HSPN Health System Performance Network

OHT Leading Projects

Pre-Implementation Phase

Facilitators & Challenges of Implementation:
The Experience of Home Care Leading Projects

Fall 2024

Objective

What are the facilitators & challenges experienced by the Home Care Leading Projects, as they planned for implementation?

Methods

Data Collection: April – October, 2024

Document Review

Applications, logic models, etc.

All projects (7)

Meeting Observations

Project specific meetings (monthly)

Cross-OHT planning and evaluation meetings (monthly)

Interviews

3 sets, pre/ post-implementation

~8 participants each;

across range of organizations & roles

Interview/Observ. cases (3)
ETHP, CK, GW

Focus Groups

3X through evaluation period, per LP

FG cases (4)
M, D, FLA, NW

Reflective Check-ins

Ongoing check-ins with project leads

(≈monthly/ quarterly)

All projects (7)

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Implementation facilitators & challenges - Key themes

- Planned levers of change
- Relationship-building
- Leadership
- Building on, testing & managing change
- Flexibility & tailoring of model
- Physician engagement
- Risk & uncertainty
- Commitment & motivation to integration

Levers of change

System-driven

- SPO selection
  - Replaces multiple service providers & fee-for-service structure
- Dual care coordinator accountability
  - Care coordinator accountable to OH@Home & OHT/ HSP
  - Encourages team embedding, indirect care coordination
- Providers have access to shared IT platform
  - CHRIS & local IT platforms often used together

OHT-driven

- Physical location of care coordinator
  - Embedded in primary care, neighbourhood hubs
- New roles, dual functions, training
  - Aimed at bridging care & coordination responsibilities
- Segmentation, early identification
- Rounds, case conferencing, shared care plan, assessments, 24/7 navigation

Different configurations of levers for different LPs

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Relationship-building

- Mature partner relationship correlated with shared vision

"… whenever we [hospital] ask you [HCCSS] to take something [on], you start from yes, and then you figure out how to do it. I think that's a bit unusual, as far as a relationship between hospital and homecare." (Hospital leader)

"… When you come to an in-person Collaborative meeting for [Name] OHT, it's like a party, it really is a unique experience." (HCCSS leader)

- Perception of limits to sharing & collaboration

"…is OH@Home truly a willing and contributory partner to these projects? […] they still hold a lot of power and sway over the outcome of the project. And we see hesitation in terms of how much buy-in we're getting. […] HSPs haven't done this before. I feel like they've asked us, 'Do you accept this set of services that we're offering?' And our response is, 'Yeah, that looks pretty good,' but we don't know what we don't know […] that just feels like an example of OH@Home saying, 'Sure, we'll do this, we'll do exactly what we're asked to do.' […] It would have felt more collaborative for there to actually be a conversation between the HSP and OH@Home to help them understand what's required to run home care." (LP leader)

Leadership

- By on-the-ground providers
  - Early progress in provider relationship-building facilitated by experienced care coordinators

"[It] is just delightful to see the knowledge being shared of the experience of the two care coordinators. They know about stuff that nobody even knew was a question. And then they bring it to the table and encourage others to share." (LP Leader)

- By partner organizations
  - Strong leaders were source of strength; could affect relationships, knowledge & project momentum if lost

"…if I call [cross-sector partner] and I say, I need something so desperately, I know she will help me figure this out because I have a great relationship with her, not because she's the vice president of [org]. She's a good human. If you replace [her], could I say that same thing? I don't know." (Community Leader)

- By OHT administrative leadership
  - Facilitates sense of inclusion

"[Leader] is very, very skillful at hearing what we say, and working with, and keeping us focused on what is possible, with what little power we have. "Would it be possible to…?" That's one of her favourites. "How might we…" So very, very skillful. And yet she's not afraid to stand up for certain principles related to the pillars. [She is…] very committed to patient-centredness. And somehow, she steered things in a way where we have three patient and family caregivers on our Collaboration Council. Three patient and family caregivers who actually have a vote." (PFAC member)

Building on, testing & managing change

- Building on existing innovations that LPs knew were working well provided a sense of confidence

- Test run of planned innovations allowed gaps to be identified

Solutions developed: Coordinators call physician's office & receptionist triages questions, mentorship provided by experienced navigator (e.g. tandem visits with care coordinators)

"…care coordinator is giving one message, and we're [partner service provider] giving a different message." (Community leader)

"Physicians were being contacted a lot" (LP administrator)

"…change is hard is because there's so much ambiguity. But to be uncertain together and to ask the questions in one space and receive that training, I can see the benefits of that." (Hospital administrator)

- Change management sessions:
  - Provided opportunity to introduce project & communicate changes
  - Allowed providers from different organizations to meet, begin team-building, ask questions, voice concerns, & provide input into plans

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Flexibility & tailoring of model

- Lack of flexibility hinders relationship-building & shared vision

"If we're thinking about this as the Thanksgiving dinner table, HCCSS is at the table but limited in their ability to eat the turkey. Constrained by, I think, a culture of risk avoidance, constrained by a directive to standardize provincially, despite there being 58 OHTs and seven leading practices that are, by design, different from each other." (OHT Leader)

- Experienced leader able to creatively negotiate tension between innovation & harmonization

"…across our organization [HCCSS], we're being told [to adopt] a consistent approach so that all seven of our home and community care programs are approaching this in the same way. [… For example] we would do a light touch eligibility and determination of what the patient actually needs, and then send it right over to the leading project. And I'm not sure that works for every population. […] I'm trying to find areas where there's wiggle room, […] find ways to influence things from a home and community care perspective, but still fit within the rules." (HCCSS leader)

Physician engagement

- OHT level
  - Strong engagement

"… the leadership from the Family Health Team, and the ability and the willingness to take the pain of adopting something quite novel [has been striking]" (LP Leader)

  - Physician gate keeping: Physician leads not allowing other physicians to refer to program until formal launch
- OHT-system interface
  - LP's lack of funding for 24/7 palliative care physicians

- System-level
  - Shifting timelines, broad project scope & need to wait for formal decisions frustrated physician involvement & existing integration

"[our existing integration effort] has been slowed down by the homecare leading project's work because… now everything needed to be official before you actually work together. So we don't meet anymore. We don't actually round anymore because we're waiting for homecare coordinators to actually be allowed to integrate with us. And then the service provider organizations are like, "Well, let's wait for the procurement process" […] certainly as a primary care provider, I do not see myself as one team with a care coordinator anymore like I did in the [previous] team model. And the work that we were trying to do with the SPOs… that work of integrating with them has completely stopped. (Physician)

  - Fee for service payment model needs to be rethought

"…If we're asking family doctors or family practitioners in general to be accountable to a population in a patient medical home model where homecare is involved, […] fee-for-service is not the right funding model. […] in building a medical neighbourhood model where homecare is embedded in primary care, you do need primary care investments to also be part of the integrated funding envelope. It can't be, "Oh, yeah, we've invested in primary care, but we've loaded to a FHT that's not really willing and interested in doing homecare." (Physician)

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Risk & uncertainty

Perception of causes

- Delays to implementation

“We need to stop meeting and having the same conversations that we've had for two years, and just do it.” (Community Leader)

- Lack of dependable, consistent funding ➡ dependency on established organizations to take on risk ➡ uneven partnerships

"There isn’t a confirmation of funding for two years, the duration of this project. And so I have to ask one of my partner boards to sign a multimillion-dollar SPO provision agreement without having the contract in place." (OHT Leader)

- Lack of system-level direction

“Give us a roadmap, so we know what to expect. […] it’s just going in circles, to be honest… we're all now a little fearful of, is this really going to see the light of the day, this project?” (Community leader)

- SPO procurement: Process & timeline

“We have been feverishly working with our [newly announced SPO] partner to figure out privacy, agreements, digital solutions. So we’re [only] now getting to, ‘What is the transitional lead going to do? What is the care coordinator doing?’ But because of the blackout period, we could not advance any of these conversations. We didn't know how well versed our SPO partner was going to be. […] I understand […] RFP and procurement rules – but just the way that the timing fell, it's an unfortunate situation.” (LP leader)

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Commitment & motivation to integration

- Commitment to LP vision, despite uncertainties

"We're working as though the project's already been funded. And it's not. So you don't do that unless you have significant trust among the partners. If [hospital] doesn't approve it at their board meeting tonight, the leading project partners have said […] we're going to move forward with it. It just means that we may have to adjust it a bit […] that we won't maybe be knee deep in it, we'll be shin deep in it." (HCCSS leader)

- Early implementation of model components provided opportunity to see results – source of motivation

"… I had a message from a PSW supervisor, that the PSW noticed the patient's confused. I know [patient] has got these frequent UTIs. So I contact the [Family Health Team] nurse and said, 'Hey, we need a urine sample, can you get me a requisition?' […] She gets the antibiotics all within less than 24 hours. […] normally [patient] would have had to probably show up in emerg and sit there for six hours waiting for an antibiotic." (Care Coordinator)

"I have seen the difference it makes to patients and staff when you have an integrated model with one record and with teams that work together across the continuum. […] I've seen the amazing shift in the motivation of staff…. when they experience actually working with families and patients, and they can do it differently, they can tailor services. And when you've had a chance to see the difference that these models make, you want to be a part of them at any time you get a chance." (LP Leader)

In conclusion: A vision for the future

- Rules (distanced from local context) seen as impairing innovation

"Homecare modernization is removing some of the rules-based thinking that care coordinators are just authorizers of service, that this can't be funded, or this can't be provided because it doesn't fit in our rule-based system. It is one of the things we are unfettered by in [hospital-run homecare program], for the most part. When the team sometimes sheepishly comes to me and says "In order to get this person home, we needed to get them a mattress, so we went and bought a mattress from Sleep Country and had it delivered. Is that okay? I'm like, "Yeah, that's okay, because at least I can say they would have stayed five more days in hospital at $1,000 a day versus the $133 you've spent on a mattress." […] ***the outcome of rules-based thinking is not person-centred care****."*
(Hospital Leader)

- Concern that what really matters to patient isn't being addressed

"… I have workers from the SPO here sitting with my mother, listening to music, doing this and the other thing while I run around, cleaning, doing her laundry, putting in the orders for her supplies, and on and on. And I think, shouldn't I be the one sitting with my mom? Shouldn't somebody else be doing those other things? And they're [PSWs] very, very limited in what they can do. Once I had made the PSW a cup of tea, as it puts you in a better mood for caring for my mother. And as she left she says, 'Oh, I put my cup in the kitchen for you.' Okay. But there are things that they're not allowed to do that I kind of shake my head. […] ***It doesn't cost any more money. It's a better use of the worker's time. But we don't touch that. We're looking at the structure*** *- should it be this agency or that agency who's in charge of homecare?"* (PFAC member)

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Recommendations: OHT stakeholders

- Signal upfront to on-the-ground providers that their patience and buy-in will be required to identify and work through early implementation challenges, so that they are aware that their partnership will be required for eventual seamless patient and provider experience.
- Have open conversations to understand scope for and benefits of both a tailored and standardized approach, in different contexts.
- Unexpected SPO changes will require attention to developing new trusting relationships that was not part of original plans. This may require additional work & time, but is important given evidence that trust is key enabler.

Recommendations: System stakeholders

- Be aware that:
  - Many OHT stakeholders thought that the LPs did not necessarily address key issues pertinent to patients (E.g. PSW roles) and providers (E.g. privacy regulations).
  - Project delays & lack of directional consistency and dependable funding frustrated OHTs' ability to engage stakeholders & hindered understanding of long-term vision.
- Flag expected outcomes in relation to timelines - e.g. what is expected in the short, medium and long-term ⟹ mitigates OHT anxieties, by acknowledging that certain impacts may take time, while providing a realistic roadmap of direction and accountability.

Recommendations: System stakeholders

- The tense relationship between many OHTs & OH@Home needs to be addressed for meaningful collaboration:
  - Is there scope for working on timely responses to requests, given interdependencies?
  - Is there scope for getting all stakeholders on the same page about the legal framework within which OH@Home operates, to mitigate finger-pointing?
  - Is there scope for collaborative guidance provided to LPs/ HSPs to help them understand the intricacies of what is involved in delivering homecare?

Questions?

THANK YOU!

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