Ontario Health Teams Central Evaluation

Closing the gap between program implementation and system design: Exploring how implementers and system stakeholders approach the development of Ontario Health Teams

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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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Introduction

Ontario's Ministry of Health (MOH) introduced a new integrated care initiative, Ontario Health Teams (OHTs) in 2019, with the aim of reforming healthcare delivery. At maturity, it would involve health care and social service providers working together across sectors to deliver clinically and fiscally accountable coordinated care, with the engagement of patients, families and caregivers. A low-rules environment was in place during this early phase, to accommodate local priorities and experimentation. Therefore, while OHTs could define the patient populations for which they planned to be responsible in the first phase of their implementation journey, their eventual aim was population health management – every Ontarian would belong to an OHT that provided them with seamlessly coordinated care across the hospital-community continuum, from cradle to grave.

The Health System Performance Network (HSPN) was funded by Ontario's Ministry of Health (MOH) to lead an independent, centrally coordinated evaluation of OHTs. This involved a formative phase (2019 – 2020) focused on understanding participants' experiences of early OHT development[1] and a developmental evaluation (DE) phase (2021 – 2022) that researched and guided the development of six OHTs[2]. While this work shed light on the internal, local-level challenges many OHTs were wrestling with (from the preponderance of solo physicians in certain geographies to the dearth of trust in others), it also revealed that a key challenge shared across OHTs was, in fact, external in nature – anxiety about the system and policy environment within which OHTs operated.

While OHTs were navigating integration on a new scale, the systemic structures required to support this change were themselves under transformation. In 2019 – the same year the first cohort of 29 OHTs was announced [3] (there are now 58 OHTs across the province)[4]– the provincial government announced significant structural transformation in the broader health care landscape. The province's 14 Local Health Integration Networks (LHINs, regional authorities responsible for the health services of a geographically defined population) and other key healthcare institutions would move over to a newly created "super agency," Ontario Health (OH), which would have the task of overseeing the health care system's planning and delivery.[56]

Over time, OH organically developed a "corporate" and "regional" structure designed to coordinate and deliver both central and locally-relevant supports. Meanwhile, responsibility for home and community care delivery would transfer to - Home and Community Care Support Services (HCCSS)7, until these services could be gradually transferred to OHTs themselves. Key OHT-related policy and guidance was also being developed during this time. This included the modernization of the Personal Health Information Protection Act (PHIPA) regulations to facilitate the sharing of patient data within OHTs. The task of implementing and supporting health care integration was therefore one undertaken in a changing landscape by both OHT and system stakeholders.

This phase of evaluative research therefore focused on identifying OHT stakeholders' concerns about the system and policy context and understanding how system stakeholders responded to these concerns and where their own concerns lay.

Methods

We conducted 18 hour-long semi-structured interviews with system and OHT participants from November 2022 to February 2023. Reflecting our focus on the system and policy context, six were conducted with OHT participants, 10 with system stakeholders and two with participants whose positionality crossed OHT-system boundaries. OHT participants were largely key leaders of their OHTs, while system participants crossed a range of units, levels and areas of expertise of both OH and the MOH. None of the

system participants included were politically appointed; all were career professionals and bureaucrats working at different levels of the health system.

Our lines of enquiry were guided by system-related insights gleaned from the DE phase and validated through an in-person symposium that brought OHTs that participated in the DE together in September 2022 and a subsequent webinar attended by a broad array of OHT representatives in October 2022. OHT interview participants were invited to specifically reflect on system-related encounters, concerns and successes during OHT development. System participants were invited to comment on OHT reflections as well as share their own concerns and successes relating to the policy and system context. The reflections of the two participants who crossed OHT-system boundaries are reported within the grouping with which they best aligned, and separately, when their views substantially differed from both. Interviews were conducted by three researchers. They were then transcribed, thematically coded and iteratively analyzed.

RESULTS

OHT and system participants identified system-related gaps, responsibilities and remedies in four areas: 1) setting direction and the levers to enact change, 2) accounting for local priorities while encouraging standardization, 3) the role of and responsibility for funding, and 4) system-related roles and relationships. The views of system and OHT participants are presented in tandem and provide insight into how differently located participants prioritized and gave meaning to different aspects of OHT design and implementation. The "quotes" that introduce sections voice the collective, synthesized views of participants, rather than that of any single individual.

1. Setting direction and the levers to enact change

OHT perspectives

"We lack direction and the levers to enact change."

The perception of a lack of direction and the inability to enact meaningful change was felt in a range of areas, affecting progress in governance, homecare, the digital arena, performance measurement and primary care. Progress in **governance** was particularly hampered: "Without any governance direction from the Ministry, why are we rushing ahead?" (P7) OHT participants asked. They worried about committing too much energy and resources to a not-yet sanctioned course of action, only to be told to go back to the drawing board. In November 2022, the MOH responded to this often-levelled critique by calling for OHTs to form not-for-profit corporations to enable then to realise clinical and fiscal accountability [8]. However, this too was seen as lacking the level of specificity required to make it actionable:

> …they [MOH] were, "Every OHT, you decide on your own governance model." And you know what? It's a mess. […] They now think they've landed on a solution, which is incorporation. […] It's like saying, yes, you need a house. Great. How many bedrooms? How many bathrooms? How many floors? How big? How small. What's in it? What's not in it? It is a shell. (P15)

Similarly, the many **digital** initiatives enabled by the funding opportunities announced by OH were seen as tests of change that risked creating chaos and wasting resources, as there would be many OHTs that "invested in digital tools and solutions that won't be part of the larger provincial strategy" (P6).

OHTs were also uncertain about what the future state of **Home and Community Care (HCC)** would look like under an OHT umbrella. OHTs were waiting for direction on everything from "where do the contracts go, and who holds them" to understanding how to "navigate the navigators" (P10). "Not knowing what [PHIPA] legislation was going to look like" resulted in them being "handcuffed" and "put them in an unbelievably tough situation," a participant said, noting that the HCC sector was often left out of founding partnerships and decision-making tables (P6). Therefore while HCC was present at some OHT planning tables in project-specific ways, it could not be more holistically involved in the redesign of care.

Performance measurement was another area that confounded OHTs - many did not fully understand what should be measured and what tools were most appropriate for the task. The population-level data (that included data on ALC, ED visits, and preventative visits, all in one place for the first time) provided by OH to guide implementation was also confusing; "I don't think the group understood how to use it," said an OHT participant (P10). Another spoke of the challenge of being asked to figure out what to measure before they had a clear sense of their own priorities, in the absence of external direction: **"**Without that direction piece […] a lot of the early struggles […] were just understanding what questions we should be asking ourselves." (P6)

Many OHT participants also worried about the constraints imposed on **primary care** by certain physician payment models. They found it difficult to engage fee-for-service solo physicians who lacked an incentive to be engaged, in contrast to their blended-capitation and salaried counterparts who were already working in teams or community health centres. A participant wanted to see the MOH incentivizing the integration of solo physicians and Family Health Organizations (FHOs) within FHTs:

> … if you actually had FHOs attached to a family health team, think about the power in hiring residents? […] you're seeing more patients, and you're getting more learners to become primary care. […] think about how powerful they are then [if] your family health teams are tied into hospitals? (P7)

The perceived lack of systemic incentivization required OHTs to develop incentives on the local level. This took forms such as offering staff training, QI assistance, shared resources and stipends for attending meetings. Despite this, engaging primary care physicians – beyond the dedicated few who led or participated in working groups, on-the-ground initiatives and regional tables – was an ongoing struggle for many OHTs. Challenges included a perceived lack of relevance and value, exacerbated by lingering anger over historical unilateral fee cuts and cynicism that the OHT initiative would be met with the same dubious success that prior initiatives such as Health Links had been. It was the reason the Ontario Medical Association (OMA), while supporting integration itself, had not yet officially endorsed OHTs: "we're really big on integration, but OHTs are a government thing, and we're a little suspicious of the government" (P15).

System perspectives

"Our understanding of available supports and end-state vision helps mitigate our concerns."

While many system stakeholders shared the anxieties of their OHT counterparts, they also had a deeper understanding of current and planned systemic supports, as it was they who were leading its design. This helped temper some of their concerns. System participants, for instance, knew of a recently launched business intelligence platform where real-time attribution data would inform OHT decision-making on which populations to focus on, with whom they should partner, and where patients should go for care (P9). They knew of infrastructure planned to enable funding envelopes to be issued more predictably and

equitably, and of efforts to track demands being made of OHTs to mitigate the "mass confusion" resulting from different groups reaching out to them separately (P8). They spoke of an OHT Liaison Committee that had been formed to co-design an engagement framework and set expectations for how communication should take place with OHTs (P8). And they had in-depth knowledge of the availability and potential of the provincial committees and working groups where OHT stakeholders could meet monthly, receive updates and provide input into the design of initiatives (P1).

Some spoke of work being undertaken at a provincial level to bring together multiple data systems into a single repository, create hubs, networks and system awareness, enhance access to expanded services and encourage a "feeling of togetherness" for physicians currently siloed within their own payment models. Indeed, system participants displayed a keen awareness of the need "to create the business case for the health service providers to actually engage in that work" (P1) and were aware of systemic efforts to incentivize physician interest in the OHT model. They pointed to the guidance provided under the MOH's Digital First for Health strategy, the development of a regional approach to online appointment booking and the leveraging of regional delivery partners to help with change management and reducing administrative burden for OHTs.

There was recognition that a recent MOH announcement on governance would spawn multiple OHT workstreams and generally "require unpacking." However, while OHTs worried about how to go about implementing this guidance, system participants were working behind the scenes to advance implementation: "The Ministry and OH have plans to support the bringing in of legal expertise at a provincial level to assist in the development of guidance and templates and tools that will help teams to approach this activity in a more consistent manner," a participant said (P8) - information that would have been welcomed by OHTs.

"OHTs need to spend time learning and building capacity first"

While system participants had a good understanding of available system supports, they were concerned that their OHT counterparts did not. This gap was observed in everything from home care and population data analysis to collaborative partnerships and funding. System participants knew that HCCSS provided a wide range of services, from intake, triage, service navigation and care coordination to updating Healthline and contracting services to approved home care delivery organizations. It was a "behemoth of an organization" that "provides a lot of services in a very complicated and convoluted way very well," as a participant noted (P12). System participants worried that the infrastructure needed to seamlessly support over 700,000 visits a day "may be invisible to OHTs" (P5). Perhaps OHTs could figure out what they did and who they served while waiting for clarity on the future of HCC, suggested a participant.

System participants were also concerned that OHTs didn't understand how to centre primary care – a cornerstone of the OHT model [9] – without excluding other sectors, resulting in unsuccessful funding applications developed in silos. This could happen when primary care drove decision-making, with the acute care sector worrying about being seen as taking over, while other sectors such as LTC were sidelined. "Now it's all about primary care […] we've swung a little bit too far," said a participant who wanted to bring acute care specialists back into the fold (P15).

There was also a broader sense that some OHTs lacked an understanding of how funding worked – both in terms of submitting successful funding applications and administering funds to partners in the future. A participant described helping an OHT understand how to approach funding applications:

> …. you have providers who don't know the system very well. […] So they would say, "Oh, well, if we get a funding letter, we can only do what's exactly in the funding letter. And we wait until the Minister requests something, and then we respond." And so I said, no, no, we actually need a plan [aligned with MOH/ OH direction that informs funding proposals]. (P10)

Another participant worried that in a future state where OHTs had to "actually collaborate and administer scarce resources" to realise savings, they would not "have the capability and capacity and the ability to administer funding to partners" (P9) and spoke of how communities of practice that provided OHTs with financial and risk management skills could help mitigate this. There was also greater concern from system stakeholders than their OHT counterparts that OHTs did not truly understand how to analyse the population level data packages or harness the performance measurement expertise available to them.

In fact, a key benefit of the early low-rules approach and the pace of guidance for the few system participants comfortable with it, was the time it afforded to build capacity, relationships and knowledge. An early direction heavy approach would have tempered enthusiasm and participation, worried a system participant, and "the act of trying to sit around a table and determining how you're going to work together is an important part of a team's formation rather than just getting a sheet of instructions…" (P16). Yet another participant spoke of the very success of the OHT model as contingent on this "slower evolution":

> That is probably perceived as government barriers to things. […But] you're trying to nudge Jell-O along. […] simply moving all of the levers to the OHTs is not going to do anything. That's just re-creating the 50-some LHINs. So it's how do you create the cultural differences of integration and population health management integrated care that will stick? […] as a bureaucrat, I'm very comfortable in this type of zone. And I know that people on the frontline of planning and delivery are like, "You've just described a nightmare to me because you're giving me no clarity." I get that. But […] there's no shortcut by simply saying, "I'm giving you this […] and that will make everything else happen." (P5)

"Our inability to tell OHTs how to get to the end state concerns us, but is beyond our control"

The majority of system participants, however, validated and empathized with OHT participants' desire for greater structure and direction. Their inability to provide guidance worried many of them as much as it did OHT participants. The demand made of OHTs was like "expecting them to climb a mountain with no gear, with no people coaching them, and potentially without any funding to help support them," said a system participant (P1). The "choose your own adventure" approach had resulted in the lack of "a common thread to be able to scale and show impact," said another (P9). They felt that the 'what' (a clear vision of OHT end state) had been articulated, but not the "how do we get from here to here," resulting in an environment that was "a little bit Wild West-ish." (P14). How would public and private assets be incorporated, for instance? Would legal support and base funding to support incorporation be forthcoming? How would specialists negotiate the complexity of servicing regional geographies rather than a single OHT's attributed population? (P12). They were also aware that the variety of physician remuneration models and billing restrictions challenged participation at meetings in general, and solo practitioner engagement in particular. As a system participant noted, "it's very challenging to require 'involvement of primary care' and at the same time not have the mechanisms in place and the system to support that to happen" (P12).

System participants spoke of the time, effort and political will that policy decisions required. Bringing in HCCSS providers into primary care offices where they could support a wider population "has taken a very long time, and is very political" (P1), said a participant. Another noted that service providers being compensated differently in different settings for providing the same service would need to be resolved, but "from a policy perspective, we're maybe not ready to have that conversation yet because of the current fiscal situation that we find ourselves in" (P11). Yet another noted that OHTs should focus on "articulat(ing) the value proposition of OHTs" rather than waiting for incentivization through changes in physician compensation, as it was "a really hard lever to pull" (P16). They were simultaneously concerned and pragmatic about their inability to provide the roadmap OHTs were clamouring for:

> We haven't committed all of the steps to the maturity vision […and] that's what keeps me up at night. […] And our inability to be very transparent about that is to be expected [because…] if you set out every step of the way, out to the very mature vision, there are some very hard policy decisions to be made, very big things to move. [This is partly because of…] the politics, but it's very big, difficult stuff [and] I don't know that there's yet comfort in taking those steps (P16).

Despite their location within the system, system participants saw themselves as constrained by a range of factors beyond their control. This included policymaking cycles and opportune time windows within which policy decisions could be made, their ability to only contribute to certain parts of policy documents and their need to adhere to "government speaking points" when speaking about OHTs (P17). Filling the "void of what goes beyond the eight building blocks" and clarifying how OHTs should navigate the implementation supports that were rolled out was seen as "decisions government needs to make":

> … it's with the government to make a decision about whether it wants to change how homecare is structured**.** And it's up to government to decide whether they continue contracting. […] I see my role as dealing with what decision gets made and making the best out of it. (P17)

The recognition of the limits of their ability to enact change did not prevent participants from worrying that the inability of policy decision-making to keep pace with OHT development would get in the way of the realization of the promise of OHTs:

> What keeps me up at night is […] the realization of OHTs in general, that they're not going to get to a place of maturity, and that another government's going to come in and say, "Yeah, that failed." Another thing that we tried and failed. […] The people […] are into it [….] And it's almost like we policymakers stand in the way. (P11)

2. Standardization in the context of heterogeneity

OHTs were concerned about the relevance of standardized performance indicators to their local contexts. Moreover, OHTs in rural geographies and those with predominantly Indigenous partners were concerned more broadly about the ability of a provincial template to account for their needs.

OHT perspectives

"Certain expectations do not make sense in our local context."

While the majority of OHTs bemoaned the lack of specificity as seen above, guidance, when provided, was not universally welcomed. Many OHTs were taken aback by Collaborative Quality Improvement Plan (cQIP) measures (intended to improve population health outcomes) announced by the MOH after they had developed implementation plans, requiring them to develop new initiatives or creatively incorporate these measures into existing plans. There was a lack of understanding of why specific measures had been selected and questions about their relevance to local contexts:

> … Some of them [cQIP measures] we found were probably a lot hospital-focused. So the ALC stuff, etc. […] I didn't understand why they would tackle [mammograms in particular]. Why would

> we be sending out letters again when Cancer Care Ontario already does that? […] I'm just surprised they didn't get more granular in terms of like "this is what's in your catchment area that you should be focusing on" (P7).

Primary care participants, in particular, felt that they were being measured based on how the acute care system was performing, that merely ordering mammograms and pap screenings – procedures that required mechanical button pushing, with backlogs beyond their control – had little to do with the actual work of improving population health.

An Indigenous perspective

An OHT with predominantly Indigenous partners were additionally concerned about how rigid guidance on governance may thwart local priorities:

> … we're very grounded in our Seven Grandfathers teachings. And so with that comes consensus. […] We knew we wanted to be highly Indigenous-led in our leadership principles. So that's not going to come by way of a provincial template. (P2)

This OHT also had to contend with its inability to share data across the provincial border where many of its residents sought care, in addition to meeting First Nations data sovereignty and privacy requirements. It was also unable to easily leverage the work done in urban centres that used postal codes attributed to smaller geographies to help OHTs understand their populations, when they had heterogenous communities spread over a geographic swathe that shared a postal code. This led to a call for a "different formula of how we do population health management that extends to those variations and differences" (P2).

System perspectives

"Working out how to balance standardization with contextual heterogeneity is top of mind."

System participants were glad that things were slowly shifting from "the space of choose your own adventure […] to one that is a little bit more prescribed" (P8). They knew that OHTs could differ significantly in size, some being responsible for populations ten times larger than others. They knew that rural and Indigenous OHTs, in particular, lacked the same access to Health Human Resources (HHR) and the range of health care services that their urban counterparts enjoyed, and that they were unable to hire key health providers, impacting their ability to offer best practice care. System participants spoke of the need to "set parameters" while allowing for "local flavour" (P9). This was unknown territory – how should they respond to OHTs that asked them if a non-profit really was the only way forward, they wondered? Could it be replaced by a well-working contractual relationship? How would that be evaluated? Essentially, "can we be supportive of those that want to do things a little bit differently because of the differences in geography, the differences in capacity, the differences in cultures?" (P11). In essence, they worried about how to balance standardization with contextual heterogeneity:

> … we do want OHTs to take a PHM approach. Which means, by default, there is a localness to it, a specificity to their own population. But at the same time, there will never not be provincial

> priorities for the health system. So I think that that is a tension that remains, and OHTs are in the middle of it. And we will have to find a way to manage that tension. (P16)

At the same time, there was concern that a lack of standardization might compromise equity, leaving some patient populations without access to the same type and range of services available to others. Creating standardized expectations around OHT size at the outset could have helped, a system participant thought, instead of “pawning it off on the OHT to go and figure it out locally” (P9). OHT success might hinge on future policy-level guidance, another system participant noted, given significant population differences between OHTs:

> At the end of the day if we want to be successful, we have to say “You're going to have a mental health clinic, you're going to have a chronic complex clinic, [etc…] and these are the programs and services that you need to offer as a set of services for your OHT.” (P1)

Some system participants were concerned that the small-scale of some OHTs would prevent them from realizing efficiencies, ultimately requiring broader partnerships and possibly further amalgamation. The choice facing system participants appeared to be either: “be more flexible in the standards around what is required” or “think about models that span more than one OHT” to ensure that everyone received a similar level of integrated care (P9).

“Quality improvement indicators were meant to signal expectations, not judgement”

While OHT and system participants shared a broader concern with balancing standardization with local needs, system participants had a more positive view of standardized cQIPs than their OHT counterparts. A participant spoke of them as an evolutionary milestone – OHTs had first been asked to identify what was important to them from an implementation perspective, and then a collaborative quality improvement plan was put in place. With funding attached in the future, it would evolve into performance measurement, and it was then that questions about whether the right things were being measured could be asked. Despite criticism of the local relevance of cQIPs, therefore, the evolution towards standardization was seen as “an opportunity for us to be saying something collectively” (P11).

In addition, system participants noted that cQIPs were not meant to induce OHT anxiety about being judged and compared. Instead, they were meant to be “a vehicle for discussion about change ideas” (P8), a lever to incentivize partnerships and accountability:

> … the indicators were a way to start signaling our expectations for OHTs […] it wasn't that we would expect an OHT to be able to have all of the levers to drive the changes. But they have some. And the members need to look around at themselves and say, “Oh, this is a system priority. I'm one of the people who can actually affect it. Am I pulling my weight here?” So it’s a real, I think, important signaling exercise and a way to give the OHTs a lever over the partners by saying, “We're on the hook for this. What are we doing? […] So we were really pleased to be able to start to do that signaling. (P5)

3. Responsibility for funding

OHT perspectives

“We need adequate, sustained funding to make a difference”

The lack of sustainable funding was an often-heard challenge among OHTs. At inception, OHTs received $375,000 to fund human resources and performance measurement and expand digital care[10]. In addition, they received Transfer Payment Agreements (TPA) funding and project-based funding, if they were successful in the myriad funding opportunities announced by OH. These calls, described as “the bane of our existence when they come out with a two-week turnaround,” (P10) typically funded IT-related limited term initiatives and required rapid proposal and business case development, leaving little time for inclusive collaboration.

OHTs found the funds available to them inadequate to meet their needs, key amongst which were project management and decision-making support. They needed help with understanding data provided to them and figuring out how to prioritize needs. Some supplemented their funding by asking partners to contribute to a shared coffer. Short term funding particularly challenged OHTs’ ability to plan long term and led to anxiety about human resource retention:

> I feel like these people that I've hired are like unicorns that wake up every single day and dedicate their whole life to progressing this model and working with our partners. And they've developed this trust and this relationship. And I'm terrified that because they don't know whether or not they have a job in August, that of course they would leave. (P4)

Funding also could not be carried forward to subsequent years at first, resulting, for some, in the creative negotiation of TPAs.

The lack of integration across sectoral funding sources was a further complication. Housing and health dollars were siloed, challenging OHTs’ desire to intervene in this nexus. In fact, hospitals, LTC homes, communities on reserves, and municipalities all had individual funding envelopes from different sources, with the potential for competition and conflict. And physicians working within different models were funded differently, with models that rewarded volume-based care at odds with the OHT model’s privileging of preventative care.

System perspectives

“OHTs are about value-based care; they need to generate value themselves”

Some system participants empathised with OHTs’ funding challenges. “We understand deeply,” said one, explaining that the sporadic flow of funding was tied to its interlinkages with politics (P8). However, while OHT participants emphasized the challenge of accomplishing their task with available funds, system participants largely wanted to remind their OHT counterparts that “OHTs have a genesis in value-based care […] and one of the aims in the quadruple aim is value” (P16). True sustainability, they thought, came when funds were not externally provided but rather generated from within. OHTs would realise value, they hoped, through integration, reducing duplication, pooling money and adopting a population health management approach. “Good OHTs […] have partners that kick in significant in-kind supports,” a

participant said, and while early MOH-provided implementation funding was needed, it was "not a forever solution":

> …the teams have to be extracting value back out of the system. […] We probably have to enable that to happen in certain ways. But I think that there are a handful of teams that say this is worth it so much that even if the Ministry stopped funding us, we'll still find a way to continue this work. I like that attitude a lot. I think you find that in the stronger teams who really believe in the model. (P16)

As participants explained, by keeping patients out of hospital, OHTs could move money currently locked in the acute care sector to other sectors offering care at cheaper rates while freeing up funds for reinvestment elsewhere. A future state would also involve OHT savings being retained and reinvested rather than clawed back by the MOH. However, an initial, sustainable injection of operational funding might be needed to help OHTs arrive at this point, creating a chicken and egg situation, as a participant noted. Moreover, OHTs' ability to have control of their own funding in this manner was yet to be realised. As a participant noted, "the whole value chain is broken because they're not a closed ecosystem. […] You are not rewarded for doing the right thing" (P1). However, the recently issued direction to form non-profit corporations with designated operational support partners tasked with back-office functions was seen as a first step to enabling OHTs to control their own funding, which in turn would minimize their dependence on MOH funding. As a participant noted:

> … this notion of an operational support partner reflects the government's lack of desire to end up having 54 […] budget lines. […] I think we are seeing and should anticipate the trend of finding resources from within the system. […] there has not been an appetite in the last two government mandates for money-based funding requests, unfortunately. (P8)

Alternative perspectives

"Focus on integration, not funding"

The two participants who had experience of both OHT and policy contexts situated themselves outside both worlds. Funding wouldn't address the dearth of knowledge and capacity of some OHTs, or replace the need for system-level supports, they suggested. There were OHTs that didn't understand how to leverage resources available to them – from coaches and performance measurement experts to population level data. Their focus on their local communities came at the cost of a "sophisticated… understanding of the system and how it's funded" (P10). Moving to an Accountable Care Organization (ACO)-like model with funding risk, was yet another layer of complexity:

> … it's not all gravy of more money, more money. And we in Ontario haven't experienced that before, where you actually have gain sharing, but you have loss as well. So that means if you are not performing, you move money from one place to another. You don't just advocate to the government, saying, "I need more money." […we also] need the structure above us, like a regional health authority, who's willing to break some eggs on this one. (P10)

Prioritizing funding, they suggested, would also not work for OHTs as they did not have defined geographical populations, making it difficult to create accurate risk-adjusted models. An alternative

solution, suggested a participant, was to remove funding from the equation, and focus instead on identifying gaps in integration and providing guidance on how they may be addressed.

> …take money off the table, focus on integration. […] the government thinks it's all about money. It should be about integration, and then investing where integration is not happening. [… Similarly, with health care providers across sectors], every single conversation begins with two words - more funding. [Instead of …] what are we trying to achieve? What are the steps that are necessary to achieve it? And where can we invest in those steps to effect the change? […] Is it you don't have equipment? Is it you don't have enough beds in your hospital? Is it home care's uncoordinated? (P15)

Furthermore, unlike in the UK's clinical commissioning support units, there was a lack of tangible change management supporting integration:

> … they go in and they help with a clinical commissioning group. "Here's how you send procurement. Here's how you set up your finances. Here's how you deal with your HR. Here's how you set up your communications." We have no OHT support team. There should be a Ministry branch which is, "We're going to come in and tell you, here's what you need to do. […] Here's how you define what is lacking based on the pathway within your region. And here's how we're going to give you the access to the money you need." (P15)

4. Roles and relationships

OHT perspectives

"We are confused about system-level roles and uncertain about their value"

OHT participants attended meetings not only at their own OHTs, but also those organized across OHTs, in addition to the multifarious webinars, meetings, workshops and communities of practice organized by the MOH, OH and support organizations such as Rapid-Improvement Support and Exchange (RISE), HSPN, and Accountability, shareD leadership and goVernANCE (ADVANCE). The roles and linkages between these different stakeholders were often unclear. This was particularly a concern as it related to OH, which as one participant noted, had "too many tables," with different tables catering to specific sectors, programs, projects, and OHTs (P10). These tables often tackled the same things OHTs had been tasked with, but at a regional or provincial level. However, there was often little communication and liaison between them:

> … I asked the OH [clinical population-specific] lead to come to the OHT and present. And when they did, it was a kerfuffle, of course, because everyone's like, "What! All this work is happening! What is our role? If that's your role to develop all the pathways and all these things, what the heck are we doing here?" (P10)

This participant was concerned that "multiple accountability is no accountability." In fact, "I don't really understand OH's role" (P7) was a frequent refrain across OHTs. This confusion was exacerbated by uneven communication between OH and OHTs:

> Half the time I reach out to Ontario Health, I get no response. Which is actually painful for me because that's where I came from, and I have relationships with these people. I think it's just maybe because no one has any answers anymore. (P4)

In this perceived vacuum, OHTs reached out to other OHTs for help. This made OHT participants wonder "how do you take what you've learned and really extrapolate it to all other OHTs" in a systematic way (P7)?

An OH "relationship manager" had in fact been assigned to OHTs, a role that was meant to act as a conduit between OH and OHTs. However, some OHTs found the role redundant. ""It feels like they're listening to our complaints, and then it goes nowhere," said an OHT participant (P4). "Don't even ask me what their name is," said another, "we're on our own" (P7). Yet another OHT participant could not understand why the seamless process of reporting directly to the MOH had now changed to one featuring "lots and lots of people with lots and lots of big titles" (P2). It seemed to them that their relationship manager was simply relaying emails the participant already received and translating messages from MOH and support provider meetings that a designated OHT member attended anyway: "I can read my own email […], we didn't need anybody to translate for us" (P2). OH seemed like a recreation of LHINs – the very structure that the province had recently dismantled:

> We got rid of the LHINs and now we've created OH. Why did you get rid of the LHINs then? […] I don't understand the need for the layers. […] give them [the role of] OHT executive lead, and we'll go back to our desks. […] it just seems like we have [positions] that are funded by OH through our funding. If we don't need that, that's money that can go elsewhere. (P2)

In this environment, a participant who crossed the system-OHT divide, appeared to be able to make a difference. They were able to explain to OHT participants that "OH is not an enemy […] they're not just your funders and your performance administrators, they're your partner in planning" (P10). OH was therefore invited to meetings at this OHT, despite a past tenuous relationship. They hoped it would not only allow OH to provide input into OHT development, but also help OH understand OHT challenges, such as that of bringing multiple providers together to collaborate, approve and endorse proposals within short timelines.

System perspectives

"We understand our roles and need patience with the evolution underway"

System participants were far more tolerant of the role-related uncertainty in the system landscape than their OHT counterparts. OH, system participants said, was new; it had been introduced at the same time as OHTs and had involved the merger of 22 organizations. Ministry operational functions would transition to the newly created organization, which also had the task of doing much of the work once done by the 14 LHINs, while building regional expertise and seamless coordination across regions. Furthermore, OH Regions were even newer than OHTs themselves, participants said, as they had not been part of the original OH/ OHT design. Things were therefore "very much evolving" (P11), and it was inevitable that "there are growing pains that come with that" (P8). Participants wished everyone would "take a deep breath and recognize it's a maturity pathway and be a supportive partner so we can co-design the future together" (P5).

Perhaps unsurprisingly, system participants also had a clearer understanding of system roles and how the MOH, OH Corporate, OH Regions and OHTs worked together. The Ministry were the funders and the

policymakers, they said, while OH were the operators, operationalizing TPAs, data and clinical pathways. A participant explained the relationship as follows:

> … the Ministry sets the policy. OH Corporate says, "Okay, this is how we will roll this out in the province." And the Regions say, "Okay, here's what you need to know about rolling it out in this geography with these people" (P12).

OH Regions also "knit services together," and provided "insight into where gaps exist," acting as a "navigation service" to help OHTs figure out who they needed to partner with to provide care (P9). OHTs too small to provide specialized cardiac services or have their own endocrinologist could be referred to regional partners. Some participants also spoke of OH's role in trying to "advocate" and "influence" by "remind(ing) our ministerial partners that ongoing funding will be needed to keep these teams going" (P8).

While they had greater clarity about the scope and inter-relationship of their roles, many system participants were aware that OHTs found the newly designed OH structure obtuse and difficult to navigate. "Does it matter who does it," asked a system participant, as long as OHTs know that "if they need something done, they can ask one of us and we'll try and figure it out?" Yet, they too acknowledged that "there will become a time where we're going to need to clarify and carve out specific roles" (P11).

"The value of system partners is not fully recognized"

While system participants largely took a more tolerant view of the system-in-transition, a few agreed that structure, efficiency and transparency could be improved and resources could be better aligned to support front line transformation:

> OH is building its structure upside-down, we are too top heavy. […] you need the bodies and the teams on the ground working with the providers because that's where the magic happens. […] But look at our corporate teams at OH. Wow! Like we have teams that help teams. […] If you notice, we don't share organization structures either. (P12)

Yet, they simultaneously thought that OHTs did not understand the value of OH and its regions. Participants were aware of a tension between some OHTs and OH Regions in particular. The narrative around the need for a transition from LHINs to OH and its regions ("LHINs were the fat in the system and needed to be removed") had resulted in a power struggle. As a participant noted "there was a period of time where OHTs said, 'we will replace the LHINs. You don't need the LHINs. We will be the LHINs'" (P12). System participants felt that this was the result of an incomplete understanding of the role and potential of OH Regions.

This discrepancy in understanding was visible in the different attitudes of OHT and system participants to the relationship manager role. System participants appeared unaware of the depth of their OHT counterparts' feelings of redundancy about the role: "I'm sure the OHTs feel, that we are way more hands-on than any LHIN ever has been," said a system participant, "we are the feet on the ground working with them, if they need something, they can come to us" (P3). The work of relationship managers, system participants said, included supporting funding proposals, gaining input from OHTs, flagging key messages such as funding opportunities for OHTs, helping individual organizations navigate challenges and working with organizations that were yet to become formal OHT members. A key part of the role involved filling gaps in communication and knowledge translation between MOH and OHTs. The recent MOH guidance on "next steps" had resulted in myriad questions from OHTs, for instance: Were OHTs supposed to start tackling all identified conditions at once? Should they go out and get legal advice about incorporation? A relationship manager could calm anxieties by letting OHTs know, for instance, that

certain teams with leading practices had already been identified as pilot sites for pathways, with the intention of spread and scale over time:

> …because this OHT wasn't a pilot site or a leading project site for either of the two pathways that have already rolled out, they just hear it differently. They're not aware that, oh, okay, this is already happening. (P12)

Indeed, relationships with system stakeholders were not uniform across OHTs. OH worked more closely with some OHTs – those selected to implement promising homecare models, for instance – leading to a closer relationship between system stakeholders and select OHTs.

OH Corporate, meanwhile, was aware of "hostility from OHTs towards the OH Regions," and felt caught in the middle. Some OHTs thought of OH Corporate as an "escalation tactic," which put an OH Corporate-based participant in "a very, very awkward position" due to the assumption that they had a mandate that they did not feel they had (P17). Instead, an OH Corporate participant saw both OH Regions and OHTs equally as clients, and thought OHT hostility was misplaced:

> … in an ideal state, they see their OH Regional counterparts as sources of regional expertise, as allies in their entryway to OH, and as a really positive source of information, and brokering across OHTs. I know that is not how OHTs see OH. But […] OHTs have maybe an unrealistic expectation of the level of administration and control they could have at the scale that they currently exist at. (P17)

Certainly, thinking of OH Regions as "allies," let alone as the driver of efficiency was far from the minds of most OHT participants.

Discussion

OHT participants voiced four specific concerns about the system: a) the inability to forge ahead confidently with program implementation given uncertainties in a system environment that was itself still under construction, b) the perception of imperfect alignment between local needs and provincial priorities, particularly as it related to performance measurement, c) the need for adequate and sustainable funding in order to make a long-term difference, and d) confusion about system-level roles and relationships. System-level participants were somewhat familiar with many of these concerns – they had been communicated by system support stakeholders and voiced by OHT participants themselves at multifarious meetings and symposia over the last couple of years. However, partly due to their association with government, system participants were unable to freely share their responses to these concerns. OHTs, therefore, were far less familiar with how system participants approached these concerns, and if they had any of their own. In response to OHTs' concerns noted above, system participants wanted OHTs to know that a) while they empathised with the need for processual direction, it was beyond their control, and in the interim, there was much knowledge and skill that OHTs themselves needed to acquire, b) balancing local and provincial priorities was top of mind, c) OHTs need to focus on generating funding from within through savings from providing value-based care, and d) confusion about roles and relationships was due to the transformation underway, and could be mitigated with patience and an understanding of the value of system-level roles and structures.

Both OHT and system participants shared a lack of understanding of the other. OHT participants, for the most part, did not look at the transformation under way from a health system perspective; their focus on

local priorities often came at the expense of an understanding of those of the health system. OHT participants had a tendency to see themselves as separate from the system, and sometimes even in competition with parts of it. This was exacerbated by the lack of communication and translation by system stakeholders. And exceptions apart, OHT participants lacked an understanding of the limits of their own capacity and knowledge. Meanwhile, system participants were not cognizant of the importance of communication and translation. They seemed unaware that the motive behind chosen performance measures had been misunderstood, and that it was not enough for system-level stakeholders alone (alongside select OHTs) to know about plans for the future and have role clarity; that OHTs not knowing these things did matter as it affected these teams' confidence in forging ahead with implementing OHT vision. System participants expected OHTs to understand the importance of identifying and filling knowledge gaps and generating value from within without explicitly reiterating this need and guiding the work required to get there. Finally, while they understood the importance of demonstrating the value of OHTs to physicians, they lacked an understanding of the need to demonstrate the value of Ontario Health – and OH Regions in particular – to OHTs.

Recommendations for System Supports

The recommendations that follow are aimed at bridging gaps in communication, translation and value-demonstration that were highlighted in the interviews. Recommendations focus on system stakeholders as those focusing on OHTs have been discussed at length elsewhere[2].

1. Build trust through communication and transparency with OHTs.
    a. Share ongoing and (where possible) planned designs and initiatives to mitigate OHTs' anxieties about the lack of a plan at the system level and as a reminder of end-state vision.
    b. Build even relationships with all OHTs as much as possible, so that those that are not pilot sites for various initiatives do not feel left behind.
    c. Don't assume OHTs have the same understanding of the logic of system planning that system stakeholders do. Share the motives, hopes and challenges of system stakeholders with OHTs where possible, and partner with them to negotiate/ realise them together.

2. Set clear expectations about what the system expects of OHTs and what OHTs can expect of the system.
    a. Reiterate the expectation of value generation and work closely with OHTs to help them realize this goal.
    b. Clarify the purpose and planned evolution of quality improvement indicators to alleviate OHT anxieties about their present inability to show significant improvement on certain indicators.

3. Demonstrate the value of system-level structures, supports and roles
    a. Clarify the roles, capacities and functional boundaries of OH Corporate and OH Regions as they relate to OHTs, to mitigate confusion about responsibilities (E.g. role played in providing advice or bringing providers together to advance integrated care pathways).
    b. Clarify the capacities and functional boundaries of system-level roles OHTs often encounter, to help OHTs understand their purpose and potential, and to manage expectations. (E.g. Relationship Managers).
    c. Encourage the embedding of OH at OHT tables in a meaningful and systematic way.

4. Work with OHTs to identify and address gaps in knowledge and capacity.
    a. Work closely with OHTs in a system-endorsed, tailored way to identify and address knowledge gaps and capacity-building needs, whether in relation to partnerships or performance measurement capabilities.

   b. Monitor the needs of OHTs with contextual factors that affect capacity-building (E.g. Indigenous or rural OHTs), as part of an equity-driven approach.

5. Establish or endorse individual and common supports that OHTs can draw upon.
   a. Establish new or endorse existing supports to provide OHTs with shared skills and resources for leadership and front-line implementation (E.g. in areas such as governance, performance evaluation, data, etc.) that they can systematically draw upon with confidence that they have system approval and cross-OHT applicability.

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