

ONTARIO HEALTH TEAM CENTRAL EVALUATION

Formative Evaluation: Document Analysis

First Cohort of Ontario Health Team Applications

WHO'S INVOLVED



100%
INCLUDE HOSPITALS



100%
INCLUDE PRIMARY CARE



97%
INCLUDE COMMUNITY SUPPORT SERVICES



97%
INCLUDE HOME CARE



273 Primary care practices

156 Community support services

74 Mental health and addiction organizations

65 Home care service provider organizations

47 Hospitals

47 Long-term care homes

33 Community health centres

22 Municipalities

106 Other¹

¹ 'Other' includes Aboriginal health access centres, Midwifery, Retirement homes, Independent health facilities, Children's treatment centres, Indigenous interprofessional primary care teams, Laboratories, Pharmacy, Paramedic services, Public Health Units, Hospice, Client & Family Advocacy Groups, Weight Management Clinic, Community-based rehabilitation, Dentists, Schools, Housing services)

WORKING TOGETHER



100%
HAVE MEMBERS WHO HAVE WORKED TOGETHER PREVIOUSLY

GOOD NEWS

ROOM FOR IMPROVEMENT



MAJORITY HAVE EXPERIENCE WITH QUALITY IMPROVEMENT²

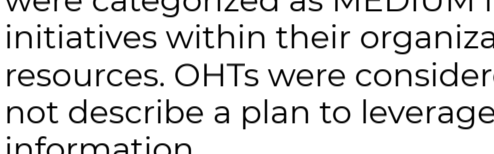
HIGH: 19 MEDIUM: 9



26/30 HAVE HIGH OR MEDIUM LEVELS OF PATIENT ENGAGEMENT⁴



HIGH: 18 MEDIUM: 8 LOW: 4



8 OHTs INCLUDED PATIENTS, FAMILY AND/OR CAREGIVERS AS SIGNATORIES ON THE APPLICATION

² Experience with Quality Improvement: 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. Two OHTs did not provide this information.

³ Cross-provider funding: 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.

⁴ Patient engagement: 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 patient/family/caregiver were consulted for input (e.g. town-halls, invited to meetings) and not a signatory.

PRIMARY CARE INVOLVEMENT



SIGNIFICANT VARIABILITY IN THE NUMBER OF PRIMARY CARE PHYSICIANS INCLUDED IN OHT APPLICATIONS

RANGE IN NUMBER OF PRIMARY CARE PHYSICIANS

20 to 186

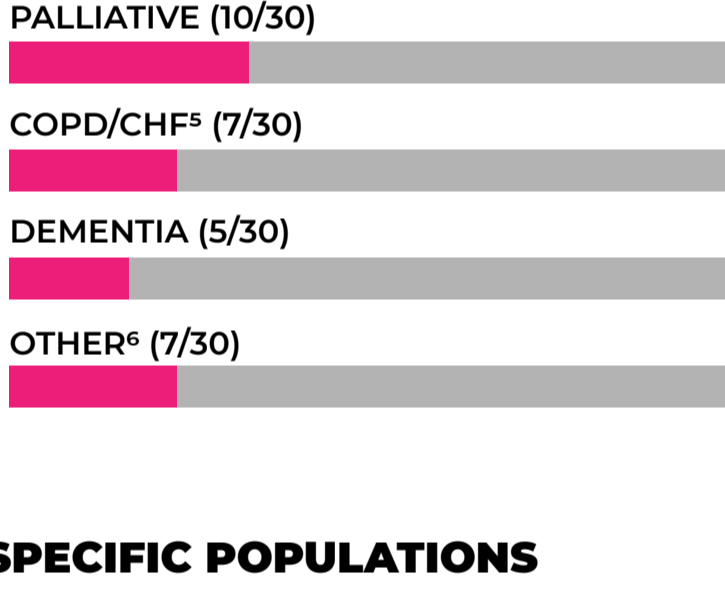
NOT YET A CRITICAL MASS OF PARTICIPATION

PARTICIPATION OF PRIMARY CARE ORGANIZATIONS

NUMBER OF PARTICIPATING ORGANIZATIONS	NUMBER OF OHTS PARTNERING WITH ORGANIZATIONS
122	29
33	21
41	18
50	13
34	10
10	9

PRIORITY POPULATIONS

OHT YEAR-1 POPULATIONS



PLANS FOR SPECIFIC POPULATIONS

INDIGENOUS COMMUNITIES ⁷	FRANCOPHONE COMMUNITIES
RECOGNIZE IMPORTANCE OF ENGAGEMENT	RECOGNIZE IMPORTANCE OF ENGAGEMENT
ENGAGEMENT PLAN DEVELOPED	ENGAGEMENT PLAN DEVELOPED
VALUE CULTURALLY-SUITABLE SERVICES	VALUE CULTURALLY-SUITABLE SERVICES
ENGAGED IN PLANNING	ENGAGED IN PLANNING
INDIGENOUS REPRESENTATION	INDIGENOUS REPRESENTATION
RECOGNIZE UNMET NEEDS IN AREAS NOT REQUIRED TO PROVIDE SERVICES IN FRENCH	RECOGNIZE UNMET NEEDS IN AREAS NOT REQUIRED TO PROVIDE SERVICES IN FRENCH

GOOD NEWS ROOM FOR IMPROVEMENT

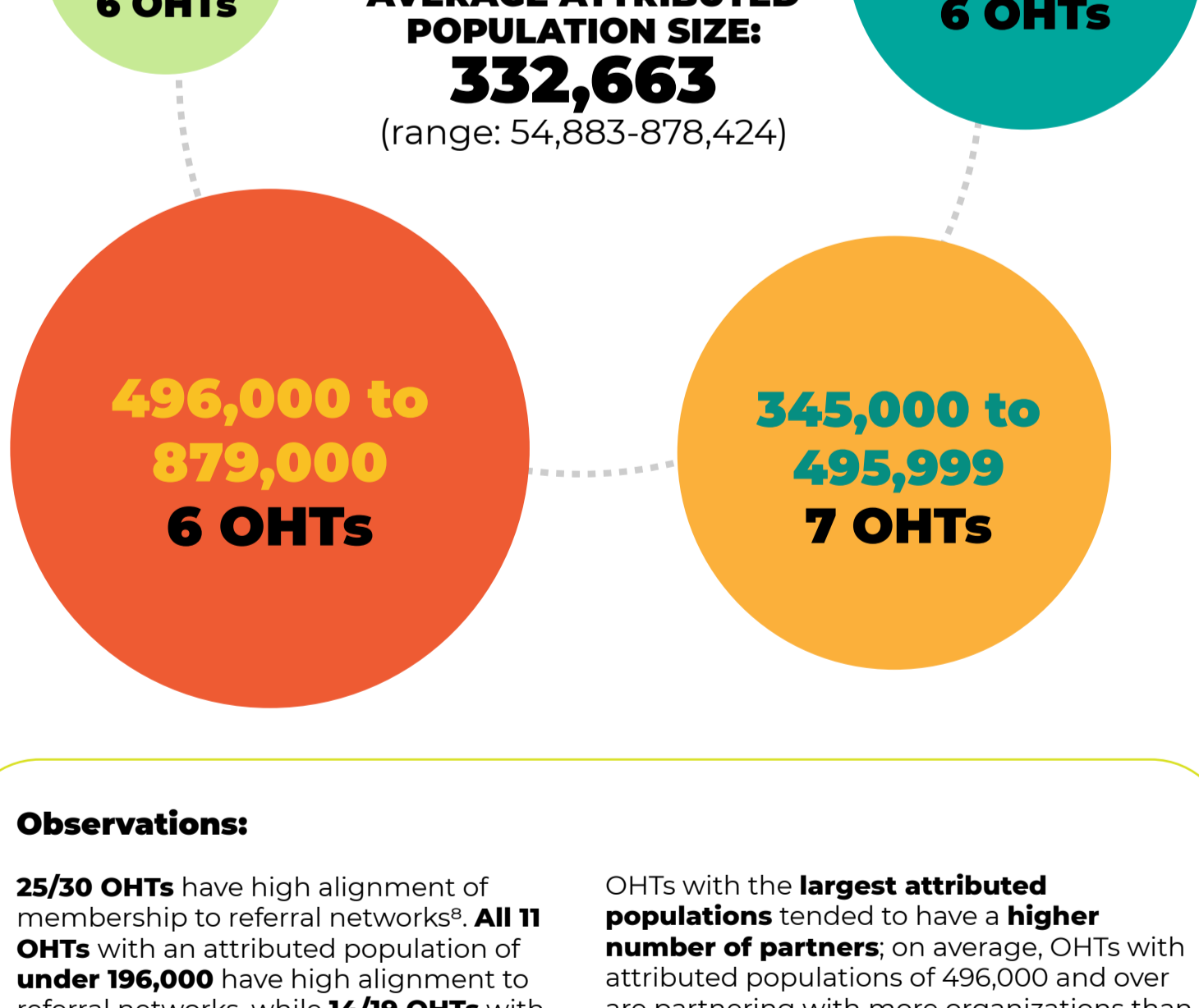
⁵ COPD/CHF: Chronic Obstructive Pulmonary Disease/Congestive Heart Failure
⁶ 'Other' includes older adults receiving care from multiple partners, children with complex care needs, people with complex conditions/Ambulatory Care Sensitive Conditions, people with episodic/minor acute issues, high health system users, caregivers
⁷ There was one Indigenous-led OHT.

ADDITIONAL POPULATIONS IDENTIFIED AS EXPERIENCING SERVICE GAPS INCLUDE:

refugees and new Canadians, lower socioeconomic status populations, LGBTQ, homeless, marginalized and vulnerable, and uninsured.

ATTRIBUTED POPULATIONS

NUMBER OF ONTARIO RESIDENTS AN OHT WILL BE RESPONSIBLE FOR



Observations:

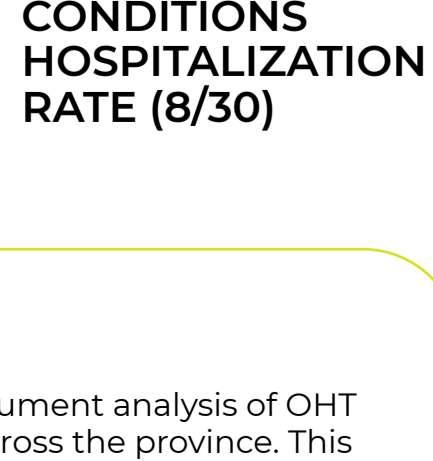
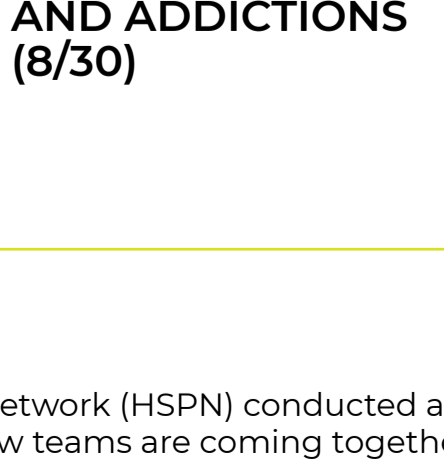
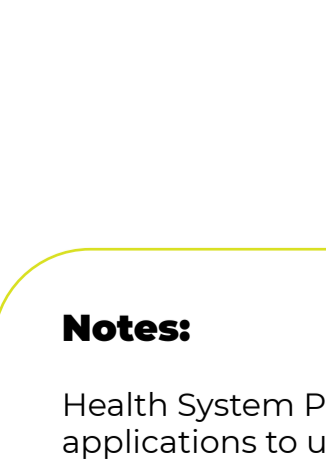
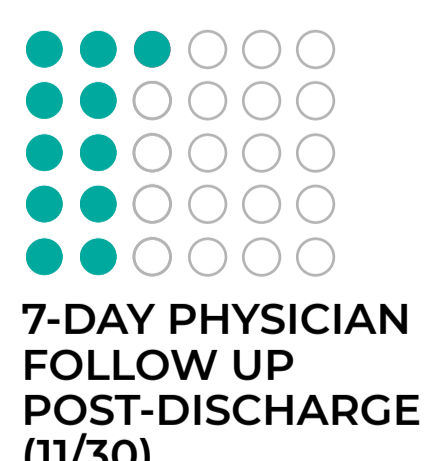
25/30 OHTs have high alignment of membership to referral networks⁸. All 11 OHTs with an attributed population of under 196,000 have high alignment to referral networks, while 14/19 OHTs with an attributed population of 196,000 or higher had high alignment.

OHTs with the largest attributed populations tended to have a higher number of partners; on average, OHTs with attributed populations of 496,000 and over have more organizations than those under 496,000 people (average of 28 partners vs. 16 for other OHTs).

⁸ Referral networks: Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through analysis, teams received information about which patient/provider referral networks the physician and hospital members are part of and self-assessed their alignment.

MEASURING SUCCESS

THE MOST COMMON PERFORMANCE METRICS IDENTIFIED BY OHTS



Notes:

Health System Performance Network (HSPN) conducted a document analysis of OHT applications to understand how teams are coming together across the province. This infographic summarizes the findings from plans described across the first 30 OHT applications, extracted in December 2019.

The document analysis is part of a larger, multi-year OHT Central Evaluation funded by Ontario's Ministry of Health.

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