HSPN Webinar Series – "What Is Needed to Advance Towards Maturity?"

Zoom Chat Transcript

October 25th, 2022

Please find below a transcript of the Zoom chat messages for HSPN's webinar on OHT development, held on October 25th, 2022.

These messages have been read by HSPN staff and sorted into one of two categories:

- Questions (and their respective Answers).
- General comments and conversation threads – these comments have been separated into two topics:
    - On Personal Experiences/Roadblocks – Webinar attendees detailing their experiences and difficulties in developing their OHTs.
    - On OHT Development – Comments related to helpful suggestions/insights on OHT development.

All messages have been anonymized, and some may have been slightly edited for grammatical purposes. Effort was taken to preserve the original spirit/argument of the message, so some grammar errors may still exist.

Questions and Answers

Question	Answer
I may have missed it- were these [Developmental Evaluation] OHTs all Cohort 1 or 1 and 2?	The 6 OHTs were all selected from Cohort 1 as we began this work just as Cohort 2 was being announced.
Are you able to share the slides with the participants?	Please visit https://hspn.ca/evaluation/ontario-health-teams/ for more on OHTs! We will post the recording and slides, as well as relevant links, related to today's webinar on our website soon! [See above website under "Webinars" link]
[The following bullet point are comments from participants in response to this discussion question] → So how could we have done [OHT development] differently if we could press replay?	• Provide time and space to focus on care redesign work that actually improves health outcomes as opposed to all of the planning deliverables that orbit that work • Funding for care - not just planning • Funding for long term improvements, not just pilots. • Emphasizing OHT work over organizational work • OHTs need the ability to fund activities or allocate funding for activities that improve pop health. Trying to get everyone to agree on chipping in is not sustainable. • More bottom up than top-down planning. • Focus on the priority population work (as mentioned by others) - this is where the value of OHTs sit • Truly believing in the idea of an attributed populations

	• Aligned strategic goals in the strategic plans of each organization to the OHT - this would mean that every org in the OHT would have a shared strategic goal in their org strategy plans which then means a portion of org is aligned to OHT/POP H • Co-design vertically as well as horizontally • Continuous evaluation • MoH can remove policy barriers to support our integration work. • Clear expectations on "what and when" plus flexibility to innovate and make change with ability to secure seed funding easily
Can you please provide key trends in engaging primary care?	We can talk about these teams work in primary care but also want to know about the many other teams' activities. We'll respond for the teams here.
Do we think the vision for OHTs is the same as pre-pandemic or has it or should it morph?	Good question - how does this align to the originally published OHT maturity goals by MOH? Could probably update the vision, as well as be clearer on roadmap to "maturity"
Do you have a sense of how many teams have gone to NFP?	Only Hamilton has incorporated to our knowledge, but others are considering

General Comments (Sorted by Topic)

<u>On Personal Experiences/Roadblocks</u>

- The lack of clarity re: HCCSS and their ability to participate in OHT work results in challenges to creating integrated systems across hospitals and community"
- Also hard to hire a strong core team with limited funding
- One of the recommendations for both OHTs and PMs that I would have thought was important is shared decision making and priority setting
- Primary care- can't be the cornerstone when burnt out and not organized
- I hear HHR issues as a continuing issue
- "related to the reporting arrangements, but having MOH/OH set on annual planning cycles (what can you do this fiscal year?) as opposed to multi year (what is your 5-year plan)?, the latter being more conducive to population health management
- very broad responsibilities of the OHT - too much too soon as we build up our partnership.
- Hard to hire AND retain quality HR on short term contracts
- Difficult to prioritize some issues given other time commitments
- Top-down deliverables take away from bandwidth to act on identified local priorities
- Engaging primary care and hiring support team has been challenging
- Engagement from our partners with specific requests to complete deliverables
- The role of the hospitals is challenging - how involved should they be is not clear
- Centralized supports for very specialized areas of expertise are a gap - e.g. enacting EDI-AR
- Not having any guarantee of funding going forward to support the OHT work.
- Extremely hard to do population health management with limited resources. The current OH funding (ALC, ED diversion) is an example of OH going around the OHTs directly to providers with little or no engagement with OHTs. Hard to know if we're on the same team or working at

cross purposes. Also, $750k per year is not enough money to support this work, even if sustainable.

- While we have primary care engagement (CHCs, FHT Executives, NPLC) we have limited engagement with physicians.
- Deliverable about ""sustainment plan"" is somewhat distracting at this early level of development without a clear understanding of MOH and OH future vision of OHTs.
- Lack of governance, lack of long-term strategic vision, constantly changing directions, and accountabilities structures such as MSAW's etc. really hampers progress.
- Lack of vision and strategic planning with OHTs from province/OH. Understanding OHT roles and responsibilities: we seem to have a clearer vision of our local aim and strategy. Cohort 1s had to wait until OH "caught up".
- We need clarity on where feedback from primary care can be escalated as often their pain points are not within the scope of OHTs to enact change on
- Governance, accountability and decision making - what is role of Ontario Health Corporate, Ontario Health Regions, OHTs, individual service providers? All have similar priorities (it seems) but often delays in decision making and stalemates in strategy because of how we are structured
- What is the impetus for family physicians to be involved? Hard to articulate.
- The discrepancy in what folks make in wages across partners of an OHT could influence stakeholder engagement and participation success.
- General lack of clarity around evolving mandate/role of OH/OH Regions and it is feeling a bit duplicative to the OHT mandate/role on some files.
- Too much paper chasing i.e. deliverables vs tangible concrete activity. I feel like pop health management is a lofty goal that requires more organization (i.e. governance changes) than we currently have.
- Feels like we are just recreating LHINs in a roundabout way
    - Agree… we seem to be recreating LHINs in the OH Regions
- Tensions between organization goals and OHT goal, complex change facilitators to hold space with multiple perspectives to enable break-though, sense making the landscape and translating what it means for the OHT/s, naming the elephants that get in the way of progress and how to make breakthrough, building capabilities to develop collaborative leadership, collaborative governance and point of care leadership to enable integration as a lever for pop health, true shared power for decision making an models with patients, citizens, caregivers, opportunities for OH to be an enabler, opportunities for MOH funded supports even more connected to enable OHT progress.
- Primary care engagement requires payment for their participation as members /leads/chairs of the groups. Our OHT has very good engagement with primary care, however a big chunk of the OHT budget is allocated to pay for their time commitment, at least in our OHT. If work of primary care is paid separately from OHT funding, that would help greatly.
- Legal issues related to liabilities of members and how to set it up in a way that meets needs of all partners
- I think that timelines and expectations are unrealistic. Most of the presentations of 'successes' of OHTs have commented that the work commenced prior to the OHT formation (including SCOPE possibly I think). It takes significant time to develop successful initiatives, but we feel pressured to deliver results immediately.

- We need a roadmap that is built in partnership with OH so we can all get on the same page re: strategy, priorities, funding and accountability. Transparency about what is coming down the pipeline is necessary for appropriate planning at all levels.
- Key issue - we need more family physicians and don't have mechanism for addressing that.
    - Yes to more family physicians and also for allied health providers nurses etc. just...need...more...
- Honestly, we have made very little progress. We have spent decades trying to squeeze every ounce of excess capacity already without funding, and now we need to start to invest again in capacity. We hear the Ministry constantly announcing little investments that never seem to reach us on the ground.
- OHTs can continue to develop, but will be limited in our ability to deliver meaningful change if we continue to be directed by OH/MOH and not involved in setting the provincial direction
- Struggling with building a plan for sustainment when not clear on provincial plan for OHTs - has anyone moved forward on this?
- We are challenged now with demand from our partners wanting to do more and collaborate more with limited resource capacity to support it. We have been leveraging part time local experienced resources for short term specific projects.
- Lack of expertise in specialized areas - we have a select few organizations that have experience in project management, data analytics and evaluation. They don't have the capacity to completely support the OHT. Much of the time we are depending on the same people which will lead to burnout.
- It is apparent that many OHTs agree on the current challenges - sustainability, progression to maturity, planning, care models, etc. We need to move beyond acknowledging the concerns to collectively addressing them.

<u>On OHT Development</u>

- I find the "siloing" of digital health solutions as its own thing isn't well aligned with how the work often progresses (at least for us). Viewing digital health as an enabler of all aspects of our work
  seems to resonate more with our partners.
    - We've also experienced that the series of digital projects was initially siloed and teams have benefitted from bringing them together and thinking through a more integrated approach. Digital health is a great example of this intersection.
- For our cohort, the OHT activities read kind of like a roadmap - we've travelled to some and are setting a course to others.
    - Agree re: the roadmap comment. I'm also curious how this research aligns with the Advance OHT roadmap on collaborative governance - is it just on the leadership/governance element? We have a number of different maturity models that have been presented and it can be a challenge to integrate these at times as we try to decide how to proceed.
- Governance guidance is key. If OHT are to be broader health focused, then lead committees should have more input/participation by non-physician resources engaged in the system.
- Key enabler for us = trusted relationship building through authentic & ongoing members engagement (org & client partners). This requires time & space to do so.
- Key suggestion – building a backbone team.
    - Yes - Our output has an OHT has easily doubled, if not more, since we had a solid backbone team in place

    - I agree that strong backbone supports are required to progress the work. Expecting volunteers to come together organically without shepherding is false.
    - Agree - strong and committed Backbone team/Implementation staff, including internal expertise on Population health management through OHT fellowship
    - Strong backbone team was key, but it was so hard to find the right people for these positions during the pandemic
    - Agreed - trying to build a strong backbone team to get the work needed to be done was very hard to find the right people while competing with OH who were hiring similar positions at much higher wages.
- Important to provide space for our community and partners to identify their priorities for initial projects/improvements vs. prescribed approach. This builds trust and engagement
- [Good idea to engage in] regular, informal dialogue with other OHTs in our region
- For us, having patient partners as decision makers helped build trust across partners. Everyone saw we were behaving in lock step with our vision to co-create with our community and that shifted perspectives to not put their organizations first, but rather population-based decision-making
- [Critical to have] primary care participation, strong back bone team, in-kind supports from partners, single vision from all partners, connection to other OHT Leads in the region.
- A key enabler: telling the OHT impact story - the difference that has been made with people and their families and those that work in health and social care as a result of being in and apart of an OHT. When the actual impact/difference that has been made is shared it serves as feeding the social movement for change.
    - Agree, effective communications functions within the OHT are a huge enabler
- Introducing transparent processes for dialogue and decision making
    - Community and provider engagement is key to achieving collaborative governance
- Linking data sources to priority populations has created legitimacy for OHT work
- We built our decision-making processes after doing ADVANCE training couple of years ago. Shout out to Advance:)
- Decision making framework - who makes what decisions under what conditions has been very helpful.
    - Agreed that a collaborative decision-making framework was key but many times we needed to be reminded to listen to the patient/family/caregiver with lived experience and our priority populations before any decision is made
    - we've found that a decision-making framework is helpful for the kinds of decisions that you can anticipate, but there's lots that you can't that still pose challenges
- Would love to take advantage of fellowship [to support OHT development], but hard to get one to come to our rural area.
    - Agreed - the fellowship program actually created a lot of inequity in capacity amongst OHTs
    - French or bilingual candidates for the OHT Fellowship Program would be important as well
- OHTs need to continue to build on their strengths: trusting relationships across the providers and sectors so we can accomplish together what we can't do alone. That is the value proposition of an OHT in healthcare planning.
- Is there some education around the OHT model (for OH staff) that could be done as OH teams continue to be built up?

- I'd like to start thinking about aligning multiple organizations to have cohesive digital health teams and strategies/platforms, decision support teams, etc. However hard to do in context of "are OHTs continuing?"
- We found doing a “strategic planning" process really helped highlight priorities that ALL agreed on
- On involvement of primary care and physicians:
    - We are looking at offering different ways for physicians to engage with our OHT, through research, quality improvement ops, small adhoc engagement sessions, curriculum development and as leads in pop health management. Some have garnered great support, others less so...
    - We are hosting in-person Town Halls for primary care to bring physicians and NPs together under a keynote topic most pressing to them (i.e. MHA) with a keynote speaker. We also use this time to get their feedback on their challenges in their practice and provide opportunities to get involved in leadership or project capacity.
    - We have been fortunate to have strong local physician leadership. Peer to peer engagement and working on initiatives meaningful to them e.g. SCOPE, digital, HHR recruitment.