Ontario Health Teams
A Primer for Boards

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Algoma NPLC Board of Directors
February 8th 2021

Alliance for Healthier Communities
Alliance pour des communautés en santé

Overview

Introduction

Transformation of Ontario's Health System: Legislative Context

Ontario Health

Ontario Health Teams

- What are Ontario Health Teams?
  - Future State vs Current State
- What is the role of governors?
- Health Equity and OHTs
- Commitments as Alliance members

Transformation of Ontario's Health System: Legislative Context

The People's Health Care Act, 2019
Connecting Care Act, 2019

Legislative Context:
The People's Health Care Act, 2019

The People's Health Care Act, 2019 (Bill 74) has three parts:

- *Connecting Care Act, 2019*
  - Establishes a central agency **Ontario Health**
    - Consolidates multiple provincial health agencies to form Ontario Health
    - Authorizes the creation of new integrated delivery systems called **Ontario Health Teams**
  - Authorizes Ontario Health to provide funding under a Service Accountability Agreement to Ontario Health Teams
- Amendments to the *Ministry of Health and Long-Term Care Act*
- Amendments/repeals to 29 pieces of legislation – enabling implementation, removing LHINs and providing for Ontario Health

Future state
OHT TPAs currently with MOH
OHT Division

Introduced February 26th 2019
Passed April 19th 2019

Source: "Ontario Health Team Handbook for Boards", The Osborne Group, Association of Family Health Teams of Ontario

Legislative Context: Equity in the preamble

"The people of Ontario and their government…

Believe that the public health care system should be guided by a ***commitment to equity*** and to the ***promotion of equitable health outcomes***;

Acknowledge that the public health care system should recognize the diversity within all of Ontario's communities and respect the requirements of the French Language Services Act in the planning, design, delivery and evaluation of health care services for ***Ontario's French-speaking communities***; and

Recognize the role of ***Indigenous peoples*** in the planning, design, delivery and evaluation of health services in their communities."

Connecting Care Act, 2019, Preamble

Indigenous Health in Indigenous Hands

Alliance members are committed to the principle that health care for Indigenous people should be managed by Indigenous-governed organizations.

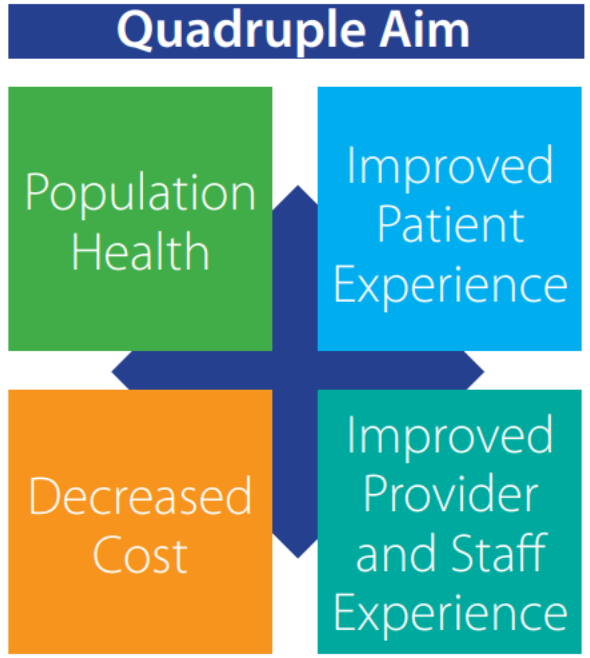
Honouring this commitment is essential to “walking the walk” of reconciliation and allyship.

We are working with our Indigenous partners and the guidance of the Indigenous Primary Health Care Council (IPHCC) on how we can best support them in the *Ontario Health Team* process.

Objectives of Health Care Transformation

In addition to the commitment to equity, to French-speaking communities and to indigenous peoples, other objectives include:

- A health care system that centres around people, patients, families and caregivers
- Continuous improvement of the patient experience
- Promote better value and ensure best outcomes
- Improve the overall physical and mental health and well-being of Ontarians
- A sustainable, digitally enabled, publicly funded health care system
- Empowerment of providers to work together to deliver high quality coordinated care



Source: "Ontario Health Team Handbook for Boards", The Osborne Group, Association of Family Health Teams of Ontario

Legislative Context:
Duty of Health service providers and *Ontario Health Teams*

The Agency *[Ontario Health]* and **each** health service provider and integrated care delivery system *[Ontario Health Teams]* shall separately and in conjunction with each other identify opportunities to **integrate the services of the health system to provide appropriate, coordinated, effective and efficient services.**

Connecting Care Act, 2019, Section 30

Ontario Health

https://www.ontariohealth.ca/

Ontario Health

Sign up for their newsletter
Ontario Health Connection

Ontario Health is an agency with a mandate to connect and coordinate our province's health care system in ways that have not been done before, to help ensure that Ontarians receive the best possible care.

2020-21 Mandate Letter from the Minister of Health

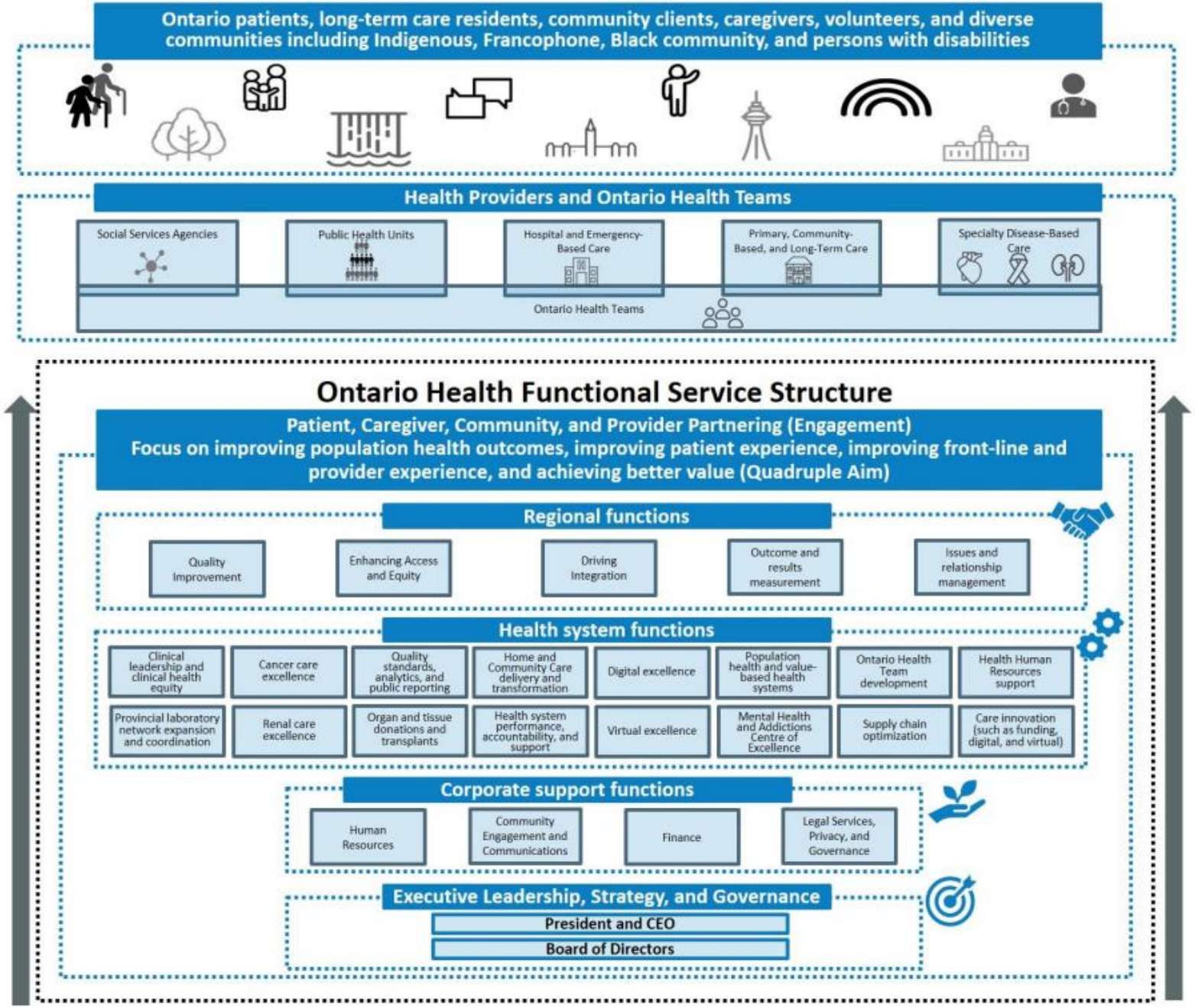
Transferred in 2019

- Cancer Care Ontario
- HealthForceOntario
- Health Quality Ontario
- eHealth Ontario
- Trillium Gift of Life Network
- Ontario Health Shared Services Ontario

To transfer in 2021

14 LHIN RLISS

except Home and Community Care



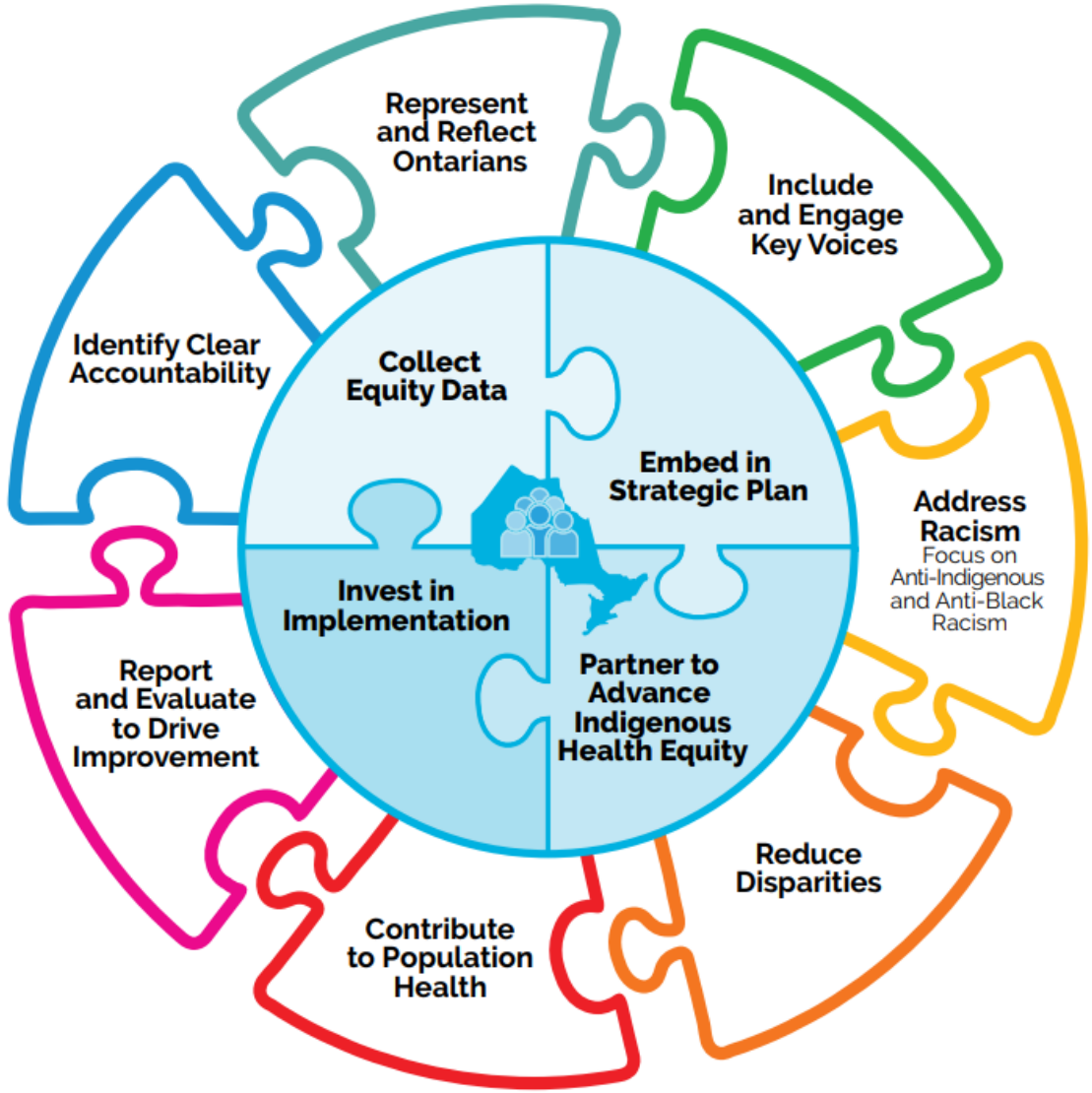
Source: [Ontario Health's Operating Model: Patient Perspective and Integrated Top-Line Organizational Structure]

Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

With a focus on addressing anti-Indigenous and anti-Black racism

11 Areas of Action

- **Collect Equity Data**
  Set up systems and supports to collect, analyze, and use equity data to report findings and inform future decisions
- **Embed in Strategic Plan**
  Ensure efforts to address equity, inclusion, diversity, anti-Indigenous and anti-Black racism are at the highest priority for the organization
- **Partner to Advance Indigenous Health Equity**
  Recognize that strong relationships with Indigenous leadership and communities - founded on respect, reciprocity, and open communication — are critical in ensuring that the new health care system in Ontario reflects and addresses the needs of Indigenous peoples.
- **Invest in Implementation**
  Apply the financial and people resources needed for success and ongoing sustainability
- **Identify Clear Accountability**
  Establish and assign "who" is responsible for "what"
- **Represent and Reflect Ontarians**
  Strive for all levels of the organization to reflect the communities served
- **Include and Engage Key Voices**
  Listen to the staff and communities and include their ideas and feedback into the design, delivery and evaluation of programs and services
- **Address Racism** Focus on Anti-Indigenous and Anti-Black Racism
  Identify and address discriminatory practices and procedures in all forms and all levels using targeted approaches
- **Reduce Disparities**
  Use data and best practices to establish standards, identify disparities and implement corrective action through a focus on access, experience and outcomes for the population
- **Contribute to Population Health**
  Work with other arms of government and agencies in planning services to improve the health of the population
- **Report and Evaluate to Drive Improvement**
  Publish Framework metrics publicly with all reports including an equity analysis



For more information, go to: ontariohealth.ca

Ontario Health

Source: [Ontario Health - Equity, Inclusion, Diversity and Anti-Racism]

Building a Common Understanding

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism. In order to achieve better outcomes for all patients, families, and providers within Ontario's health system, we must explicitly identify and address the impacts of **anti-Indigenous** and **anti-Black racism** as part of our commitment.

This framework builds upon our existing legislated commitments and relationships with **Indigenous peoples** and **Francophone communities**, and recognizes the need for Ontario Health to take an **intersectional approach** to this work.

The definitions below help to provide a common understanding as we work together to create a shared culture focused on equity, inclusion, diversity, and anti-racism.

Anti-Racism
An anti-racism approach is a systematic method of analysis and a proactive course of action. The approach recognizes the existence of racism, including systemic racism, and actively seeks to identify, reduce and remove the racially inequitable outcomes and power imbalances between groups and the structures that sustain these inequities.

Anti-Black Racism
The policies and practices rooted in Canadian institutions such as education, health care, and justice that mirror and reinforce beliefs, attitudes, prejudice, stereotyping and/or discrimination towards Black people and communities.

Anti-Indigenous Racism
Anti-Indigenous racism is the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples within Canada. It includes ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers, and inequitable outcomes that stem from the legacy of colonial policies and practices in Canada.

Diversity
The range of visible and invisible qualities, experiences and identities that shape who we are, how we think, how we engage with and how we are perceived by the world. These can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socio-economic status, age, physical or mental abilities, religious or spiritual beliefs, or political ideologies. They can also include differences such as personality, style, capabilities, and thought or perspectives.

Equity
Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

Health Disparities
Differences in health access, experience or outcomes in a way that is systematic, patterned and preventable.

Inclusion
Inclusion recognizes, welcomes and makes space for diversity. An inclusive organization capitalizes on the diversity of thought, experiences, skills and talents of all of our employees.

Intersectionality
The ways in which our identities (such as race, gender, class, ability, etc.) intersect to create overlapping and interdependent systems of discrimination or disadvantage. The term was coined by Black feminist legal scholar Dr. Kimberlé Crenshaw and emerged from critical race theory to understand the limitations of "single-issue analysis" in regards to how the law considers both sexism and racism. Intersectionality today is used more broadly to understand the impact of multiple identities to create even greater disadvantage.

Structural Racism
Is a system in which public policies, institutional practices, cultural representations, and other norms work in ways to reinforce and perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed white privilege and disadvantages associated with colour to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.

Systemic Racism
Organizational culture, policies, directives, practices or procedures that exclude, displace or marginalize some racialized groups or create unfair barriers for them to access valuable benefits and opportunities. This is often the result of institutional biases in organizational culture, policies, directives, practices, and procedures that may appear neutral but have the effect of privileging some groups and disadvantaging others.

**Definitions extracted from the McGill University Equity, Diversity and Including Strategic Plan (2020-2025); the UHN Anti-Racism and Anti-Black Racism (AR/ABR) Strategy; and the 519 Glossary of Terms around equity, diversity, inclusion and awareness*

***Connecting Care Act 2019 (Link to: https://www.ontario.ca/laws/statute/19c05)*

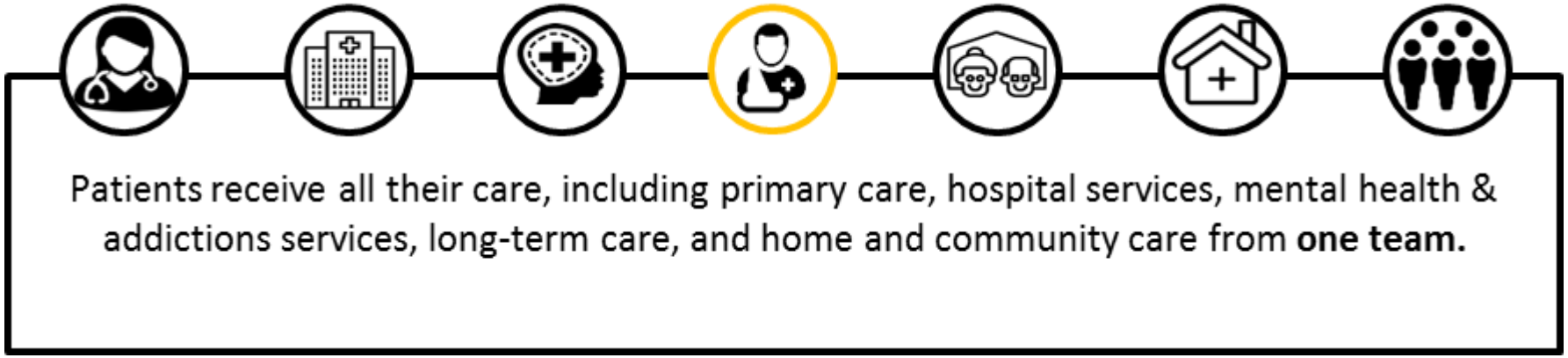
Ontario Health

Source: [Ontario Health - Equity, Inclusion, Diversity and Anti-Racism]

What are Ontario Health Team?

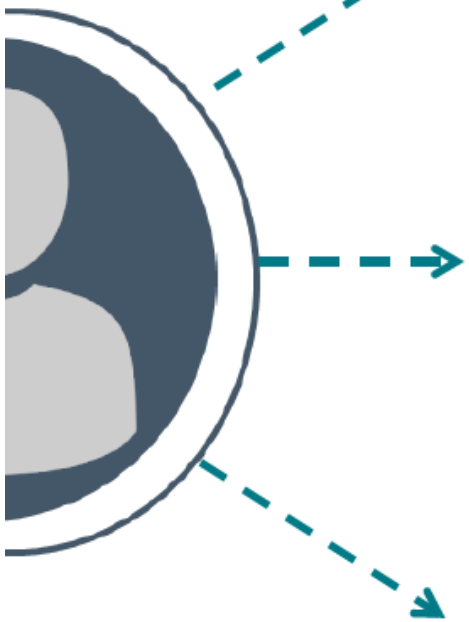
Ontario Health Teams

are groups of providers and organizations that *at maturity,* will be **clinically** and **fiscally accountable** for delivering a full and **coordinated continuum of care** to a **defined geographic population.**



A Vision for Ontario Health Teams

At maturity, every Ontarian will have access to an Ontario Health Team that will:



- Provide a full and coordinated continuum of care for an attributed population within a geograp… 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 patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and 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: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/oht_intro_webinar_en.pdf

OHT Model Components

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

Integrate

more connected, seamless, and coordinated care centred on improving people's outcomes and experience plus value

NOT legal relationships or structural integration

Source: "Ontario Health Teams: Guidance for Health Care Providers and Organizations"

Appendix A – Ontario Health Team Model: From Readiness to Maturity Summary

	Readiness Criteria for Ontario Health Team Candidates	Year 1 Expectations for Ontario Health Team Candidates	Ontario Health Teams at Maturity
Patient Care & Experience	Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.	Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the Team's services are in place. Expanded virtual care offerings and availability of digital access to health information.	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.
Patient Partnership & Community Engagement	Demonstrated history of meaningful patient, family, and caregiver (P/F/C) engagement, and support from First Nations communities[7] where applicable. Plan in place to include P/F/C in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient engagement framework, and patient relations process. Adherence to the *French Language Services Act*, as applicable.	Patient Declaration of Values in place. P/F/C included in governance structure(s) and patient leadership established. Patient engagement framework, patient relations process, and community engagement plan are in place.	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.
Defined Patient Population	Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1.	Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population.	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.
In-Scope Services	Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in full continuum of care and include or expand primary care services.	Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary care coverage for a significant proportion of the population.	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.
Leadership, Accountability, and Governance	Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for team, reflecting a central brand, and where applicable, putting in place formal agreements between team members.	Agreements with Ministry and between Team members (where applicable) in place. Existing accountabilities continue to be met. Strategic plan for the Team and central brand in place. Physician and clinical engagement plan implemented.	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.
Performance Measurement, Quality Improvement, & Continuous Learning	Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality improvement activities, engage in continuous learning, and champion integrated care.	Integrated Quality Improvement Plan in place for following fiscal year. Progress made to reduce variation and implement clinical standards/best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative.	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.
Funding and Incentive Structure	Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fund holder, and reinvesting savings to improve patient care.	Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data.	Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.
Digital Health	Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners.	Harmonized Information Management plan in place. Increased adoption of digital health tools. Plans in place to streamline and integrate point of service systems and use data to support patient care and population health management.	Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

Source: "Ontario Health Teams: Guidance for Health Care Providers and Organizations"; p.15

1 Patient Care & Experience

Access when & where they need it

Year 1 Expectations

- **Care has been re-designed for Year 1 patients**
- **Improved performance** against access, transition, coordination of care, and integration targets determined in consultation with the Ministry
- Every Year 1 patient who received care across multiple providers or settings experienced coordinated care; **zero cold handoffs**
- Any Year 1 patient can access **24/7 coordination and system navigation services** from their Ontario Health Team (e.g., someone with access to their health information who can help with system navigation, when something goes wrong with their care, or when they have a complaint)
- The majority of Year 1 patients who received a **self-management plan** and/or access to health literacy supports understood that plan, as appropriate, and/or used those supports
- **10-15%** of Year 1 patients who received care from the Ontario Health Team **digitally accessed their health information**
- **Expanded virtual care offerings from baseline**, and 2-5% of Year 1 patients who received care from the Ontario Health Team had a virtual encounter in Year 1
- **Information** about Ontario Health Team's service offerings is readily **available and accessible to the public** (eg. a website)

2 Patient Partnership and Community Engagement

Driven by the needs of patients and communities

Year 1 Expectations

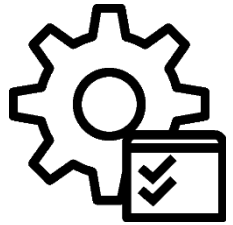
- The Ontario Health Team has a **Patient Declaration of Values** in place, aligned in principle with the *Patient Declaration of Values for Ontario*.
- Patient(s), families, and/or caregiver(s) are **members of governance structure(s)** and patient leadership established
- Well-defined **patient engagement, consultation, and partnership strategy/framework and patient relations process** are in place, developed in partnership with patients, families, and caregivers
- **Community engagement plan** is in place to inform continued implementation and out-year planning

3 Defined Patient Population

Where patients typically access care

Year 1 Expectations

- Patient access and service delivery target met;
- Number of patients who identify as having a sustained care relationship with the Ontario Health Team has been reported;
- Plan in place for expanding target population



Equity Lens

- Who else is missing from the attributed population?
- How can you continue developing sustained care relationships with people who are racialized, non-English speaking, marginalized, living in poverty etc.

Attributed Populations

Methodology

- Ontarians have been **attributed** to care providers through naturally occurring networks based on an analysis of existing patient flow patterns.

Reminder:

- Ontario residents are not attributed based on where they live, but rather on how they access care.
- Determines # of who the OHT is responsible for but does NOT determine where patients need to access care.
- Patients cross geographic boundaries to seek care.
- There is no restrictions on where residents can receive care.
- Population profile will change over time as residents move and potentially change where they access care.

Attributed Populations
Data

In each teams data packages, **maps** have been created to illustrate patient flow patterns and natural linkages between providers which will help inform discussions regarding ideal provider partnerships.

Our data is missing for attribution

- Alliance members do not roster their clients in physician enrolment models (PEMs).
- CHC/NPLC and AHAC data were NOT included since ICES is only able to provide data back to the Ministry of Health that the Ministry has sent ICES.

The Alliance encourages each OHT supplement their attribution data with the data that is on the www.ontariohealthprofiles.ca

OCHPP
Ontario Community Health Profiles Partnership

4 In-Scope Services

Full and coordinated continuum of care

Readiness Criteria

- Deliver coordinated services across at least three sectors of care in Year 1 and has adequate service delivery capacity to serve the care needs of the proposed Year 1 target population
- Plan/process has been proposed to phase in the full continuum of care, including primary care engagement.

Year 1 Expectations

- Additional partners identified and engaged for inclusion in Year 2
- Plan in place for expanding range and volume of services provided in Year 2
- Primary care coverage for a significant proportion of the Ontario Health Team population.

4 In-Scope Services

Full and coordinated continuum of care

Which partners are at the table?
Which partners are missing along the health and social care continuum?

- ❑ **Primary Care**
  (interprofessional primary care and physicians)
- ❑ **Secondary Care**
  (in-patient and ambulatory medical and surgical services (includes specialist services))
- ❑ **Home care**
- ❑ Community support services
- ❑ Mental health and addictions
- ❑ Health promotion and disease prevention
- ❑ Rehabilitation and complex care
- ❑ Palliative care
- ❑ Residential care & short-term transitional care (supportive housing, LTC homes, retirement homes)
- ❑ Long-term care home placement
- ❑ Emergency health services
- ❑ Laboratory and diagnostic services
- ❑ Midwifery services
- ❑ Other social and community services and other services, as needed by the population.

5 Leadership, Accountability and Governance

Trusted established partnerships

Readiness Criteria

- Commitment to OHT vision and goals, developing a joint OHT strategic plan, reflecting a central brand, and, where applicable, putting in place formal agreements between team members

Year 1 Expectations

- Agreements between team members and Ministry remain in place and existing accountabilities continue to be met
- OHT strategic plan and central brand in place
- Physician and clinical engagement plan implemented

- *For OHTs that are comprised of multiple, separate organizations; building **shared governance and accountable relationships** requires **trust** and **may take time** to establish.*
- *There is no "right" governance structure. Teams will self-determine the governance model. Fit-for-purpose to meet the needs of patients.*
- *CDMA must meet attestation criteria checklist (will touch on this later in presentation)*

6 Performance Measurement, Quality Improvement, and Continuous Learning

Evidence-based, clinical standards, ongoing focus on QI

Year 1 Expectations

- Integrated Quality Improvement Plan in place for the following fiscal year
- Progress made to reduce variation and implement clinical standards or best available evidence
- Complete and accurate reporting on required indicators
- Participation in central learning collaborative

- *While Alliance members are well versed in all existing OHT measures (QIPs, AAs), the OHTs will be held accountable through these to their attributed population at the **system level**.*
- *All measures should be **equity** stratified.*
- *Alliance and our members will be looking to ensure there are system measurements in place that are equity informed measuring **healthy populations** and **community vitality**.*

7 Funding and Incentive Structure

Prospective integrated funding envelope

Year 1 Expectations

- Continued allocation of **individual funding envelopes** for organizations, calculated using current methods in the near term
- A better understanding of an integrated funding envelope and **analysis of financial data**
- A **single identified fund holder** by end of Year 1 in anticipation that an integrated funding envelope will be allocated in future years

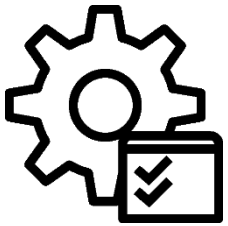
8 Digital Health

Patients – Front Line Providers – Team Improvement

Year 1 Expectations

- Harmonized information management plan in place
- Increased adoption of relevant digital health tools amongst the Ontario Health Team partners (e.g. ONE-ID, provincial clinical viewers, eConsult)
- Plan is in place to streamline and integrate point-of-service systems consistent with provincial frameworks and to use data to support enhanced patient care and population health management

- *Capacity to share data so people and their providers have access to the full patient story.*
- *The Alliance will be working with ELs closely on Digital Health Strategy*

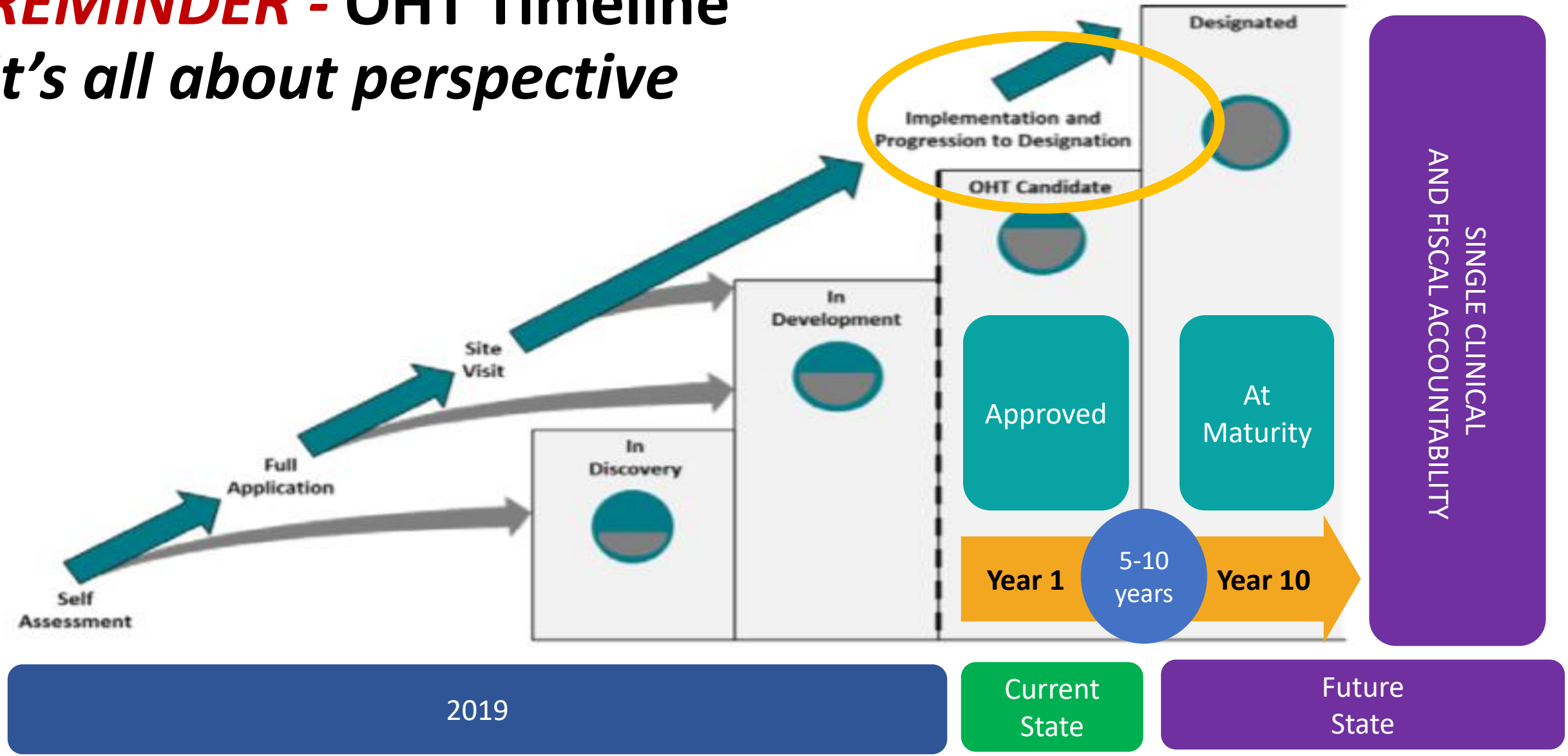


Ontario Health Teams: Digital Health Playbook

Released August 2019

REMINDER - OHT Timeline

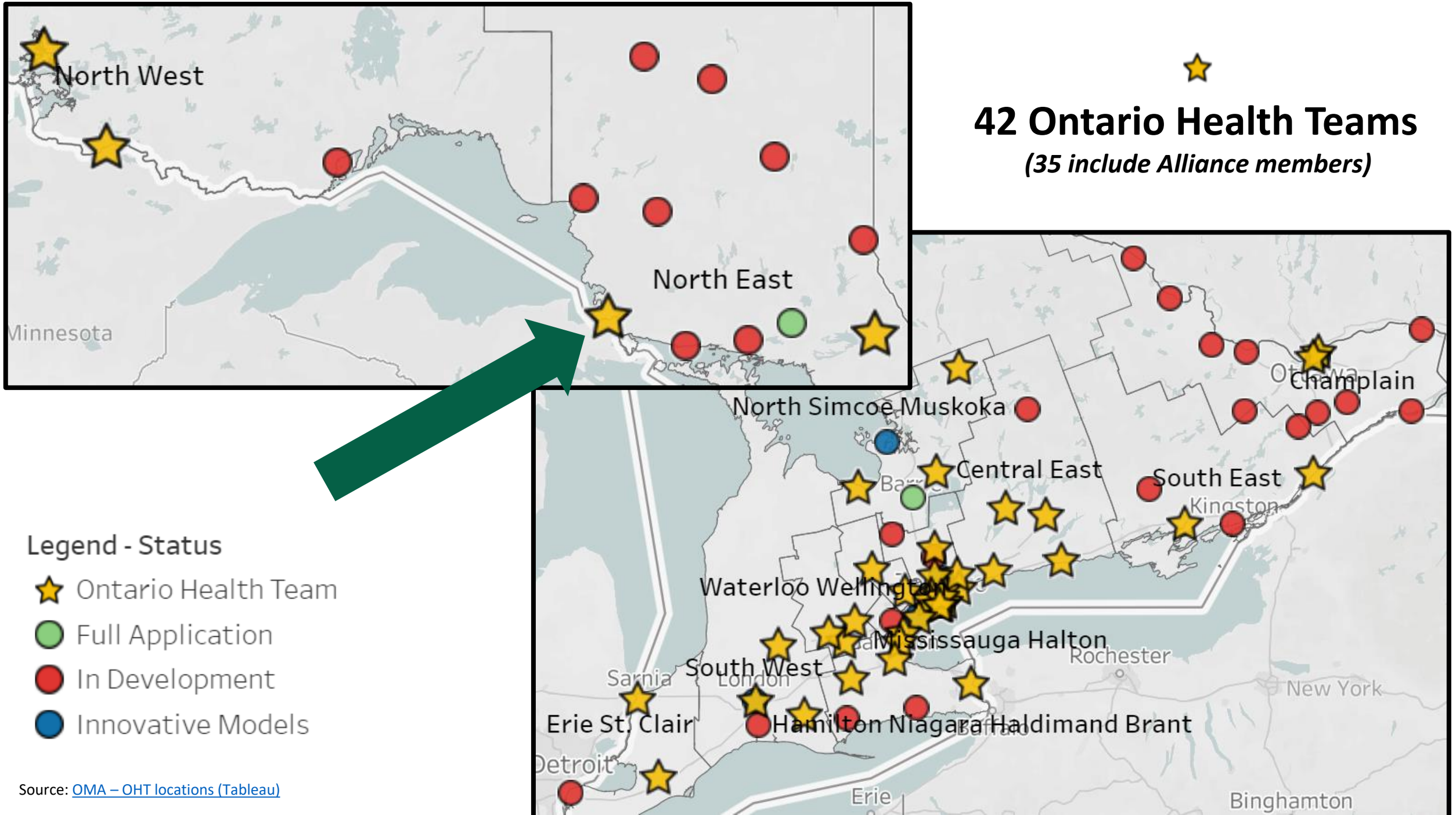
It's all about perspective



OHT – Provincial coverage and expansions

- 42 teams approved OHTs (will cover over 86% of Ontario at maturity)
- The MOH will be focusing on building up teams in areas that don't already have approved teams in place. Teams will be invited to complete full applications on a case-by-case basis.
- At the same time we will **continue to grow provider partnerships in existing Ontario Health Teams.**

Source: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/



42 Ontario Health Teams

(35 include Alliance members)

Source: [OMA – OHT locations (Tableau)]

ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

https://www.algomaoht.ca/

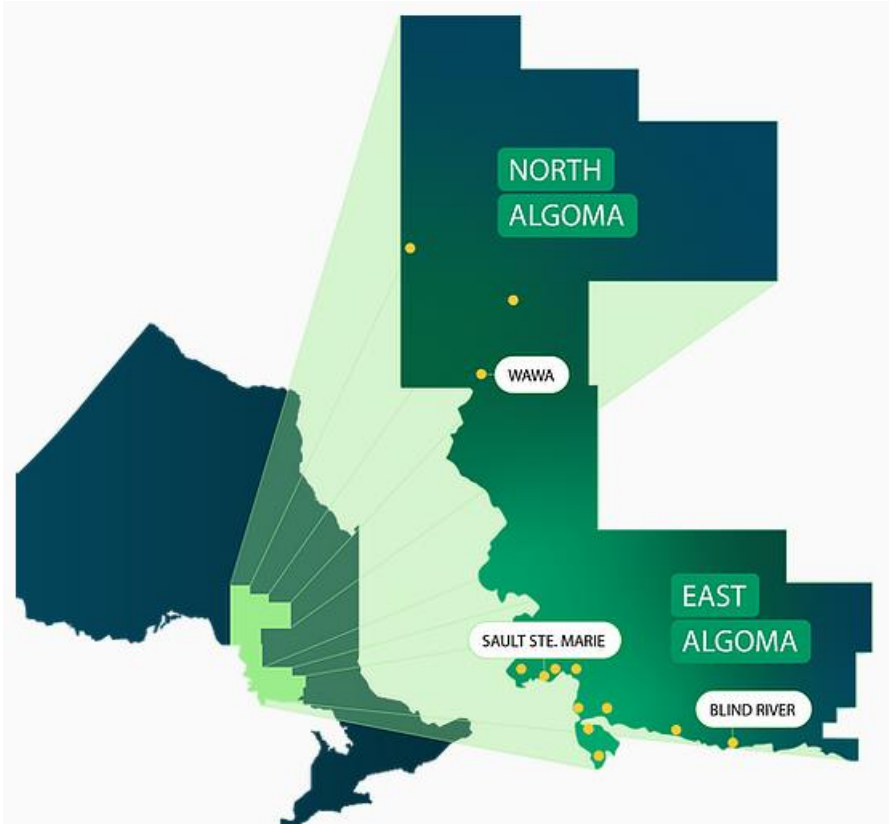
Algoma NPLC is a member of the AOHT Leadership Council

AOHT Guiding Documents

- Guiding Principles of the Algoma OHT
- Full OHT Application & Appendices
- OHT Building Block Framework (RISE Brief)

Integrated Care

- **integrated care means coordinating efforts across health and social service organizations** to improve the experience of Algoma residents.
- Understanding Integrated Care (International Journal of Integrated Care)

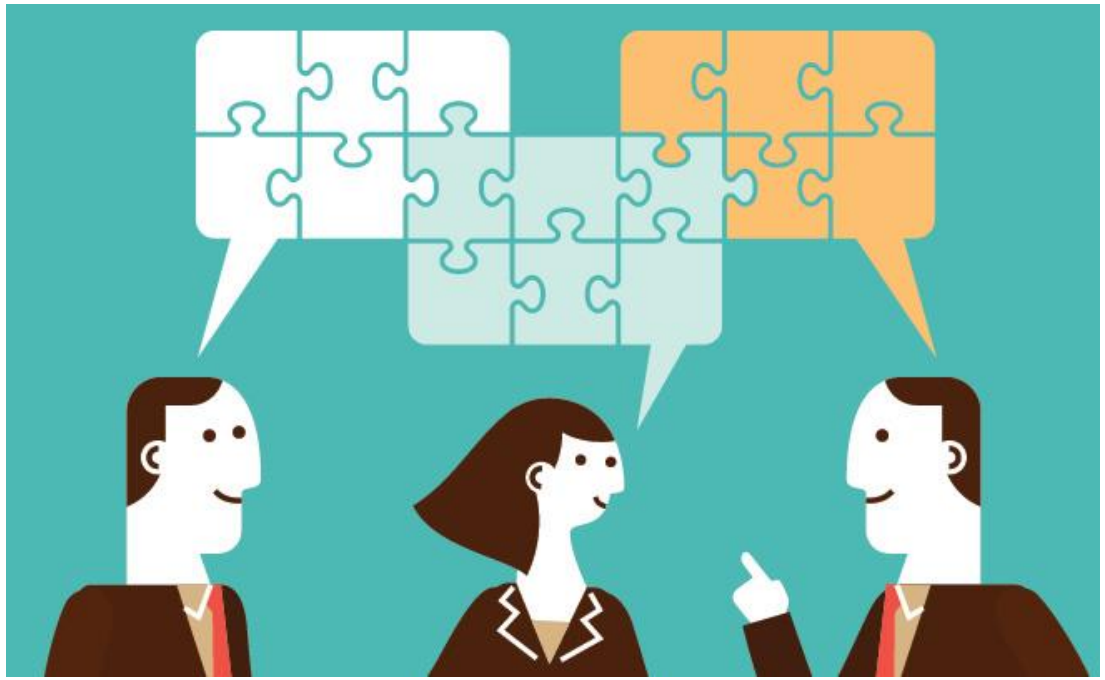


OHT & Governors

Governors Role in OHT

will need to go beyond traditional role/comfort zone

- Think beyond your own organization
- Be system thinkers
- Put people of entire community and all their needs first
- Require new set of skills, especially in governance: collaborative leadership



Learn more

Creating Containers and Co-Design: Transforming Collaboration

(Tamarack Institute)

Pillars of Integrated Care

Knowledge Tree

Building a guiding coalition of shared purpose, vision, values and culture

Developing collaborative capacity

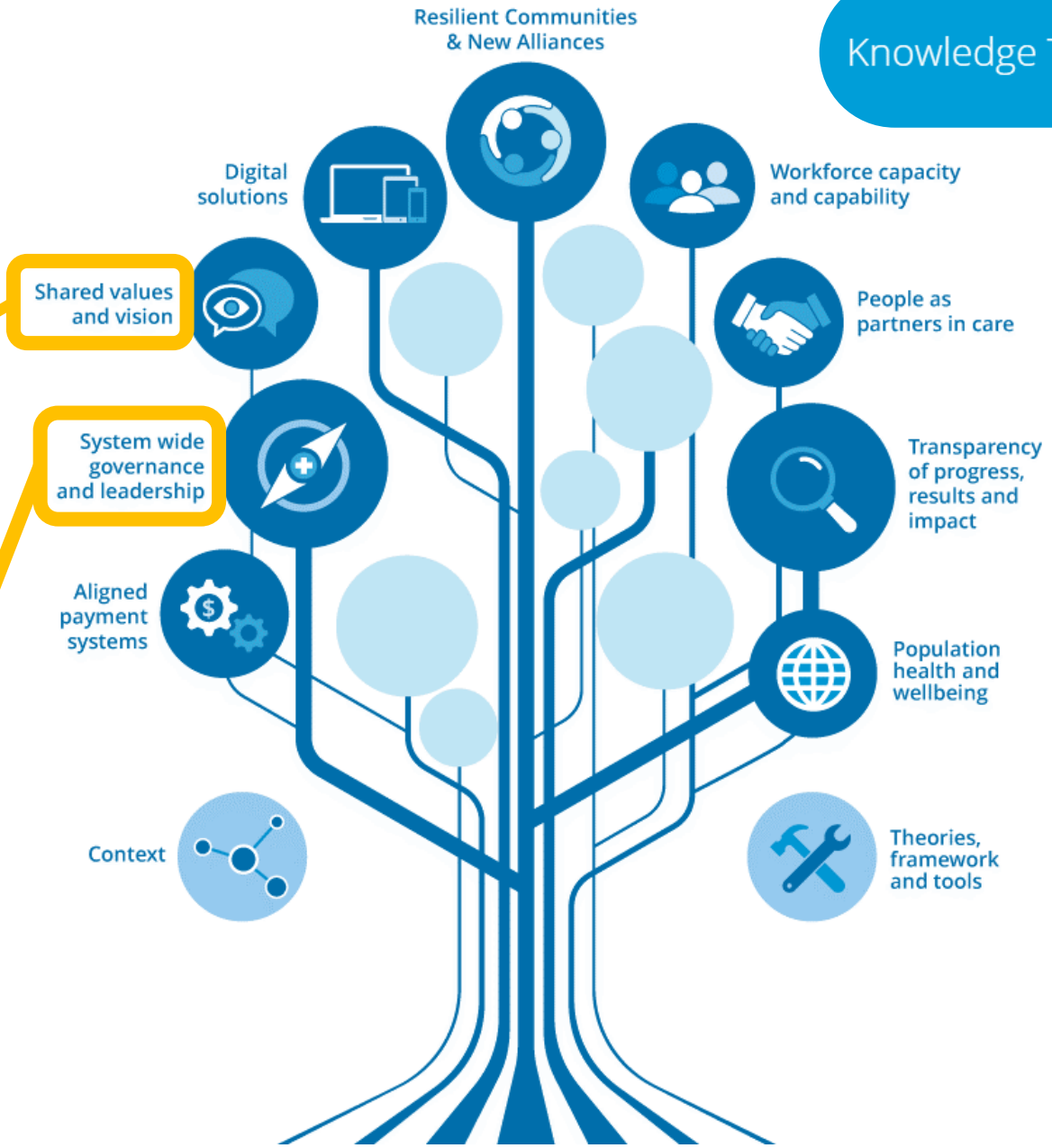
needs to be centred on people, clients, family and providers experiencing health and care as ‘one team’ and ‘one system’.

Collaborative Decision Making and accountability

Integrating health and social care

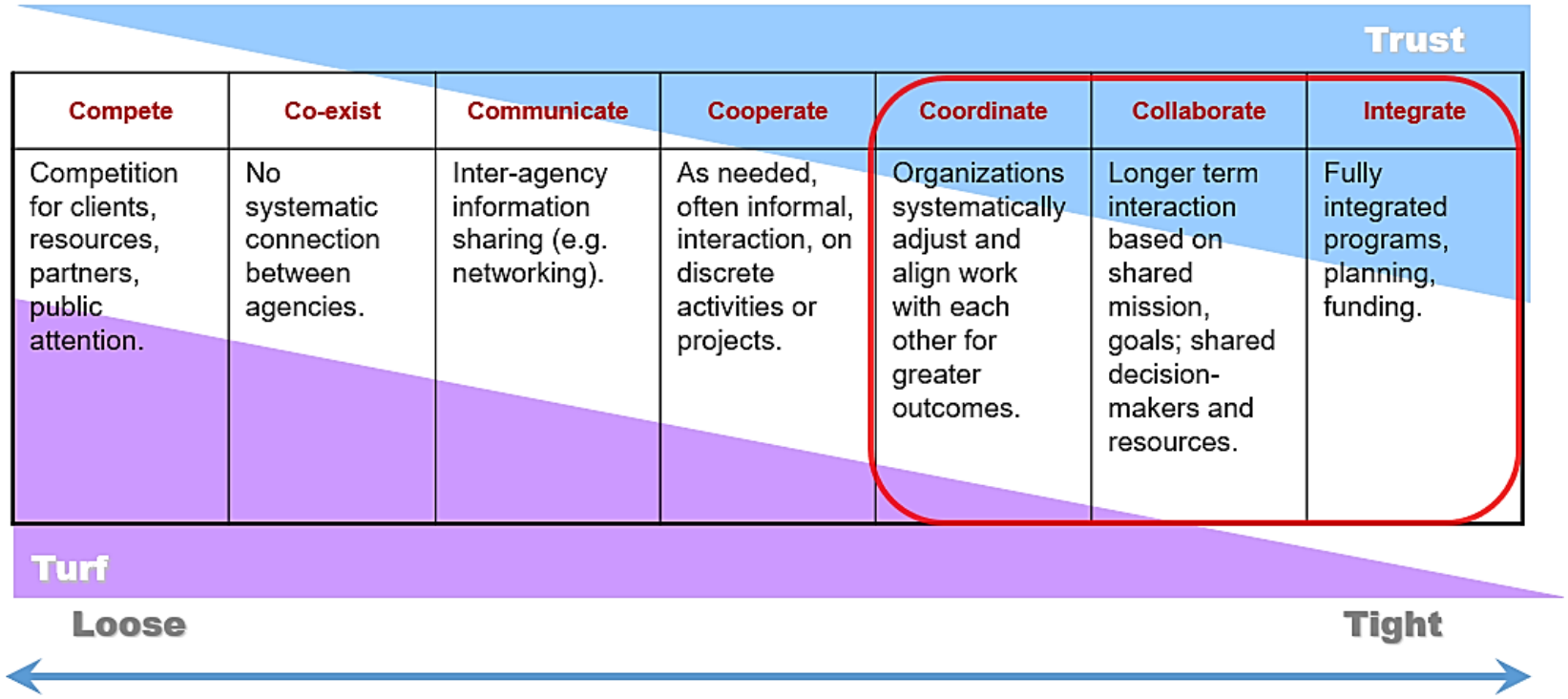
Model of Health and Wellbeing

Quadruple Aim



https://integratedcarefoundation.org/the-knowledge-tree

Collaboration, and Collaborative Governance approaches, fall along a continuum based on trust.



- How are you building trust within your OHT?
- Have you had board to board meetings with your OHT partners?
- What does your OHT CDMA outline What is the plan going forward to formalize structures and/or processes that support these relationships so trust continues to be developed over time?

Source: Collaboration Spectrum Tool (Tamarack Institute)

Collaborative Governance
is a governing arrangement in which leaders from organizations drawn from multiple sectors engage in a collective decision-making process that is deliberative, consensus-oriented, and directed to the achievement of a shared goal
(in OHTs' case, the quadruple aim).

Source: "RISE brief 3: Collaborative governance"

Collaborative Decision Making Agreement

CDMA vs. "governance"

focus on defining the mechanisms through which a foundation for collaborative decision-making can be built to support and enable progress towards a more mature state while focusing on service integration and Year 1 priorities

Aligned with principles of collaborative governance

Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System

Checklist for OHT CDMAs

Each OHT's collaborative decision-making arrangement (CDMA) must:

- ☐ Be formalized in writing
- ☐ Be informed in its development by engagements with:
  - ☐ local communities;
  - ☐ patients, families, and caregivers; and
  - ☐ physicians and other clinicians
- ☐ Include a shared commitment to:
  - ☐ achieving the quadruple aim
  - ☐ a vision and goals for the OHT
  - ☐ working together to fulfill MOH expectations for year 1 and beyond
- ☐ Provide for direct participation in OHT decision-making by:
  - ☐ patients, families, and caregivers
  - ☐ physicians and other clinicians
- ☐ Address:
  - ☐ resource allocations (including of any implementation funds)
  - ☐ information sharing
  - ☐ financial management
  - ☐ inter-team performance discussions
  - ☐ dispute resolution
  - ☐ conflicts of interest
  - ☐ transparency
  - ☐ identifying and measuring impacts on priority populations
  - ☐ quality monitoring and improvement
  - ☐ expansion to more patients, services, and providers
- ☐ Identify a qualified entity who members agree will receive and manage any one-time implementation funds on behalf of the OHT

Organizations:

- need a shared vision, principles and commitment to OHT
- remain Independent

OHTs determine:

- own legal structures and inter-member relationships
- their own membership and entry criteria
- how to make decisions on key topics
- decision-making roles of patients, clinicians, etc.

MOH is **NOT** requiring that OHT members:

- establish a new not-for-profit corporation, legal partnership, or other legal entity to constitute the OHT; or
- adopt a particular type of agreement between members, e.g. a joint venture, collaboration, alliance, network, or other type of agreement between organizations that otherwise continue to operate in their own right.

Source: Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System

Collaborative Decision-Making Arrangement

Role of Governors

EXAMPLE

Chairs Council

Supports Board to board engagement

- Co chair model
- Advisory to Collaboration Council (Leadership Council)
- Keep boards informed
- Terms of reference

QUESTIONS TO CONSIDER

How have you been involved as governors in your OHT?

- Organization level
  - Regular updates from ED/CEO
    - Shared communication
    - Standing item at board meeting?
    - Discussion and approvals of documents (e.g. application, MOU/CDMA, …)
- OHT level
  - Regular updated from OHT?
  - Governors to Governors Meeting(s)?
  - Chairs Council?
  - Other?

Board R.O.L.E.S

Questions for consideration

Board R.O.L.E.S

Best governance practices recommend the following four jobs for Boards:

1. **Represent the Ownership**
   - ✓ Understanding external ownership accountabilities
   - ✓ Proactive communication with that group, listening and acting on their behalf
2. **Lead the Organization**
   - ✓ Clear and well-communicated mission
   - ✓ Mission is “the outcomes expected for certain groups of people in our community” and the value or cost of doing so
3. **Evaluate the Operations**
   - ✓ Clear delegation of operations to CEO/ED
   - ✓ Rigorous evaluation of the CEO/ED and operations in accomplishment of mission and risk mitigation
4. **Exercise Governance Transparency (Sound Governance System)**
   - ✓ Sound governance system
   - ✓ Board policies to clarify roles, articulate values, including structure, committees, decision-making, self-evaluation

1. Represent the Ownership

- How can your OHT ensure its ability to meaningfully “act on behalf of” and “report back to” all of its moral owners (ie. entire attributed population)?
- How can the OHT be accountable to, engage and communicate with, and report back to its attributed population, especially priority populations and people facing barriers?
- Are the voices of the communities being served by the OHT meaningfully informing and driving the development of the OHT’s vision, priorities, and outcomes? Are they part of the ongoing evaluation and learning? Are they helping shape the evolution of the OHT?
- Is particular attention being paid to cultural safety, self-determination, and allyship for Indigenous communities? Francophone communities? Black and racialized communities? Rainbow/LGBTQ communities? Other priority populations?

2. Lead the Organization

- Do you have a common agenda and shared vision for change across all OHT partners?
- What is the plan to develop an OHT strategic plan (and integrate OHT vision as part of your organizations strategic plan/directions)?
- How will your organization work with partners to work towards a **Collaborative QIP**? Balanced score card?
- As governors you are responsible to ensure all participants are participating in the process:
  - Did you include *community members* — especially those that face barriers to care and to better outcomes?
  - Are all relevant *service provider partners* included in a way that supports building trust? Have you had all governors meetings? Meeting of chairs?
  - What about *patients, families, caregivers* – especially from communities facing barriers?
  - *How did you engage clinicians and other primary care providers?*

3. Evaluate Operations

- Do you need to adjust your ED performance to include:
  - Achieving system level OHT targets?
  - Demonstrating collaborative leadership competencies?
  - Ensuring that your organization its meeting its requirements under the OHT?
- Is your ED adequately supported to take on this added responsibility? Do you need to adjust other priorities or build in additional support to accommodate this extra work?
- How are you ensuring governors of the OHTs are collectively responsible for:
  - establishing the common agenda and strategic plan for the OHT?
  - setting targets and monitoring the progress on the performance metrics?
  - ensuring health outcomes improve for all people in the OHT especially those who face barriers to health?
- How will you hold the partner CEOs/EDs collectively accountable for OHT outcomes?

3. Evaluate Operations

Identifying Risks – Funding

- How are you ensuring any funding re-allocations support commitments and common agenda?
- Is there a clear process for any resource re-allocation and/or resource sharing commitments outlined in the CDMA/MOU? This will ensure that these decisions will be negotiated and agreed upon by all OHT partners who have signed on.
- Is the OHT's identified fund holder (current and future) is a trusted partner with a proven track record?

4. **S**ound Governance **S**ystem

- What policies and other key documents are needed to support a sound and transparent governance system for OHTs?
- Have roles and accountabilities been clarified?
- Has a collaborative governance structure been put in place aligned with the stage of development of your OHT?
- Do you have an MOU in place that outlines these agreements?

Health Equity & OHTs

Questions for consideration & discussion with your Board

- How is your OHT advancing health equity by identifying priority populations most at risk of poor health outcomes in OHTs?
- How are you pushing the OHT to ensure stratification of data to inform OHT planning and priorities?
- Has your OHT looked at the Ontario Health's **Equity, Inclusion, Diversity and Anti-Racism Framework** and how they can align with the 11 areas of action?
- Has your OHT committed to collecting sociodemographic and race-based data?
- Has your OHT considered co-design with marginalized folks facing the most barriers to access to care? Ensuring PFAC is reflective of populations served.
- Have you discussed the Health Equity Charter with your OHT partners?

Resources

Alliance and partners

- Alliance Member portal OHT group (includes examples from sector)
- Partner & Stakeholder Communication Briefs
- Community Health Ontario - Building Collaboration Capacity for OHTs Webinar Series

Ministry of Health & RISE

- OHT Guidance Document
- CDMA Guidance for OHTs (MOH)
- RISE Brief #3 Collaborative Governance
- RISE Brief #19 Collaborative Governance Templates

RISE
Rapid-Improvement Support and Exchange

Does your OHT / organization have resources you would like to share with your colleagues across the province? Please e-mail Meghan.Perrin@allianceon.org

Making our *Ontario Health Team* work worthwhile no matter what

Our commitments

EQUITY

We will measurably advance health equity for those facing barriers

WELLBEING

We will shift from illness care to codesigned wellbeing by scaling the model of health and wellbeing

PEOPLE

We will collaborate with people throughout in their roles as patients, caregivers, peers, etc.

COMMUNITY

We will prioritize the role and voice of community is guiding system transformation.

Questions?
Comments?

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