Ontario Health Teams Central Evaluation

Formative Evaluation

Document Analysis of the First Cohort of OHT Applications

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The opinions, results and conclusions included in this report are those of the authors and are independent from the funding sources.

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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Executive Summary

Background

This report highlights findings based on information extracted from the first 30 Ontario Health Team (OHT) applications in the fall of 2019.

Methods

A document analysis extraction guide and protocol were developed. All 30 applications were reviewed, and information was extracted by trained research assistants (RAs). Data validation was conducted. Each RA was assigned sections of the full application. The data extracted from the full applications fell into three categories: (1) general characteristics, including, types of members, patient and community engagement, and prior partnerships; (2) target populations and plans for vulnerable populations; and (3) measuring system performance. Document analysis results were reviewed by the entire research team.

Key Findings

The first cohort of OHT applicants were a two-thirds, one-third split between urban/suburban and small community/rural, respectively. All OHTs included hospital and primary care, and the majority included community support services and mental health and addictions services. All OHTs have members with some experience working with at least one other member in the past on improving patient care and, most had a high degree of patient and caregiver engagement. The most frequently selected year-one populations identified for integrated care delivery redesign included: frail/complex seniors; mental health and addictions; palliative; and chronic conditions like congestive heart failure (CHF)/chronic obstructive pulmonary disease (COPD). The performance metrics most frequently identified include avoidable emergency department (ED) visit rate; 30-day inpatient readmissions; alternate level of care (ALC) rate; community referral wait time to first home care visit; patient reported experience and outcome measures; and provider experience.

Conclusion

The first cohort of OHT applicants demonstrated a wide range of partnerships to develop their OHT plans. Early involvement of primary care and community care are apparent. There were common first year populations and a few common metrics that may serve to create communities of OHTs with common interests. Few OHTs have extensive experience in managing shared funding though most had worked together and have experience with quality improvement to support their implementation.

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Background

As part of the formative evaluation of the first cohort of Ontario Health Team (OHT) applicants a document analysis was undertaken to create a panorama of the initial steps of OHTs' journeys toward becoming fully functioning teams. This report highlights findings based on information extracted from the first 30 full applications in the fall of 2019. By exploring the OHT full application data, we are learning about the baseline, goals, expectations and plans for OHTs to be fully implemented. We wanted to learn about how teams are coming together across the province, with a focus on the essential building blocks[1] of OHTs.

The purpose of this document analysis is:

- To produce a high-level summary of all OHT applications;
- To compare and contrast applications across categories that represent supporting factors for implementing integrating care and population-health management;
- To develop a baseline understanding of OHTs' plans and goals;
- To provide context for subsequent analyses of transformation over time.

Methods

A document analysis extraction guide and protocol were developed (by SLS) guided by Bowen (2009)[2] and Gross (2018)[3]. The first version of the guide was created and circulated to the core members of the research team. After discussion and changes, a second version of the extraction guide was circulated to the broader research team for finalization. The final version of the guide was then sent to three research assistants (RAs) to review and provide a brief feasibility assessment. One qualitative team member (SLS) and the three extractors reviewed extraction information to come to consensus on an extraction standard.

Three RAs conducted the data extraction and brief analysis. All 30 OHT applications were provided to the RAs. Each RA was assigned sections of the full application and to enter the information from each application into a grouping of columns in an excel document. In addition, RAs completed two additional columns to capture overall analysis of the application sections and preliminary comparative analysis of the sections across OHT applications. Document analysis results were reviewed by the entire research team.

The data extracted from the full applications fell into three categories: (1) general characteristics, including, types of members, patient and community engagement, and prior partnerships; (2) target populations and measuring system performance; (3) plans for vulnerable populations.

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[1] RISE developed eight building blocks based on the ministry's OHT guidance document and readiness assessment. https://www.mcmasterforum.org/rise/access-resources/key-resources

[2] Bowen, G. A. (2009). Document analysis as a qualitative research method. Qualitative research journal, 9(2), 27-40.

[3] Gross. "Document Analysis", in The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation. Frey, B (ed.). 2018. SAGE Publications, Inc. City: Thousand Oaks

Key Findings

Part 1: Who are the 30 Applicant Ontario Health Teams?

General Characteristics (Table 1)

Of the 30 OHTs, 20 were categorized as urban/suburban, and the remaining 10 as rural/small community. We considered an OHT to be urban/suburban if their attributable population was ≥ 170,000. The average attributable population size across the 30 OHTs was 332,663 with the estimates ranging from as small as 54,883 to as large as 878,424. The average number of primary care physicians included in OHT membership was 81, with significant variation across OHTs. Twenty-two OHTs listed fewer than 100 primary care physicians and a third (10) listed fewer than 50. The majority of OHT applicants (20) do not include information on other types of physicians, but of those that did, the number of physicians listed was fewer than 16.

Table 1: Characteristics of the first cohort of Applicant OHTs (N = 30)

Number of OHTs considered urban/suburban *	20
Mean size of population accountable for at maturity (range) *	332,663 (54,883 – 878,424)
Mean number of primary care physicians (range) ^	81 (20-186)
Range in the number of other physicians ^*	4 - 15
Number of members formally involved on other OHT applications ‡	30
Number of OHTs where members have worked together in past ¥	30
Membership organizations highly align with referral networks *	25
Number of OHTs with level of patient engagement rated high, medium, low**	18, 8, 4
Number of OHTs with previous experience with quality improvement rated high §	20
Number of OHTs with capacity to manage cross provider funding rated high, medium, low ***	13, 13, 2

* Urban/suburban was defined as ≥ 170,000 attributable population (Data Source: MOH Health Analytics Branch attributable populations sent to Applicant OHTs)
^ Section 2.1.1 of the full application, ** 20 OHTs did not indicate other physicians
‡ Section 2.3 of the full application
¥ Section 2.4 of the full application
*** In section 2.5 of the full application OHTs self-assessed low/moderate/high alignment between patient and provider referral networks. In cases where OHTs rated themselves between two ratings (for e.g., moderate-high), a review of written material was done to assign H/M/L. For example, one OHT self-assessed as moderate-high alignment and was categorized as high because the majority (71%) of patients were already receiving care in the OHT.
**** Section 3.8 of the full application. High engagement was defined as having a patient/family/caregiver co-lead, and/or part of governance tables, +/- being a signatory; medium engagement if patient/family/caregiver councils were involved with the redesign and full application (e.g., working groups) and not a signatory; low engagement if patients/families/caregivers were consulted for input (e.g., town-halls, invited to meetings) and not a signatory.
§ Section 5.2.1 of the full application. While most OHTs described themselves as having high QI experience, a team was categorized as high if they described QI initiatives that assessed performance of the partners working as a team or a network. OHTs were categorized as medium if multiple OHT partners demonstrated experience with QI initiatives within their organizations and/or have tools in place to share (and/or scale) these resources. OHTs were considered low if few partners had experience in QI and/or they did not describe a plan to leverage the experience for the team.
***** Section 5.5 of the full application. Capacity to manage cross provider funds was rated low if the OHT had no experience managing a fund with shared accountability with other partners. Two OHTs did not provide this information

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Multiple OHT Participants (Table 1)

All applications identified at least one member (individual or organization) who was also a signatory on another OHT application. Named partner organizations represented on multiple applications included: SE Health; VHA Home Healthcare; Bayshore; Victorian Order for Nurses; LOFT; CarePartners; Closing the Gap; CBI Health Group; TC LHIN; and March of Dimes. Some organizations indicated on one application as overlapping with another OHT, were not included as a formal member on the second OHT's application. Reasons for team members overlapping with other OHTs were frequently related to the organization's geography, and how they provide services in multiple OHT regions.

Experience working together in the past (Table 1)

All OHT applications mentioned their team members had experience working together in the past. The most common previous working experience described was from OHTs that included a hospital that had participated in the Integrated Funding Model and Health Links initiatives. Nearly all OHTs had team members that had worked together on small local projects.

Patient/family/caregiver engagement (Table 1)

Guided by the Carmen *et al*.'s (2013) continuum of engagement[4], we classified almost two-thirds of the OHTs (n=18) as having high engagement with patients/families/caregivers, eight medium engagement and four low engagement. High engagement was defined as having a patient/family/caregiver co-lead, and/or as a part of governance tables, and/or being a signatory; medium engagement if patient/family/caregiver councils were involved with the redesign and full application (e.g., working groups) and not a signatory; low engagement if patient/family/caregiver were consulted for input (e.g., town-halls, invited to meetings) and not a signatory. Eight OHTs included patients/family/caregiver as signatories on the application. Half of the OHTs (n=15) either explicitly stated the Patient Declaration of Values[5] with details for each value or explicitly addressed each value but did not state the Patient Declaration of Values.

Experience with Quality Improvement (Table 1)

All OHTs have medium to high experience with quality improvement (QI). Most of this experience is based on projects that individual partners undertake within their organizations, such as Plan Do Study Act cycles. There was no mention about cross-organization QI initiatives in applications. The quality metrics mentioned in the applications were mostly generic, such as reducing hospital use. Mention of theory of change linking the activities/processes that are planned by the OHTs to the outcome metrics was generally absent from applications.

Cross-provider funding (Table 1)

OHT applicants described their experience in managing **cross-provider funding**. The experience was categorized as low (2 OHTs), medium (13 OHTs) to high (13 OHTs). Those with high experience were engaged previously in large-scale, longer-term cross provider bundled care or integrated care initiatives. Those with moderate experience were engaged in smaller-scale, shorter-term funding initiatives, such as surge funds. Only 2 OHTs had little to no experience with managing funds or shared accountability.

Who are the Ontario Health Teams partnering with?

All OHTs included hospitals and primary care practices as partner organizations (see Table 2). The number of primary care practices included in OHTs varied from one to 54, with an average of 10. The most

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[4] Carman KL, Dardess P, Maurer M, Sofaer S, Adams K, Bechtel C, Sweeney J. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. Health Affairs (Millwood). 2013 Feb;32(2):223-31. doi: 10.1377/hlthaff.2012.1133.
[5] Patient Declaration of Values for Ontario. https://www.ontario.ca/page/patient-declaration-values-ontario

frequent partnerships listed in applications were with Family Health Organizations (FHOs; n=29), Community Health Centres (CHCs; n=21) and Family Health Teams (FHTs; n=18). All but one OHT included partnerships with community support service organizations and most OHTs included a home care provider organization (n=23), a mental health and addiction organization (n=22) and a long-term care organization (n=19) as partners. Very few OHTs (n≤3) included children's treatment centres, independent health facilities, indigenous interprofessional primary care teams, laboratories, midwiferies, pharmacies, or retirement homes.

Table 2: Types of organizations* included (partnering) in OHTs

TYPE OF ORGANIZATION	N	# OHTs partnering with at least one	Range across OHTs
Hospital	47	30	1-3
Primary Care	306	30	1-54
Family Health Organization (FHO) ‡	122	29	0-15
Community Health Centre (CHC)	33	21	0 - 7
Family Health Team (FHT) ‡	41	18	0-17
Family Health Group (FHG) ‡	50	13	0-15
Solo practice ‡	34	10	0-19
Nurse practitioner-led clinic	10	9	0 - 2
Community support service	156	29	0 - 17
Home care service provider organization	65	23	0 - 13
Mental health and addiction organization	74	22	0 - 19
Long-term care home	47	19	0 - 11
Municipality	22	15	0 - 4
Aboriginal health access centre	3	3	0 - 1
Midwifery	3	3	0 - 1
Retirement home	3	3	0 - 1
Independent health facility	2	2	0 - 1
Children's treatment centre	1	1	0 - 1
Indigenous interprofessional primary care team	1	1	0 - 1
Laboratory	1	1	0 - 1
Pharmacy	1	1	0 - 1
Other **	91	27	0-8

Source: Section 2.2.1, 2.1.2 of the full application.
* OHT applicants were asked to identify partner organizations and categorize them based on the type of organization.
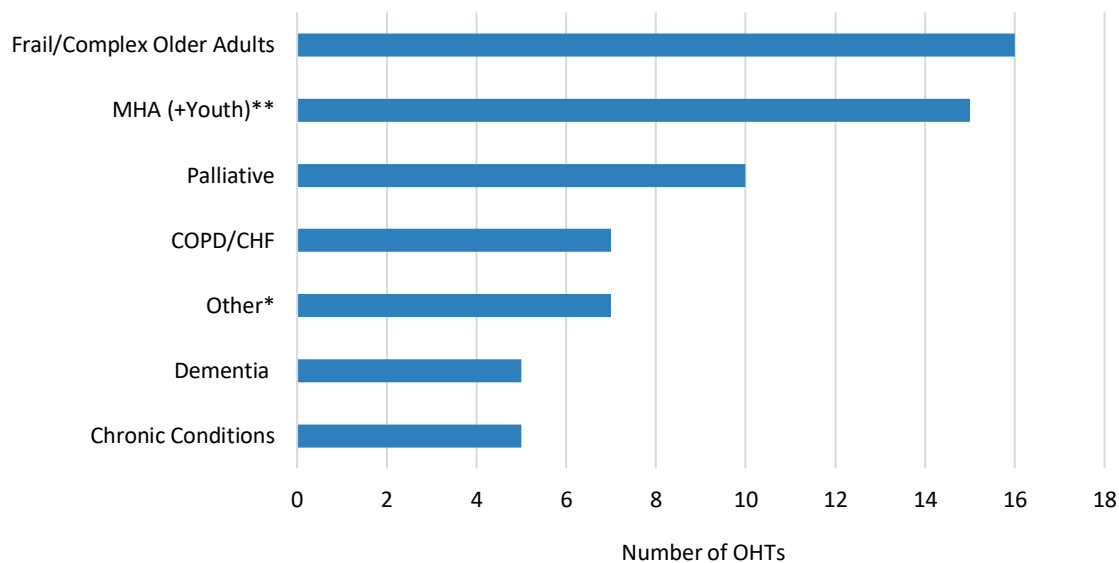‡ Section 2.1.1, column C of the full application.
** Other includes – paramedic services, public health units, hospice, client & family advocacy groups, weight management clinic, community-based rehabilitation, dentists, schools, and housing services.

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Part 2: What year-one target populations were selected?

Year 1 Target Population

OHTs were asked to identify the patient populations they intend to focus on delivering integrated care in the first year of implementation. Year 1 target population sizes varied across OHT applications. A majority of OHTs (n=21) chose to focus on one of the following three priority populations in year one: (1) frail/complex older adults (n=16); (2) mental health & addictions (n=15); and (3) palliative (n=10). There were various representations of chronic disease populations within the applications. OHTs predominantly focused on adult with exception of one that included children as part of its target population along with adults. Three OHTs decided to focus their attention on delivering integrated care to patients attached to primary care, rather than on specific diagnostic criteria.

Figure 1: Year one target populations selected by OHTs

Source: Section 1.2 of the full application.
*Other includes: Persons ≥65 years old who are receiving or require care from ≥2 provider partners; over 25 children currently waiting for services at The Hospital for Sick Children in Toronto; people living with complexities or at risk of developing complex conditions and caregivers; patients <75 with Ambulatory Care Sensitive Conditions; people presenting with episodic, minor acute issues that could be managed effectively in the community; high users (top 5%) of health care, community support, and social services; caregivers.
**Two OHTs specified youth.

Plans for Vulnerable Populations

Indigenous

OHTs were asked to describe their plans for indigenous populations. There was one indigenous-led OHT. Most applicants acknowledged the importance of having a plan to engage with Indigenous communities, however, formal plans were yet to be developed. Reported plans were largely focused on designing culturally suitable services. It was not clear if or how Indigenous representation or engagement was present. Several OHT applications described discussions with many indigenous groups; again, it was not clear if formal representatives on committees or planning tables was present.

Francophone

When asked to describe plans for the francophone population, most OHT applicants described plans to engage with francophone communities in the near future. This was true for OHT applications where the francophone population within the catchment area met the threshold for providing services in French. Again, it was not clear in applications whether OHTs had formal representation or engagement from the Francophone community. Most planning was restricted to culturally safe services.

Other gaps

Nearly all the OHT applicants mentioned the intention to plan to provide services to other populations where gaps in services do exist, such as for the following:

- Refugees & New Canadians
- Lower socioeconomic populations
- LGBTQ
- Homeless
- Marginalized and vulnerable
- Uninsured
- Unattached to primary care
- People in supportive care/long-term care

Formal plans were not present in any OHT application.

Part 3: Measuring system performance

The full application form included a list of metrics (section 3.1). OHTs were asked to identify metrics (provided or not) that were important or that they planned to measure in Year 1 (or beyond). Figure 2 illustrates the number of OHTs that identified the metrics listed in the full application form as important or planned to measure.

The majority of OHTs (n=23) selected avoidable ED visit rate, followed by patient-reported experience measures (PREMs) (including provider reported experience) and patient-reported outcome measures (PROMs) (n=19), 30-day readmission rates (n=15) followed by ALC rate and time from community referral to home care to first home care visit (n=11, respectively).

Most applicants identified additional "metrics" that were either non-specific or needed more detail. Examples included "improved patient outcomes"; "create shared resources", "provide effective system navigation"; "provide timely access to care"; "ensure patients are getting the right care at the right time from the right provider"; and "integrate electronic medical records". While many OHTs used different language to describe their chosen metrics most could be classified as either *Access* (wait time, digital and palliative) or *Efficiency*.

Figure 2: Number of OHTs identifying indicators listed in full application
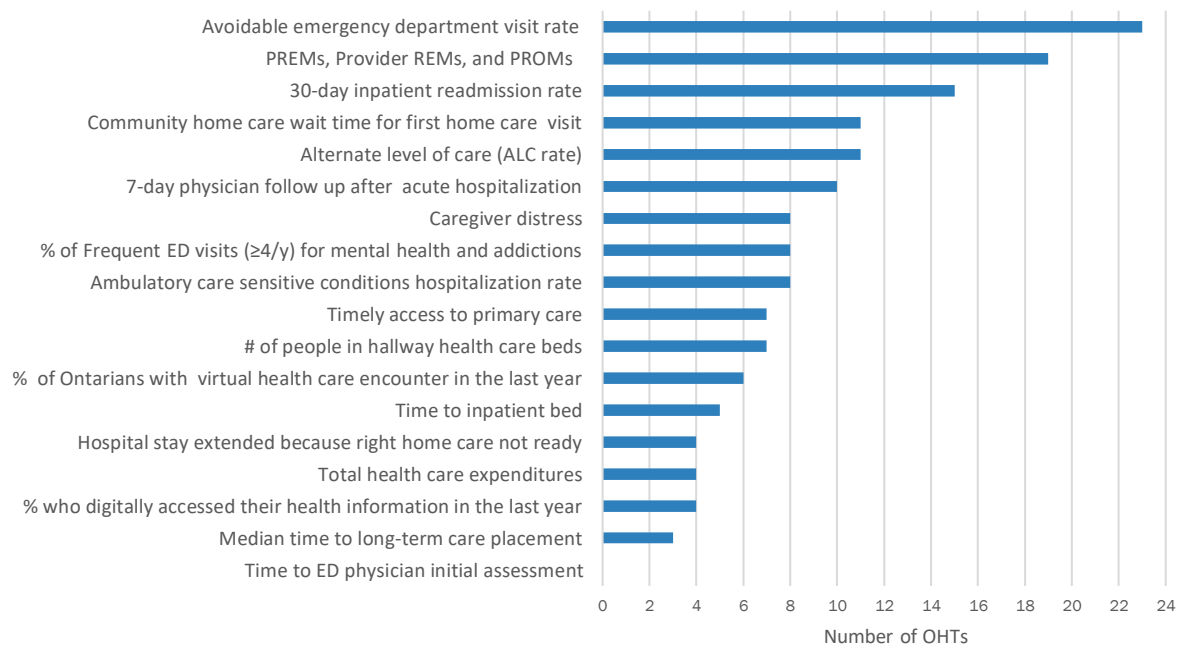
Source: Section 3.1 of the full application.

Conclusion

This report provides a high-level summary of the first cohort of 30 OHT applicants and compares them across categories (i.e., supporting factors for integrating care and population-health management). Among this first cohort, 20 were categorized as urban/suburban, and 10 as rural/small community with an average attributable population size of 332,663. All OHT applicant team members included a hospital and, primary care and all but one included community support service organizations. The most frequent primary care practice members were FHOs, CHCs and FHTs and the most frequent community members were home care provider organizations, mental health and addiction organizations and long-term care organizations. All mentioned their team members had experience working together in the past as well as experience with quality improvement (QI) projects. Almost two-thirds of the OHTs were considered to have high engagement with patients/families/caregivers.

The first cohort of OHT applicants plans and goals included identifying selected year-one populations identified for integrated care delivery redesign. The most frequent populations included: rail/complex seniors; mental health and additions; palliative; and chronic conditions like congestive heart failure (CHF)/chronic obstructive pulmonary disease (COPD). The metrics most frequently identified to monitor on their target populations included: avoidable emergency department (ED) visit rate; 30-day inpatient readmissions; alternate level of care (ALC) rate; community referral wait time to first home care visit; patient reported experience and outcome measures; and provider experience. Plans for vulnerable populations were not developed and largely focused on designing culturally suitable services.

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