, which will be governed by steering committees with representation from service providers and citizens. This approach stops short of requiring organisations to formally consolidate. The provincial government is specific in its guidelines for OHT that mergers or amalgamations are not a requirement and that OHT are not to be legal entities (Ministry of Health and Long-Term Care, 2019). Organisations within an OHT will be free to merge or amalgamate as the government has left each OHT to determine their governance structures. However, it is unlikely that all OHT members will eventually merge into a single legal structure, as the members include a mix of nonprofit and private entities. OHT could also potentially include public entities through public health units, although public health is not part of the in-scope services listed for mature OHT (Ministry of Health and Long-Term Care, 2019). Table 3 provides a summary of health care providers and organisations eligible to become OHT.

Table 3 - Summary of health care providers and organisations eligible to become OHT

- primary care (including inter-professional primary care and physicians)
- secondary care (e.g., in-patient and ambulatory medical and surgical services (include specialist services)
- home care
- community support services
- Mental health and addictions services
- Health promotion and disease prevention services
- rehabilitation and complex care
- palliative care (e.g., hospices)
- residential care and short term transitional care (e.g., in supportive housing, long-term care homes, retirement homes)
- long-term care home placement
- emergency health services
- laboratory and diagnostic services
- midwifery services
- other social and community services and others services, as needed by the population

Source: Ministry of Health and Long-Term Care (2019, p.22)

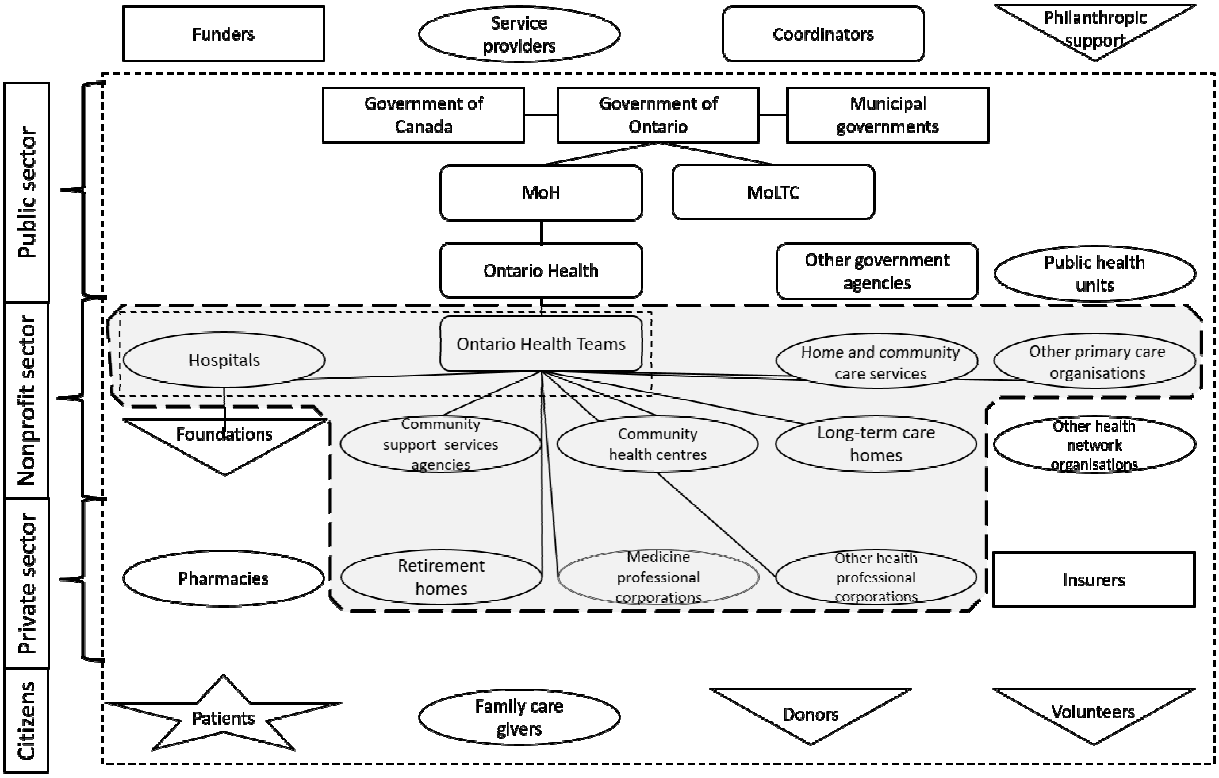
OHT will also not replace the physician model of billing the Ontario Health Insurance Plan (OHIP) for services. As such, physicians in primary and acute care will form part of the OHT leadership, but their remuneration arrangements will be excluded.

Eventually, it is intended that it will be the responsibility of OHT to formalise relationships with service providers through formal accountability agreements between the participating members and to hold them accountable (Ministry of Health and Long-Term Care, 2019). This model essentially transfers coordination responsibilities to nonprofit and private sector service providers; a role that has traditionally been the responsibility of the public sector. Figure 1 depicts in the shaded area what is envisioned for Ontario's health care system under a model of OHT. The small dotted line with Ontario Health Teams indicates the likely lead agency of most OHT.

Observations following OHT proposal

It is too soon to assess the success of the OHT model. However, a few observations can be made. As government documentation explains, OHT will have shared governance and accountability structures. However, governance and accountability are separate concepts. Shared or "collaborative" governance is an effective means of achieving common goals, which is especially important given the interdependencies that exist in the health care system (Pilon, 2019). It may be challenging to collaborate and invent a new form of governance with all the changes in the system.

Figure 1 – Overview of Organisations within Ontario's Health Care System
As Envisioned with Ontario Health Teams



As the majority of OHT submissions have been made by hospitals (Ministry of Health, 2019c), it is therefore likely that hospitals will constitute the lead agency of most OHT in the province. This is without surprise, as hospitals are the most likely to have the expertise, capacity and resources to lead OHT. As lead agency, these organisations will be receiving the collective funding and it is assumed, will be held overall accountable for performance. As they have large influence, larger organisations in the OHT, such as hospitals, may bring potential of perception takeover or real control takeover of the OHT. A shared accountability approach will therefore likely centralise responsibility with the lead agency as ultimate accountability will reside with this organisation. Who will act as coordinator?

A challenge with the proposed approach will be the need to continue to maintain clear lines of accountability. Shared accountability blurs the lines of organisational boundaries and the related delineated patterns of accountability (Bakvis and Juillet, 2004). The more integration that is achieved between organisations, the less it is possible to hold specific organisations accountable for their performance, since shared accountability increases the possibilities for service providers to shirk responsibility by making it easier for poor performers to blame others or to blame "the system". Specific accountability is generally easier to hold others to account for their performance.

As Fierlbeck (2011, p.319) wrote: “we demand clearer accountability, but we want the system to become more integrated. We want system-wide efficiencies, but we will not let efficiencies be made where they threaten our own particular interests. We expect choice and quality, but resent the cost. It’s a confusing dialectic.” These are some of the contrasting objectives that health care organisations must attempt to reconcile with the introduction of OHT. It appears that the government is reluctant to force consolidations of the sector (other than with government agencies) in fears of creating another “Montfort” crisis (Gratton, 2003). The OHT model is a ‘soft’ approach to solving system problems, in that the government is not forcing any consolidations of the sector. The effectiveness of this approach remains inconclusive. How it will work in practice?

While OHT are to “operate within a single, clear accountability framework” (Ministry of Health and Long-Term Care, 2019, p.3), this framework is yet to be defined. As such, it remains unclear how OHT will be clinically and fiscally accountable between the organisations within the partnership. When the framework will be available? What will be the content of the framework? How will the mechanisms of accountability function?

It is possible that some OHT organisations will underperformed. And so, how will performance be determined? Will OHT have the authority to remove an underperforming organisation? What will happen if an organisation’s individual performance is adequate but is not collaborating? And, will organisations look to be part of an OHT to avoid being held directly accountability for performance?

OHT will be funded through a shared funding envelope (Ministry of Health and Long-Term Care, 2019) and the funding formula is left to each OHT to determine how funds will be distributed. It is therefore unclear how funding will be allocated under OHT. For example, the Mississauga Ontario Health Team includes 50 members and 42 affiliates (Mississauga Ontario Health Team, 2019). This raises the question: Is it perhaps a possibility that larger organisations such as the lead agency could take profitable programs, and download less profitable ones to smaller organisations, leaving these (yet to be determined) services vulnerable?

From an accountability perspective, what remain to be seen is how funds will be distributed between the discreet organisations and how lines of responsibility and corresponding accountability will be established, and how effective they will be. A general lack of funding in the system is needed to reduce “wait lists” (Ministry of Health, 2019d). Will funds be added in the health system?

Coordination requires resources (such as additional funding, time, expertise, slack in personnel activities, and office space). As the initial phase is not funded, this puts capacity pressures on the various OHT partners. While the OHT will create additional administrative burdens, resources will be needed to pay for the coordination activities, some of which were performed by LHINs. Will the resources be provided considering the tight public finances? Who will pay for? Who will receive the funds? When the funds be provided?

If the system is well resourced, it can help improve the transition of hospital patients to their next level of care, thereby alleviating alternate-level-of-care (ALC) levels, increasing system integration and halting beds in hospital hallways. Will the resources be provided for ALC considering the tight public finances?

With the period of transition for home and community care functions of the LHINs, it may take a few years before the new Home and Community Care Support Services will transfer to Ontario Health (Ministry of Health, 2020). Home and community care transitions will transfer into Ontario Health Teams and other points of care. How long will be the transition?

Conclusion

The complexity of managing the changes resulting from *The People's Health Care Act, 2019* (Government of Ontario, 2019) means that the OHT model will be an ongoing and long-term process over the next several years, and there remains much uncertainty given the complexity of the system. While 24 OHT have been approved, some organisations have avoided the risks associated with being an early adopter and have chosen to take a "wait and see" approach.

This research note raises several key questions, notably: Who will act as coordinator?; How will performance be determined?; When the framework will be available?; What will be the content of the framework?; Will the funds be added in the health system considering the tight public finances?; Who will receive the funds?; When the funds be provided?; How long will be the transition?.

Adequate investments will be necessary for the transition to the new model to be effective. With new development taken place, oversight will be needed over the changes.

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APPENDIX A – LIST OF FIRST COHORT OF 24 ONTARIO'S HEALTH TEAMS

Announced on December 9, 2019 (Ministry of Health, 2019c), the first 24 Ontario Health Teams include:

- All nations Health Partners Ontario Health Team
- Brampton/Etobicoke and Area Ontario Health Team
- Burlington Ontario Health Team
- Cambridge Ontario Health Team
- Chatham-Kent Ontario Health Team
- Connected Care Halton Ontario Health Team
- Couchiching Ontario Health Team
- Durham Ontario Health Team
- East Toronto Ontario Health Team (East Toronto Health Partners)
- Eastern York Region North Durham Ontario Health Team
- Guelph and Area Ontario Health Team
- Hamilton Ontario Health Team (Hamilton Health Team)
- Hills of Headwaters Collaborative Ontario Health Team
- Huron Perth and Area Ontario Health Team
- Mississauga Ontario Health Team (Mississauga Health)
- Muskoka and Area Ontario Health Team
- Near North Health and Wellness Ontario Health Team
- North Toronto Ontario Health Team
- North Western Toronto Ontario Health Team
- North York Ontario Health Team (North York Toronto Health Partners)
- Northumberland Ontario Health Team (Ontario Health Team – Northumberland))
- Ottawa Ontario Health Team (Ottawa Health Team/Équipe Santé Ottawa)
- Peterborough Ontario Health Team
- Southlake Community Ontario Health Team