Ontario Health Teams Central Evaluation

Developmental Evaluation: The Evolution of Ontario Health Teams

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HSPN — Health System Performance Network

About Us

The Health System Performance Network (HSPN) is a collaborative network of investigators, visiting scholars, post-doctoral fellows, graduate students and research staff working with health system leaders, and policymakers to improve the management and performance of our health system. Building on Ontario's established record of performance measurement created by the 1998 ground-breaking Hospital Report Research Collaborative, the HSPN was established in 2009 and has built a track record in performance measurement, research, evaluation and improvement in Ontario with expertise in multiple domains of health system performance including perspectives of patients, providers, population health, and cost. The HSPN receives funding from the Ontario Ministry of Health.

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Contents

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OHTs were introduced in 2019 as a way of reforming healthcare delivery across the hospital-community spectrum, with the engagement of health care and social service providers working alongside patients, families and caregivers to deliver care to a defined population.

As part of this health system reform initiative, Ontario's Ministry of Health funded a centrally coordinated evaluation of OHTs, led by the Health System Performance Network (HSPN). This report is part of that evaluation, focusing specifically on learnings from the Developmental Evaluation (DE), conducted from Spring 2021 to Spring 2022. It sought to understand and guide the development and innovation of six OHTs over this period.

The six OHTs included in the DE were situated in a range of geographies, with different attributed population sizes, priority populations and histories. Researchers embedded in each OHT conducted observations over an approximate nine-month period at a range of meetings and working groups at different levels, where OHT participants formulated and forwarded OHTs' vision and priorities. The fieldnotes generated from these observations were augmented by interviews and participant journals. Findings were co-constructed by evaluators and OHT participants, informing short- and long-term change, as needed.

Analysis was guided by the Context and Capabilities for Integrated Care (CCIC) and the MOH's eight readiness criteria for OHT development (also dubbed "building blocks"), but prioritized an inductive approach where themes were also allowed to emerge from data collected on-the-ground. This meant that while we set out with specific frameworks in mind (CCIC & the building blocks), what was happening on the ground did not always neatly fit into them. This resulted in the identification of nine key areas of development that reflected not what OHTs were supposed to be focusing on as they matured, but rather what they were actually focusing on – to different degrees – during a specific phase of development:

    i.   Developing vision
    ii.   Establishing governance
    iii.   Strategic planning
    iv.   Designing and implementing integrated models
    v.   Advancing digital health
    vi.   Engaging primary care
    vii.   Partnering with patients, families and caregivers
    viii.   Establishing funding and incentive structures, and
    ix.   Enhancing performance measurement, quality improvement and continuous learning

This work resulted in the following insights:

    i.   OHTs were evolving at different paces, each at a different stage of progress in relation to the nine key areas of development. Their evolution was shaped by their existing strengths and contextual challenges. In addition, certain areas of development were prioritized over others (strategic planning over enhancing performance measurement, for instance), as work on the former was required before progress could be made on the latter.

    ii.   Despite differences in evolutionary trajectory, there were shared contexts, structures and cultures that both forwarded and frustrated progress across OHTs. For instance, making

HSPN

time for learning and sense-making forwarded progress, while gaps and uncertainties in the policy environment frustrated it.

iii. While findings largely overlapped with the MOH's eight building blocks for OHT maturity, there were key qualitative differences. These discrepancies may provide insight into the differences between the expectations of policymakers and the preoccupations of OHTs on-the-ground. Accounting for them can strengthen future iterations of the building block framework.

The report concludes with the following recommendations for both OHT participants and policymakers:

Recommendations for OHTs

1. Invest upfront work into developing a shared vision.
2. Develop locally meaningful priorities that are balanced with provincial priorities.
3. Establish formal structures for communicating progress with the OHT membership and the community at large.
4. Building relationships and trust should be an ongoing effort.
5. Make time for sensemaking and reflection.

Recommendations for Policymakers and OHT Supports

1. Set clear expectations at the outset that allow for local flexibility where possible
2. When possible, commit to providing long-term guidance and funding
3. Improve communication between all policymakers and OHT supports
4. Consider reworking the building block framework

The DE findings provide a window into the behind-the-scenes work involved in developing OHTs – how and why specific areas of development (or "building blocks") were prioritized over others in different OHTs, and the processes and structures that were needed for OHT development. Over time, OHTs' journeys of development largely mapped on to the same building blocks, with progress in some areas being faster than others. OHTs also shared the same system and policy challenges. Further research will be needed to explore how system and policy-level challenges may be addressed to allow OHTs to truly flourish.

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Introduction

Ontario Health Teams (OHTs) were introduced in 2019 as a way of reforming healthcare delivery. They would involve health care and social service providers working together to deliver clinically and fiscally accountable coordinated care across the hospital-community continuum to a defined population, with the engagement of patients, families and caregivers.

As part of this health system reform initiative, the Ontario Ministry of Health (MOH) funded a centrally coordinated evaluation of OHTs. The Health System Performance Network (HSPN) led this evaluation, which involved a formative phase from Winter 2019 – Winter 2020 and a developmental phase from Spring 2021 to Spring 2022. The formative phase focused on understanding participants' experiences of early OHT development, including facilitators and challenges of development and strategies deployed in this work. In addition to continuing these threads of enquiry, the Developmental Evaluation (DE) – the focus of this report – sought to understand and guide the development and innovation of six OHTs over a period of approximately nine months.

Methods: Data Collection and Analysis

Developmental evaluation

DE is an approach to evaluation that uses embedded research to understand and guide development and innovation. It does not 'judge' the overall performance of an intervention or innovation. Rather, it aims to support the ongoing development and implementation of innovation. A key feature of DE is ongoing collaboration between evaluators and participants, resulting in co-constructed near real-time changes in the innovation's implementation (Patton, 2011). Another is timely feedback, provided both formally and informally to inform changes and adaptations to how OHTs pursued their work.

Case selection

The Central Evaluation team, in consultation with the MOH, considered several factors in selecting six OHTs as cases for the developmental evaluation:

1. Geography: Cases were selected from geographies representing remote (1 case), rural (2 cases), large urban/Toronto (1 case), Greater Toronto Area suburban (1 case) and smaller (non-GTA) urban (1 case). Cases also provided representation of the range of population sizes and leadership organizations across OHTs.
2. Survey results: Results were reviewed from the HSPN Organizing for OHT survey (a survey aimed at understanding the context and capabilities for delivering integrated care, to identify OHTs with a high degree of success factors for integrated care that would enable them to move into the next phase of their development.
3. Document analysis: OHT full applications were reviewed to understand how teams represented themselves in relation to key application criteria, from patient engagement and vision to quality improvement and IT capacity.
4. Consent: Teams needed to have the capacity and willingness to participate.

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Data collection

We adopted an ethnographic approach to data collection, which prioritizes sustained familiarization with research participants and their setting over time. Insights are informed not merely by what is immediately evident but also the meaning behind practices, along with a deep understanding of the social contexts and positionalities of participants (Reeves et al. 2008). A range of data collection methods are used to garner this immersion, with observation privileged. HSPN researchers were therefore embedded in each of the six OHTs and adopted a flexible approach to research and evaluation that aligned with the specific needs and goals of each OHT.

The primary method of data collection was observation of virtual meetings, almost all OHTs adopting this medium in a pandemic context. Embedded researchers attended a variety of OHT meetings (e.g., leadership and steering committees, working groups and frontline provider team meetings). Detailed field notes were taken to document and reflect on observations. In addition, interviews were conducted with key OHT participants, and select participants were invited to periodically journal about their perceptions of what was working well and what could be improved. Finally, a document review was conducted to glean contextual information about cases. Data collection began in Spring 2021, with most wrapping up by Spring 2022, depending on case-specific contexts.

Analysis

A three-pronged approach to analysis was adopted. The Context and Capabilities for Integrated Care (CCIC) Framework (Evans et al., 2016) was first used to organize data collection and analysis. Subsequently, the MOH's eight "Building Blocks" for OHT development were used to translate findings in a way that could be actionable for OHTs (MOHLTC 2019). At the same time, a ground-up inductive approach to analysis was adopted throughout the research process. This allowed evaluators to be attentive to themes emerging over time that went beyond those identified by either formal framework.

CONTEXT AND CAPABILITIES FOR INTEGRATED CARE FRAMEWORK

The Context and Capabilities for Integrated Care (CCIC) Framework which has been used to study prior integration efforts in Ontario and internationally was used to identify the factors, mechanisms, contexts, and capabilities most important to the realization of integrated care. Key CCIC themes that guided data collection and analysis are set out in Appendix A, as are the building blocks referenced below.

OHT BUILDING BLOCKS

The MOH established eight OHT components in the original guidance document (MOHLTC 2019), outlining readiness criteria for year one and maturity. McMaster's Rapid-Improvement Support and Exchange (RISE) created additional support, including identifying domains for each building block that represent the strategic choices that OHTs needed to make. Seeing the building blocks as a relevant framework through which stakeholders described progress towards maturity, HSPN mapped CCIC themes onto building blocks to incorporate this framework into the analysis.

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INTERSECTIONS

As the study progressed, we explored the ways in which elements from the CCIC framework intersected with the eight OHT building blocks. Layering these different approaches to analysis and complementing them with emerging themes from the inductive qualitative research provided an understanding of overlaps between building blocks as well as additional factors that may be salient to understanding OHT development over time. This work reached beyond both formal frameworks and resulted in the identification of nine key areas of development for OHTs: a) developing vision, b) establishing governance, c) strategic planning, d) designing and implementing integrated models, e) advancing digital health, f) engaging primary care, g) partnering with patients, families and caregivers, h) establishing funding and incentive structures, and i) enhancing performance measurement, quality improvement and continuous learning.

Results

Cross-case results are reported thematically, and detail progress, enablers and challenges in relation to nine key developmental areas. Progress within each area was uneven, with some OHTs further ahead than others, due to decisions to prioritize specific aspects of OHT development, based on existing strengths, gaps and needs. Developmental areas such as performance measurement and funding structures tended to take a temporal back seat to work on vision-development and strategic planning, unable to progress without these foundational pieces in place. The six OHTs were therefore at different stages of progress in each developmental area, with a different trajectory of evolution over time. Table 1 provides an overview of key attributes of each case.

Table 1: Attributes of DE OHTs

	OHT A	OHT B	OHT C	OHT D	OHT E	OHT F
Geography	Rural/Remote	Urban/Suburban	Rural/Small Community	Rural/Small Community	Urban/Suburban	Smaller urban (non-GTA)
Size (attributed population)	<50K	450-650K	50-150K	50-150K	150-350K	450-650K
Percent of population living in the most deprived areas	15-20%[1]	15-20%	20-25%	>30%	5-10%	20-25%
Fund recipients' organization	Other[2]	Hospital	Family Health Team	Hospital	Hospital	Family Health Team
# of signatory partners[3]	14	21	7	15	18	39
Priority population	Population requiring and accessing mental health services, specifically crisis intervention	Mental health and addictions – frail seniors palliative care patients	Complex/frail seniors, palliative care	Adults >55 with comorbid conditions, mental health and additions in adults	People affected by dementia or mental health and addictions, seniors and their caregivers.	People living in congregate care settings (long-term care, residential care facilities and women experiencing homelessness)

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[1] High proportion of missing data related to placement in deprivation quintile relative to other OHTs

[2] Held by non-healthcare organizations.

[3] Some OHTs had representation from councils and other regional stakeholder who were not signatories or formal partners but who impacted OHT development.

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Developing vision

All six OHTs were committed to improving population health and the delivery and experience of care. In different albeit overlapping ways, they all emphasized the importance of collaboration and engagement, person-centred care, compassion, information-sharing, integrated pathways, and a holistic approach to healthcare. While equity and accessibility concerned all teams, these issues were of particular interest to OHTs with a preponderance of marginalized populations and became more of a focus due to the OHTs' COVID-19 pandemic work.

OHTs' visions were informed by MOH expectations, Ontario Health (OH) guidance and their own histories and experiences of collaboration and local need. Some OHTs (OHTs A, C, F, for instance) leveraged partnerships that pre-dated the OHT. Partners at OHT C, for example, built on existing collaboration and had a shared understanding of the "pain points" that needed to be addressed, allowing for a clear articulation of key local concerns, from service gaps to unnecessary system utilization. Their smaller rural geography and relatively fewer collaborators also facilitated collaboration and trust, the latter being another key facilitator of vision development. For other OHTs without a history of working together, being able to find common ground became important. At OHT B, for instance, taking the time to listen to each other, having meaningful discussions that actively engaged patients, families and caregivers, and achieving consensus were all practices that helped construct a shared vision. OHT E held engagement sessions to inform decisions about areas of foci. OHT F and C also developed a learning orientation that informed the implementation of their vision at the micro level – OHT F collected data about the needs of the people they aimed to serve to fine-tune pathways, while OHT C eventually used data to rapidly assess if they were getting things right. OHT D, meanwhile, employed a robust strategic plan as a way of translating its vision into practice.

The development of a shared vision across OHT partners was stymied by a range of issues that included the challenge of striking a balance between visioning and doing, an over-emphasis on retrofitting existing initiatives into the new OHT framework, and the lack of involvement of all sectors and stakeholders in early development. Home and Community Care (HCC), long-term care and Indigenous partners, for instance, did not feel fully engaged. Attempts were sometimes made to address these issues. Faced with a strained relationship with HCC that dogged the progress of early OHT initiatives, OHT C participants, for instance, attempted to recenter HCC as a core partner within their fold by including them in working groups and legislation modernization discussions.

The COVID-19 pandemic was a further curveball that both challenged and shaped vision development. At first, the pandemic derailed OHT development, with little work being done to advance identified priority populations. However, as time progressed, the pandemic also became a facilitator of common ground in several OHTs. At OHT B, for instance, it brought partners, staff, and volunteers together both within and outside working hours to advance the COVID-19 pandemic response. The pandemic had an even more transformative effect on OHT F, re-shaping its vision at a fundamental level as it shifted from focusing on chronic conditions to congregate settings, informed by a renewed prioritization of equity.

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Establishing governance

Governance, broadly understood as how decisions are made, by whom, and where accountability lies [4], was a priority for all OHTs. While OHTs were at different stages of this work, many were still engaged with the relationship-building and collaborative decision-making work that preceded formal governance structures.

For OHT A, an OHT with Indigenous partners that struggled with a history of fractured trust shaped by colonialism, the formalization of governance took a back seat as members prioritized the trust-building that needed to precede it. As such, the team routinely set aside dedicated time for difficult conversations, encouraging cultural sensitivity and consensus-building at leadership meetings. On the other end of the spectrum, OHT F benefited from a long history of collaboration and could delve right into developing formal governance structures, becoming the first OHT to incorporate as a non-profit corporation with a board of directors. It did so to handle funding and service procurement better, establish policies, and guide decision-making.

Many OHTs contended with issues of representation in decision-making and the lack of a shared understanding of what governance meant. OHTs such as OHT D that included a representative of each partner organization on its steering committee recognized that a more sustainable structure would need to be implemented as it expanded. Meanwhile, OHTs such as OHTs E and F worked towards collapsing disparate interests into single seats in their governance structures. Emphasizing sectoral intersections and the common interests that united them, helped with this work.

OHT E developed a system of decision-making where a performance management committee reviewed proposals endorsed by sector-specific tables before being filtered up to the leadership table. And OHT F engaged in many thoughtful discussions about how to ensure equity and representation without simultaneously having a cacophony of voices at the table. They emphasized that chosen representatives should represent not an organization but rather the range of interests within a specific setting, and, ultimately, the people they served in their city. At other OHTs (OHTs B, C, E), some members did not always have a shared understanding of what governance in their OHT looked like, how it informed tables at different levels, or even if the right governance structure had been chosen. OHT C, an OHT with a keen focus on operational decision-making and getting things done, found long-term governance and strategy-setting challenging at the outset of the DE period. Their ability to develop long-term governance structures was complicated by differences in stakeholders' understanding of what governance meant and where accountability should reside, as well as by the lack of dedicated backbone support. Pivoting to focused, short-term strategic planning and building capacity helped them engage in governance building over time

A well-resourced staff team was a key support across OHTs, facilitating focused discussions and supporting progress behind the scenes. Distributed leadership, widespread goodwill and engagement, and a culture and history of collaboration also emerged as key enablers of enhancing capacity to create effective governance structures.

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[4] What is governance? https://iog.ca/what-is-governance/

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Strategic planning

The six DE OHTs engaged in strategic planning processes to varying degrees and at different moments during the DE period. Many engaged in strategic planning but stopped short of a detailed operational plan. OHTs outlined strategic pillars (OHT F), produced a schematic of key goals, objectives and drivers (OHT C), showed how their work aligned with the quadruple aim and high-level goals (OHT E), and worked on structural changes aimed at operationalizing their strategic plan (OHT B). This work helped to communicate OHT priorities. Some OHTs used internal/staff resources to lead this work, while others were buttressed by an external facilitator(s) and supportive leadership. Community engagement was a part of several OHTs' planning processes, with staff pivotal to translating engagement into actionable plans.

The COVID-19 pandemic created the impetus for several OHTs to re-engage with the strategic planning process by revisiting priority populations and previously set goals. OHT C was spurred on by the realization that several partners did not have a shared understanding of the scope of different working groups or how workstreams fed into strategic goals. Addressing these issues became a key focus of their work at the end of the DE period.

For some OHTs, strategic planning helped reinforce vision and reflect on their core partnership, guiding decisions about which additional groups might be needed to advance strategic goals. OHT D, for instance, had a robust engagement effort focused on internal partners and the community at large. Information from the engagement was translated into strategic goals, each with associated objectives and actions. Once their plan was established, this OHT reviewed partner organization strategic plans, identifying common themes. The strengthening of strategic capacity at the organizational level was a possible unanticipated benefit to OHTs.

The strategic planning process for OHTs could be long and drawn out, involving external engagement and multiple iterations for refinement. Engaging in strategic planning could feel like time taken away from getting the work of OHTs done; for some, this was a barrier to engaging in dedicated strategic planning efforts. The lack of assurance about future funding for the implementation of OHT programming was associated with considerable uncertainty about the value of investing time in strategic planning. Some OHTs managed this through a one-year time horizon, a practical constraint that inevitably limited the ambitiousness and complexity many hoped OHTs would achieve.

Designing and implementing integrated models

Vision-setting was foundational to model design, and for OHTs still working on building consensus across partners, model-design work primarily comprised a variety of trust/vision-building activities. Other OHTs were focused on better understanding the needs of their populations through on-the-ground needs assessments and best practice evidence reviews. Over time, some began piloting new initiatives on a small-scale, ground-up fashion at the outset. OHT A, for instance, rented space to house individuals experiencing homelessness while OHT F embedded primary care into congregate settings and organized periodic outreach events for women experiencing homelessness. OHT E launched a program that brought an interprofessional care team to deliver integrated primary care to seniors who could not access office-based care services. Others built on and adapted existing initiatives that pre-dated the OHT, targeting gaps in clinical and social services for their priority populations.

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OHTs that were further ahead in model design targeted specific gaps in clinical as well as social services for their respective priority populations (e.g., older adults with complex care needs, individuals experiencing homelessness, as well as palliative care, mental health and addictions supports). In addition – or alternatively – they focused on preventing unnecessary hospitalizations and expediting return home post-hospitalization by creating coordinated care plans and connecting individuals with the necessary resources and provider groups that would best support their care needs.

By the end of the DE period, almost all OHTs had begun building out and revising their models or focusing on priority population sub-groups. A key focus across all OHTs was supporting patients with appropriate care and services in the community to avoid unnecessary hospital visits and prolonged hospitalizations. Additionally, some OHTs were engaged in efforts to increase access to cancer screening and provide more streamlined access to palliative care supports. OHTs were also working to increase coordinated care plans for priority population sub-groups, as well as refine and expand initiatives to enable patients to return to their community residences post-hospitalization with necessary supports and services.

Despite early progress, efforts required to manage COVID-19 resulted in frequent interruptions to model-design work and delayed OHTs' ability to move forward with working group priorities, even as it also had the potential to foster intense collaboration between partners across sub-sectors to provide COVID-19 support and roll-out vaccinations. Several OHTs also engaged with learning supports such as HSPN, RISE Population Health Management Coaches, OHT Impact Fellows, as well as other external facilitators, some of whom served as essential enablers for model-design work.

Advancing digital health

Two main areas of focus in the digital health arena were the sharing of patient information and supporting virtual care. Some OHTs made a clear distinction between these two streams, helping with priority-setting for workstreams and investments. Advancing digital health also required foundational work on privacy. OHTs were required to submit a Harmonized Information Management Plan in 2021 that set out their plan for the digital recording and sharing of health information across partners - data that could be used for population health management, operational insights and the reporting of outcome indicators.

OHT work in the digital arena took different forms. OHT A, for instance, established data sharing agreements and joint privacy committees between its two primary care organizations, each with its own EMR, as they worked towards having one community based EMR record for all patients and providers. OHT C was eventually able to bring organizational partner groups onto common platforms that would facilitate the exchange of patient information. Meanwhile, OHT F developed a digital health plan that combined local and provincial priorities while leveraging some of the mature digital models in place. Two OHTs also undertook initiatives to provide access to the internet. OHT A partnered with an information technology company and an internet provider to connect remote community nursing stations to reliable high-speed internet. And OHT D partnered with a local public library to provide access to laptops, Wi-Fi, and privacy pods that could be used for events such as medical appointments and job interviews.

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Work in this space was enabled by a range of factors: the ability to leverage partner legal resources and knowledge to create shared health information management requirements across the OHT (OHT B); learning from and partnerships with other OHTs, and support from OH regions. Challenges included the difficulty of creating a single community-based patient record due to changes in partnership and funding (OHT A), the lack of a strategic, well-coordinated plans, unclear procurement approval processes, feeling bombarded by myriad digital funding opportunities with short turnaround times, and the uncertainty of funding and concern about the possibility of new policy direction. Together, this often resulted in a reluctance – if not the inability - to move forward with implementation.

Engaging primary care

While the six OHTs adopted different approaches to engaging primary care providers and physicians, these stakeholders were invariably brought together over time in organizational bodies such as primary care or physician councils. In areas without these structures, developing them required effort and creativity. OHT F leveraged the virtual town halls held to plan the city's COVID-19 response to introduce and foster engagement for the OHT model. It was hoped that this would facilitate a unified primary care voice for the OHT while also allowing it to connect with provincial and national groups.

The governance of primary care councils also took a good deal of thought and planning. In most OHTs, physicians were part of the leadership or steering group. Some OHTs benefitted from the active involvement of primary care organizations such as Family Health Teams (FHTs), Nurse Practitioner-Led Clinics (NPLCs) and Community Health Centres (CHCs) at their leadership tables. OHT B, for instance, worked to include representatives of a range of primary care delivery models, from the hospital-affiliated and FHTs to the less-connected fee-for-services physicians. In addition to adopting a similar approach to OHT B, OHT F emphasized the need for primary care representatives to speak beyond their own organization or model. While OHT D included specialists at the council, non-physicians were excluded. Their voices were represented instead by providers and organizational representatives on working groups and steering committees.

For OHTs with established councils, primary care/physician council members were empowered to get involved in planning initiatives supporting improved patient care access. In OHT B, council members proposed and obtained funding for new programs from OH Digital Health funding opportunities, while OHT E's primary care council members were engaged in launching and supporting OHT projects such as re-designing a mental health intake and referral form.

Physician leads also often drove outreach initiatives. OHT D, for instance, initiated a monthly email to all regional physicians, keeping them informed about OHT initiatives and hoped to administer surveys to better understand physician and primary care provider experience. OHT B also leveraged existing physician networks, with members outside the council actively engaged in launching OHT initiatives. In OHT D, a physician member led a project to improve access to cancer screening rates during the pandemic for unattached patients. And key OHT F priority areas and working groups were led by primary care physicians. Physician outreach and engagement was therefore an important consideration in OHT development, facilitating their sustained growth and stability.

HSPN

Early involvement in the co-design process showed physicians that their input was valued. Clear communications and a focus on how the OHT could add value and help solve physician challenges in caring for patients also helped. For some OHTs, project management support and remuneration to compensate for time spent by providers on primary care advisory councils and leadership and working groups helped, particularly in their early development.

Partnering with patients, families and caregivers

While OHTs had varying approaches to involving patients, families, and caregivers, they were moving towards having a designated patient, family, and caregiver council (PFAC), with its representatives participating at leadership tables and working groups. PFAC members supported or advised on initiatives, with some encouraged to move beyond consultation to decision-making. OHT F, for instance, featured two patient advisors as leads in the initial OHT application process itself who also co-led OHT planning and information-sharing activities.

Dedicated OHT staff resources to support PFAC members was a strong enabler for engagement. Staff support could provide administrative support for PFAC functioning, help the PFAC engage with other PFACs and gather resources to build their own capacity. These resources, in addition to a culture of recognizing the importance of patient, family and caregiver voices, demonstrated that patient engagement was a priority rather than an afterthought for OHTs. OHT D also made efforts to evaluate their PFAC engagement, the work of reflecting on the process and structure of engagement itself helping to forward this work.

Several teams experienced challenges with recruiting and retaining PFAC members and establishing a clear understanding of their roles. OHTs C and E had early involvement of patient representatives but found recruiting and retaining new members difficult. One focused on developing a robust recruitment plan, resulting in PFAC representation on their leadership committee and plans for further expansion. OHT A also focused on robust planning of what their council should look like, developing a skills matrix for members. After a PFAC re-set, OHT C's PFAC members sat on various working groups, actively driving its outreach and engagement work. OHT F circumvented the lack of clarity around roles and PFAC scope by collaboratively developing clear engagement principles, forms, values, and roles and responsibilities from the outset.

Patient, family and caregiver partners often had caregiver or self-management care duties to contend with on top of their OHT involvement, which could include responding to multiple time-sensitive funding opportunities. This stretched them thin and resulted in burnout for many. An additional concern was the lack of volunteer diversity. This could be mitigated by recruitment efforts that ensured a sizable group of patients, families and caregivers to support OHT work, as well as a clear succession plan.

Establishing funding and incentive structures

The OHT model's aim of encouraging sustainable health reform at a population level was frustrated by the lack of a stable funding structure that stymied OHTs' ability to engage in long-term planning and resourcing. While all approved OHTs received the same Transfer Payment Agreement (TPA) funding, certain OHTs, particularly those in urban centres, benefitted from resource-rich partner organizations that could flow funds to cover costs for additional staffing and other initiatives. Several OHTs also decided to require partner contributions (e.g., 1% of

HSPN

their operating budget) at the outset of OHT development, giving them additional stable funding sources to be used at their discretion.

The MOH and OH also released a variety of targeted funding opportunities tied to specific initiatives, most often in the area of digital health. These incremental resources were seen as opportunities even as they presented challenges and frustrations. Several OHTs felt considerable pressure to apply for funding despite the funding not always aligning with their current work. Each call required a fair amount of work and support from already-strained backbone resources, particularly given short turnaround times. Furthermore, the calls did not include adequate funds to support human resources tied to initiatives being funded. One OHT needed to re-negotiate the funding to secure funds to hire clinicians to ensure their work would be feasible and sustainable. Ultimately, several OHTs adopted a strategic approach to funding, applying only for funds that aligned with and forwarded the needs of their priority patient populations and strategic goals. OHT F, in particular, made progress by developing well-structured guidelines to provide a meaningful way of assessing interest in, reviewing and coordinating funding opportunities in a way that helped advance their priorities.

Enhancing performance measurement, quality improvement and continuous learning

All six OHTs showed a strong commitment to ongoing learning and recognized the importance of enhancing their capacity and capabilities to engage in data-driven strategic planning and the development of associated performance measurement and quality improvement frameworks. The MOH mandated Collaborative Quality Improvement Plans (cQIPs) further pushed some to improve their performance measurement and co-design capacity. OHT E developed and implemented measurement plans across its various working groups at the outset of the DE period and continued to incorporate key performance indicators in their work. Towards the end of the DE period, two OHTs (OHT C, D) had made considerable progress in this area, including identifying key indicators for cQIPs, developing dashboards and performance measurement frameworks and plans at OHT-wide and working group levels, as well as using system-level data to design and pilot initiatives for sub-groups of their population through a quality improvement lens. These OHTs were able to leverage learning supports such as RISE coaches, Health System Impact Fellows and HSPN as well as external facilitators to work with population segmentation data, engage communities in co-design initiatives and develop monitoring and evaluation plans. While performance measurement and quality improvement were considered necessary in other OHTs, they had not yet begun to advance work in this area. The lack of appropriate funding (which in turn affected staff capacity) delayed meaningful work in performance management for some, as population management data and tools could not be appropriately harnessed.

Discussion

While nine key areas of development were identified through this work, the attention OHTs paid to each one varied, informed by contextual and temporal dimensions of development. Despite this, there were shared factors that facilitated or challenged progress, and we focus on two particularly salient elements below: the importance of making time for sense-making (i.e. understanding how and why people interpret the world and give meaning to it in the way they do) (Weick et al 2005) as a facilitator of OHT development, and the uncertainties of the policy context as a challenge. In conclusion, we review discrepancies between our findings and the

HSPN

eight building blocks set out by the MOH that outline readiness criteria for OHTs' progress towards maturity and offer suggestions for their reimagination.

Contextual and temporal dimensions of OHT development

The development of an OHT, as a complex integrated care innovation, unfolded in contextually sensitive, unique ways; there was no one "right way" for an OHT to move forward on its journey to maturity. OHTs, after all, were situated in different geographies, with different attributed populations sizes, and comprised of diverse partner groups with distinctive histories. Furthermore, the frequently cited lack of clear guidance at a policy-level also shaped the diversity of OHT journeys. Yet, despite important differences between the early evolutionary trajectories of OHTs, their paths overlapped across nine key areas, namely: developing vision, establishing governance, strategic planning, designing and implementing integrated models, advancing digital health, engaging primary care, partnering with patients, families and caregivers, establishing funding and incentive structures, and enhancing performance measurement, quality improvement and continuous learning. While each of these areas has been discussed independently in this report, they are not discrete. On the contrary, OHTs, like all complex adaptive system, are composed of interacting and mutually informing structures, processes and functions. Accordingly, progress in each of these areas built on and informed progress in other areas. Developing performance measurement and quality improvement plans, for instance, first required work on strategic planning and model design, amongst other things.

The conditions of progress

Across all nine areas of development, progress was associated with the following: a) high levels of trust, b) shared values and priorities, c) the ability to make time for sense-making and learning, d) alignment between organizational and OHT priorities, e) the engagement of partners, community, provider groups and sectors, e) clearly delineated and distributed leadership structures, f) strong communication, g) a prior history of collaborative working relationships and h) human and financial resources - dedicated staff members to undertake OHT work being particularly important. Conversely, progress in all areas was stymied by: a) fractured trust among core partner groups, b) stakeholders and organizations whose participation was required but who were not actively engaged in the work of the OHT, c) a lack of clarity and communication around key priorities and initiatives; d) ambiguously defined leadership and accountability structures, e) burnout and human resources challenges, f) a lack of financial resources, and g) divergences between organizational priorities and OHT priorities. External contextual factors such as evolving and uncertain policy and system-level contexts, including changes in legislative, oversight and reporting structures, as well as the release of competitive incremental funding opportunities also impacted OHT development, as did the COVID-19 pandemic. In many cases the pandemic resulted in a prolonged pause of OHT planning activities. It also strengthened relationships between partner groups and spurred new digital solutions and outreach initiatives.

Making time for sense-making

Over the course of the DE, we observed OHTs navigate striking a balance between planning work and implementing initiatives. Some OHTs, for instance, prioritized developing robust macro-level (cross-OHT) structures and processes to support their work (e.g., governance and strategic planning). Others spent the early part of the DE engaged in work at the organization

HSPN

(meso) level to build internal capacity for effective partnerships and collaboration. Time was also spent on renewing trust among organizational partner groups, developing and supporting patient, family and caregiver councils and conducting formal engagement work with primary care and the broader community. Still others began by piloting and improving small-scale initiatives addressing systemic gaps impacting sub-sets of their priority populations, while pausing at times as it became clear that not all partners had a clear understanding of how initiatives were aligned with broader OHT priorities. Implementation could also be held up by poor collaboration between member organizations, the absence of certain stakeholders, pandemic-related complications, and the sheer time needed to cultivate the attitudes, relationships, practices and learning cultures that enabled progress in the context of new inter-organizational networks. For a range of reasons, therefore, almost all OHTs slowed down to learn and iterate, and engage in challenging conversations. This involved a variety of different sensemaking and learning processes, from conducting evidence reviews and engaging with learning supports to bringing in external consultants. This sensemaking resulted in the development of new knowledge, skills, mindsets, norms and integrated ways of working – the foundational work needed to transform a system of discrete organizations into an integrated, interorganizational network.

The policy context

The need for clear and coherent policy and system level direction was expressed by all OHTs. At the outset, policies and system-level resources that were not overly prescriptive allowed OHTs to set out priorities that were relevant to their local contexts. However, it quickly became clear that OHTs were also navigating a policy vacuum and changing accountability and reporting structures, while attempting to work around pre-existing system constraints, such as the inability to share patient data across sub-sectors or fully engage sectors such as home and community care. Ultimately, navigating the policy context was one of the greatest challenges experienced by all OHTs. This included the lack of assurances around funding renewals that hampered OHTs' ability to commit to longer-term initiatives, and the need to address reporting requirements, cQIP indicators and funding calls that were experienced as uncoordinated and not always aligned with OHTs' own priorities. OHTs also received different and at times conflicting information from representatives of the MOH, OH Provincial and OH regions, and some OHTs felt that they could not make commitments or build out programs because they were unsure of the direction being set by policymakers. Others, by contrast doubled down on their commitment to setting forth a direction that was locally relevant, before new policies and system directives were announced.

Reimagining the building blocks

The MOH set out 8 OHT components, setting out how OHTs were expected to progress towards maturity in each area. These were further developed and presented as "building blocks" by RISE (2019), which described them as a list of "mutually exclusive and collectively exhaustive domains where OHTs will need to make strategic choices." While all components are certainly relevant to OHT development, empirical data collected during our evaluation suggest discrepancies between how OHTs were meant to develop and how they actually did. OHT development on the ground further suggest that the building block domains are not necessarily mutually exclusive. In fact they intersect and inform one another. As currently set out, the building blocks also categorically combine key areas of development such as "leadership, accountability and governance" (building block 6) and therefore risk eliding

important nuances in the types of resources and activities required to achieve progress in each of these areas. Acknowledging that certain aspects of OHT development can only begin once progress in other foundational areas has been made may also provide reassurance to OHTs, while moving the building block framework beyond a "check-box" list of items that can be achieved in a delimited time period.

A note on Developmental Evaluation

HSPN researcher participation in OHT activities and meetings varied across OHTs, informed by where OHTs were at on the maturity journey, their capacity to engage in the DE process, and the types of meetings attended by evaluators. Not all OHTs were able to engage with learning supports in the same way, whether as a result of developmental readiness or staffing shortages. Embedded researchers also engaged at different levels in OHTs. All participated in on-the-ground working group activities in some form. Some also focused on groups such as digital or leadership committee meetings, where information was shared across OHT members at a higher level. In addition, some helped OHTs build their capacity to use data to support performance measurement and quality improvement, where needed. All DE OHTs received formal and informal feedback from embedded researchers based on data collected throughout the DE period. DE participation required time and resources on the part of OHT participants and evaluators attempted to maximize the value of the DE approach while minimising its burden on those working on the ground. Learning how to do this effectively is ongoing work.

Recommendations

For OHTs

1. *Invest upfront work into developing a shared vision*
   Developing a clear patient-centred vision that is meaningful to the participants in the OHT is essential. From there, specific patient populations can be identified and new strategies implemented. Having a shared vision enables trust building, seen as essential for working across disciplines and sectors.

2. *Develop locally meaningful priorities that are balanced with provincial priorities*
   As a starting point to transforming care delivery, OHTs were asked to identify priority populations for which care would be improved. Familiarity with issues relevant to providers, PFAC, and the community is valuable in understanding what is locally relevant. Responding to local needs can drive enthusiasm and engagement in the work of OHTs. There is, however, a need to balance local and provincial priorities. Understanding how local priorities will spread or expand to address population health management can support alignment with provincial priorities.

3. *Establish formal structures for communicating progress with the OHT membership and the community at large*
   Good communication will involve establishing a formal structure of how various subgroups (e.g., working groups, councils, committees) convey their progress and ensure members recognize relevant systems and processes. This communication can promote a shared

HSPN

understanding in critical areas such as decision-making processes, member roles and responsibilities and OHT priorities. Making space for informal communities is also essential both in addressing unanticipated challenges and building relationships.

4. *Building relationships and trust should be an ongoing effort*
Making time for relationship-building and fostering trust among members is vital, even for teams with established working relationships and trust. Relationship-building should be ongoing, particularly as new member organizations join. This includes attention to team dynamics and creating a safe space for all members' voices. All members, particularly leaders, should consider the power dynamic involved across individuals, professions, sectors and organizations.

5. *Make time for sensemaking and reflection*
OHTs with a willingness to reflect and learn will improve over time. Part of this practice is to use data to drive decision-making and reflect on performance and other OHT processes. This should be an inclusive process involving PFAC members and clinicians. As noted above, creating safe spaces for all members' voices will be vital.

For Policymakers and OHT Supports

1. *Set clear expectations at the outset that allow for local flexibility where possible*
Where possible, the overall vision and expectations for OHTs should allow OHTs to flexibly identify local needs and success measures. However, where provincial standardization is desired, expectations should be clear and shared as early as possible, to prevent OHTs being reluctant or unable to proceed with implementation for fear of changing expectations.

2. *When possible, commit to providing long-term guidance and funding*
OHTs face many challenges when there is uncertainty in financial sustainability; a shared experience is the loss of qualified staff when job security is limited. Long-term funding and guidance will strengthen the belief that the OHT model will be sustained and supported provincially.

3. *Improve communication between all policymakers and OHT supports*
OHTs have limited capacity to engage and take advantage of various supports; a well-coordinated support system can help to reduce redundancy and burden on OHTs. In particular, role clarity and process alignment between policy and support stakeholders could help to improve system efficiency and create confidence and commitment in OHTs.

4. *Consider reworking the building block framework*
Revising the eight building blocks of OHT development so that they better reflect the myriad components of integration readiness and reflect OHTs' experience on the ground will help make expectations clearer and more achievable. Particular attention should be given to teasing apart building block 6.

HSPN

Conclusion

The DE findings provide a window into the behind-the-scenes work involved in developing OHTs – how and why specific areas of development (or "building blocks") were prioritized over others in different OHTs, and the processes and structures that were needed for OHT development. While the leveraging of local contexts and needs may have produced unique teams, there was much that was shared too. Over time, OHTs' journeys of development largely mapped on to the same building blocks, with progress in some areas being faster than others. OHTs also shared the same system and policy challenges. Further research will be needed to explore how system and policy-level challenges may be addressed to allow OHTs to truly flourish.

HSPN

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HSPN

Appendix A: Guiding Frameworks

Context and Capabilities for Integrated Care

The following are the core components of the Context and Capabilities for Integrated Care (CCIC) Framework (Evans et al., 2016):

a) Context
b) Vision/ Values
c) Relationship/ trust-building
d) Resources
e) Governance & Accountability
f) Information Sharing
g) Leadership
h) Clinician Engagement
i) Patient and Family Advisors
j) Partnering
k) Care Coordination
l) Performance
m) Activities/ Processes
n) External factors/ Recommendations

OHT Building Blocks

The following are the eight components of readiness for OHTs, for year one and maturity set out by the MOH (MOHLTC 2019):

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

HSPN

OHT A

OHT A is the result of several years of system transformation efforts across the city and nearby communities, stemming directly from the Partnership, established in 2017, to address the sustained challenges to the provision of health, social, and community care for their populations. Partners recognized that their population, notably Indigenous communities, were experiencing disproportionately poorer health outcomes and access to health services in Ontario, driven primarily by recruitment challenges for primary care physicians and other health human resources. The history of the Partnership is essential to understanding the evolution of the OHT, as the disentanglement between the Partnership and OHT remains an ongoing sensemaking challenge for the team, and one with direct implications for current decisions and future directions around governance and entity status, among other things.

OHT A was formed as a strategic 'supplement' to the existing Partnership, an opportunity to leverage vitally necessary funding to secure additional resources for the Kenora region and surrounding communities. Because of this, OHT A benefits from the years of experience already accumulated by the Partnership itself. This benefit is most tangibly felt in a clear and shared cohesive vision: all working groups and partner organizations share a foundational vision to meet the unique needs of this region's communities in a manner that is person- and patient-centered, equitable, and accessible. Partners seem to equally understand and agree that fundamental transformation of the health system is required to accomplish this goal, as current models of care are insufficient. The operationalization of this transformation has centered on a few key areas that form the core working groups of the OHT: mental health and addictions (the priority population for initial OHT activities); housing and homelessness; digital health; and primary care. All of these working groups are supported by a Patient, Family, Elder Advisory Committee (PFEAC), which was founded through a deliberative and equitable process that involved a temporary planning committee. Though PFE involvement was not substantive in the early planning phases of the OHT, the direction of the OHT through PFEAC leadership demonstrates a clear commitment to engage individuals, communities, and groups as equal partners moving forward.

The pre-existing history of the OHT partners, however, has also created an equally lengthy history of challenging and sometimes tense relationships between and among partner organizations. This is driven in part by substantial resource limitations and perceptions of disproportionate resource deprivation among certain communities (e.g., on-reserve First Nations). Resource limitations exist in the areas of health human resources, programmatic funding, and sufficient administrative/project management infrastructure, but also in fundamental resources around phone and internet access for tele-/virtual care and housing for the most deprived communities in the region. Such constraints weaved across nearly all working group meetings and discussions and were further underpinned by a dearth of appropriate and applicable population health data to guide evidence-based decision-making. This, in turn created an environment where partners were forced to respond – with limited planning and organizational capacity – to rapid funding calls, which may or may not directly align to the strategic aims of the OHT. As a result, the strategic priority population of the OHT (mental health and addictions) was often sidelined for other imminent priorities, either those that were dictated by funding opportunities, or those – such as the new regional hospital and long-term

care facilities – that were the Partnership's planned priorities but not, necessarily, priorities of the OHT in the short-term.

OHT partners engaged in several discussions about exploring formalized governance models, including becoming a legal entity and/or a health information custodian. These are decisions that are being considered methodically and re-evaluated as the needs of the OHT evolve and re-emerge. However, in the short- and medium-term, the absence of clarity on these issues creates challenges for certain partners, for instance in accessing personal health information by those who are not designated healthcare organizations (e.g., municipal partners, city representatives, etc.). Governance and accountability models also have direct implications on the extent to which the OHT can envision and concretely advance on transformation in primary care models, for instance by defining the roles and services offered by specific primary care partners. This issue extends further into the organization of the leadership roles of both the Partnership and OHT A, ensuring communication and collaboration across all working group members, leads, the Partnership co-leads, and the OHT Executive Lead.

In light of this highly ambiguous environment, the successes of the OHT in a limited time frame – standing up numerous working groups, advancing substantially on digital health innovation, multiple successful funding applications, etc. – reflect the immensely strong commitment of OHT partners, in spite of the stated barriers. To accomplish this work, trust has become more of a guiding principle and narrative, rather than a formal barrier or enabler. There is an openness and willingness by partners to acknowledge the historical lack of trust in the region, while simultaneously pushing themselves to move forward with a belief that past harm can be repaired, and trust, in turn, built among organizations. Demonstrations of trust manifest concretely, with substantive efforts towards intentional dialogue, frank conversation, and a recent retreat to 'reset' the strategic partnership. These efforts will be essential to the sustainment of the OHT, particularly as partners navigate a system that often works against building trust through lack of transparency in funding.

OHT B developed from a broad engagement strategy with a wide range of partners including organizations with existing accountability to payers (hospital, long term care, primary care team) and other service delivery and community-based members (home care service delivery companies, community mental health organizations, Alzheimer's society etc.). A "Compassionate [City]" was founded on the guiding principles of shared purpose, community members at the centre of co-design, distributed leadership, connected and collaborative action, an innovation mindset and commitment to diversity, inclusivity and equity. This OHT aimed to accelerate growth through a collective impact approach, described as moving from responding individually to health care issues towards working together to address complex system issues. The original proposals for this OHT included work on frail older adults and a particular emphasis on an alternate level of care (ALC) diversion program to enable older adults needing long-term care to be discharged from acute hospital and be cared for in the community with high levels of home care support. There were additional initiatives relating to a palliative care program and community mental health.

There was a great degree of collaboration and collectivism in this OHT and a notable feature of this OHT was the willingness of many of the partners to contribute resources to shared activities. Individuals from many member organizations dedicated in-kind time toward working groups, a backbone team as well as weekly meetings with all OHT signatory members throughout the COVID-19 pandemic. This collaboration was most explicit through responses to the pandemic, from staffing testing and vaccination clinics to outreach programs with community ambassadors and mobile teams that would visit various community locations to meet the community where they were.

There was also a considerable emphasis on developing and supporting the Patient and Caregiver Health Council (PCHC). This council was empowered to design the community engagement approach to be employed across the OHT. A health equity framework was also developed collaboratively with an expectation that it be used in the development of community engagement and co-design of OHT programs. These foundational pieces supported the development of individual initiatives within the OHT.

The primary care group was also an active constituent in this OHT with several digital health initiatives including online appointment scheduling, virtual care with patients and physician rapid access to specialist consultations through a virtual platform.

The OHT is now moving ahead with reorganizing the leadership to create a new operational committee to distinguish implementation activity from the governance and leadership group. Workstreams and initiatives are also being reorganized alongside population groups which is more in line with a population health management approach.

OHT C came together focused on improving care delivery and experiences of care for frail seniors and their caregivers, as well as the experiences of the providers who serve and support these seniors. Members of the OHT leadership team represent organizations and provider groups with extensive experience serving older adults in the broader community, and there was strong representation from primary care organizations throughout this OHT's development. The group had a shared and clear understanding of the specific gaps and system-level barriers contributing to the fragmented care frail seniors in their community were receiving. They were also able to articulate clearly how this resulted in unnecessary system utilization, adverse health impacts as well as burden and frustration for older adults, their caregivers and providers.

Not only did members of this OHT come to the table with a shared understanding of their "pain points," but because the OHT was located in a smaller rural geography, many of its founding partners and collaborating organizations also had an established history of working together. Critical assets the group identified were the trust they had in one another ("none of us would ever hesitate to pick up the phone and ask for a favor)," and a patient-centered culture ("we do what we need to do" to serve patients). The leadership team saw themselves as "doers" and "operational" leaders, who were adaptive, knew how to meet the immediate needs of patients and actively involved in on-the-ground initiatives. A sense of needing to get things done pervades this OHT. At the same time, there was recognition that they moved too quickly at times, and many members expressed interest in finding ways to slow down, learning how to improve and becoming better able to engage in data-driven work.

This shared set of operational norms and orientations, as well as the tension between moving quickly and slowing down to learn, characterized how this OHT worked at the outset. The OHT began by "doing." The early focus of their work was re-designing or creating new care pathways for frail seniors, its year 1 priority population, and extending this out to its year-2 and other identified priority populations: people in need of palliative care and people adversely impacted by determinants of health. Several of its working groups dove into developing and implementing micro-integration initiatives that addressed specific procedural redundancies, (e.g., duplicated assessments) as well as system-level barriers and inequities (e.g., sharing patient information across provider groups and organizations, lack of access to primary care for people experiencing homelessness, as well as significant gaps in end-of-life care) that they knew were impeding high value integrated care. These working groups began at the ground level, looking at how to improve specific cross-organizational pathways for sub-sets of their priority population that were falling between organizational cracks (e.g., primary care and hospital; homeless shelter; hospice, home and community care, primary care, hospital) At the same time, parallel work streams, focused on improving digital health infrastructure and building out data capabilities and performance management resources were unfolding to support these micro initiatives, as well as work that was happening at meso and macro levels in the OHT.

The progress of all initiatives and workstreams was hindered by a series of challenges including human resources shortages, the need to prioritize resources to respond to the pandemic, as well as the inability to engage in longer-term planning and hiring, because of how funding was provided to OHTs. Nevertheless, when resourcing to support project management, digital health infrastructure, as well as data and performance management decision support stabilized, with several critical pieces of this OHTs' vision coming together. This included using digital solutions to support shared-care plans, and the ability to drill down into data segments to determine how

HSPN

to prioritize, resource and scale micro-initiatives more effectively. Specifically, the OHT was able to re-focus on bringing organizational partner groups onto common platforms such as Health Partner Gateway that would facilitate the exchange of patient information. The team also engaged with HSPN learning supports and were focusing on enhancing their capacity to use different sources of data to drive and monitor the work being undertaken by working groups and to build out OHT-wide quality improvement and performance measurement frameworks.

Ultimately, the tension between doing and learning evolved into a productive complement for this OHT. At the close of the DE period this OHT had set out clear and coherent short-term strategic priorities with an eye to a longer-term strategic plan and the OHT's PFAC had become more active in the work of the OHT. Additionally, the OHT re-mapped its organizational structure, prioritized the creation of new director positions and additional project management support, engaged in system-mapping, community engagement and co-design work, and onboarded new partner organizations that would be critical to supporting the work set out for coming years.

The overall vision for OHT D is "achieving the best health and well-being together." This OHT takes a holistic approach to health, considering the whole person and their family. A collaborative attitude is integrated into their vision and comes through in practice with their collaborative approach to leadership. OHT D takes pride in their collaborative relationships and working together for the community's best interest. Being a smaller rural community, OHT D had many partnerships in place before the OHT was established. Trust and respect had already started to form, contributing to their ability to come together quickly to address a common goal. OHT D does have opportunities for improvement in ensuring equity of voices and learning to have differences in opinion and work past them. They have therefore undertaken activities to strengthen team climate and communications.

OHT D invested in building a solid foundation for their OHT. Strategic planning efforts dominated their spring of 2021, and OHT D is now well-placed to achieve their vision. A robust engagement effort focused on internal partners and the community at large. Over 1700 community members provided feedback, identifying broad issues with clear priorities. Themes were translated into strategic goals, with objectives and actions associated with each. Internal engagement led to refinements of the strategic plan and clarifying responsibilities of each working group related to achieving the strategic goals. A template was developed to monitor each group's progress towards completing the objectives. Support from leadership and dedicated, skilled resources from the backbone team promoted the achievement of the strategic plan development. With a clear understanding of goals and priorities, OHT D is able to navigate resource-related challenges. For example, when COVID-19 surged, they knew how to pare back, and with a diversity of funding and other opportunities available to OHTs, they have the ability and confidence to be selective. As part of deepening their shared accountability framework, OHT D reviewed the strategic plans of the partner organizations to promote alignment.

OHT D is taking a population-health-based approach and has outlined a work plan to identify priorities through population segmentation. Their initial priority population was adults 55 and older with one or more specific chronic conditions and a recent expansion to include mental health and addictions for adults. With the addition of a health system impact fellow, they have now identified a sub-population, COPD in younger seniors (aged 55-74) and a plan to focus on co-design. The focus on a key project provides the ability to move forward with a clear direction and generates momentum for the OHT.

In addition to identifying priorities, OHT D has made other investments to set up a strong foundation. The OHT has concentrated on supporting the patient and family advisory committee with dedicated resources and staff assistance. Patient and caregiver representatives participate in most working groups, and their role is valued throughout the OHT. OHT D working groups' responsibilities are grounded in the strategic plan. Their Equity and Diversity working group has remained active throughout the pandemic, increasing relationships and awareness of gaps in services. They have provided opportunities for cultural sensitivity education for health care workers. OHT D has recently created new partnerships with the community sector to address access to online services. Ongoing work in digital health and information sharing include several initiatives and has led to successful funding application from Ontario Health. As OHT D moves forward, they will shift the balance of foundation work and co-design and implementation.

OHT E established their vision through an engagement process with partners and the community. In April 2021, their leadership council formalized their mission, visions, and values. At the broadest level, there is agreement commitment and alignment with the vision and values of the OHT, which is to "improve the health of the communities we serve and foster an improved individual and provider experience." Recently, OHT E set out four strategic goals for their OHT and created a document that maps the alignment of approved initiatives to these goals. They shared their vision and recognized their achievements through their first annual general meeting.

Relationships and trust continue to build in this OHT. They are learning how other partners organizations and sectors operate. As this learning happens, there is an opportunity to clarify the vision and enhance connections to the operational level, focusing on how the vision will be achieved. OHT E leadership is able to identify areas of improvement in the vision, their structure and operations. Questions around a fulsome vision, including sectoral engagement, are raised by leadership council members. The leadership council asks itself, "what can the OHT do?" which shows their interest in creating solutions. They are, however, challenged by the limited long-term outlook provided by the MOH and the lack of clarity beyond a 1-year time frame.

With the broad goal of integrating care for their priority population, OHT E has implemented several programs that meet service needs and align care. One such program brings together a multi-professional care team to deliver integrated primary care to seniors who cannot access office-based care services. Although they have been able to launch programs successfully, challenges with COVID-19 have created delays in the implementation of some of their planned work. For example, programs that require strong engagement from specialists who have been dealing with increased patient volumes have been delayed. OHT E develops evaluation metrics for their individual programs and tracks progress through a monitoring template for all working groups and projects. In addition to launching programs within their OHT, they identify opportunities to partner with neighbouring (and other) OHTs, including submitting a proposal to Ontario Health on behalf of the three OHTs for a virtual model of care for youth mental health and addictions. As part of the foundational work to achieve their vision, they have created a governance structure with sectoral representation and have established processes for member succession. They have established methods for evaluating and approving the proposed projects.

Several factors have helped OHT E to enact their vision. A key enabler to all that OHT E has accomplished to date is partner contributions, with participating member organizations contributing a percentage of their budget. Through in-kind support, particularly from the hospital, OHT E has is well staffed. They have strong operational leadership, allowing them to do the foundational work of setting up an OHT and implementing new initiatives. From early in their development, project management resources were a strength, with PM support available to many working groups, initiatives, and core functions of the OHT (leadership performance management).

Lastly, strong physician involvement supports success. Despite limited engagement of physicians at the early stage of the OHT, OHT E is undertaking proactive physician engagement at all levels. Collaborative partnerships with primary care and community-based organizations have allowed projects to move forward effectively. Several of the initiatives launched to date

have a clinical focus and have physician members spearheading or leading initiatives. Through involvement in the OHT, physician members support a move away from an organization focus and prioritize improvement, integrations, and patient and primary care impacts.

OHT F is a (non-GTA) urban team with an attributed population of 620,000. In the context of a pandemic that brought the needs of its socioeconomically vulnerable populations to the fore, this OHT decided to focus on a congregate care strategy that included residential care facilities (RCFs), women's homelessness, retirement homes and long-term care (LTC) homes. It saw itself as a leader in the integrated care arena given its history of leading smaller-scale local initiatives. It had stakeholders who genuinely believed in the value of the OHT vision, articulated as improving population health through a focus on equity, community needs and the seamless continuum of care. OHT F's early development focused on establishing a sustainable structure upon which it could build. There was a correlative focus on process – developing integrated solutions that responded to local needs while ensuring representation and equity – that informed a thoughtful, long-term approach to OHT development.

An example of this approach is its early focus on equity and governance. An Equity, Diversity and Inclusion advisory committee was established, research conducted, and a report written on the topic. The hope was that an equity lens would inform not just healthcare delivery but also the team's structure and culture. OHT F also became the first OHT to incorporate, doing so to better handle funding, service procurement, establish policies and guide decision-making. Over many months, stakeholders brainstormed how board seats would be allocated and weighed the challenge of having many voices at the table with that of coalescing disparate sectors into a limited number of board seats.

At the same time, the team began work on developing a primary care governance model. Virtual primary care townhalls spurred by the pandemic became the springboard for working groups where a governance structure was developed for what would become a table that brought together primary care voices across the OHT. This would facilitate a unified primary care voice for the OHT while also allowing it to connect with provincial and national groups. Similar work was done in patient engagement. This OHT featured patient-family advisors (PFAs) as leads for its OHT application and had an early preference for embedded PFAs across its various committees rather than located within a separate PFA Council. Over time, a patient, family and care partner network came together to provide support for projects and input into OHT activities. Engagement principles, forms, values, roles and responsibilities were collaboratively developed by the group.

The team's thoughtful approach to OHT development extended to the way it approached digital priorities and identified priority population needs. The digital group developed a process for gauging interest in and prioritizing the myriad digital funding opportunities that came their way. Smaller working groups formed to develop proposals that aligned with strategic priorities while demonstrating clinical, executive and financial support. The OHT also decided that it needed a good understanding of its patient populations before re-designing care. Led by primary care physicians, the RCF group conducted on-the-ground research to understand who lived in specific residences and what their needs were, while the LTC group conducted similar research to understand the needs of residents, family members and frontline staff and compiled an evidence bank of best practices. They hoped that this would aid decision-making, enable a robust partner participation agreement and eventually inform broader policy.

Despite the advantages afforded by its long-standing partnerships and prior familiarity with integration initiatives, this OHT has faced challenges too. These have included having to

integrate a neighbouring geography without immediate access to funding to facilitate that integration, the challenge of incorporating new system recovery measures into already-designed, locally relevant priority areas, and the difficulty of developing a long-term OHT vision with short-term funding. The latter was of particular concern to the complement of staff who formed the backbone of this OHT, while limited-term funding opportunities and short application deadlines have impacted overall ability to plan long-term. Challenged with enacting a long-term vision for population health with short-term budgets and shifting policy priorities, OHT F is engaged in the art of the possible.