RISE
Rapid-Improvement Support and Exchange

Building block(s)

RISE brief for citizens: Establishing Intersections between Ontario Health Teams and Broader Human Services

Context and challenges

In February 2019, the Ontario government announced a transformation in the Ontario health system. The centre piece of the transformation is the creation of Ontario Health Teams that will enable providers responsible for a given set of patients to work as one coordinated team (see Figure 1). This set of patients is called an 'attributed population.' For example, more than 30 health organizations and broader human-service partners have come together in Hamilton and surrounding communities to plan and provide care for patients who receive their primary care in this geographic area. This is just one example of 51 Ontario Health Teams across the province.

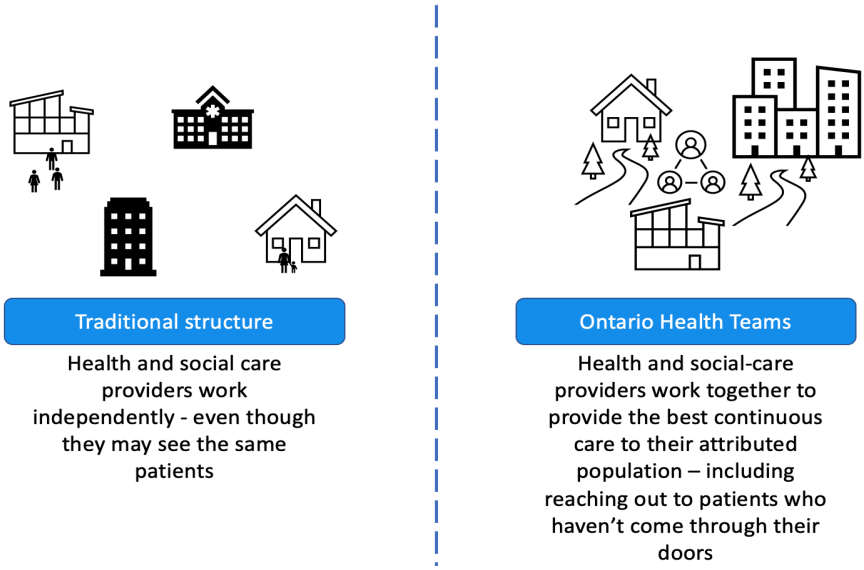
Attributed populations for Ontario Health Teams range from 800,000 residents in large urban areas to 50,000 residents in small rural communities (and possibly fewer residents in more remote parts of the province).(1) At maturity, the already approved Ontario Health Teams will cover 92% of Ontarians. Work is underway to bring the province to 100% coverage.

What are broader human services?

Broader human services refer to the range of programs and services that aim to improve the economic and social well-being of the population. These services could be related to education, employment, housing, transportation, and other community programs and services. Examples of these services include:

- children and youth services such as, early-childhood development services, special-needs supports, child-protection services, adoption services
- employment services such as income assistance, employment counsellors, re-skilling and up-skilling programs
- housing supports such as, temporary emergency shelter and affordable permanent housing
- public safety and justice such as, community policing, rapid mental health and addictions supports, and restorative-justice approaches
- recreational programming such as public and green spaces, and community centre recreational programs.

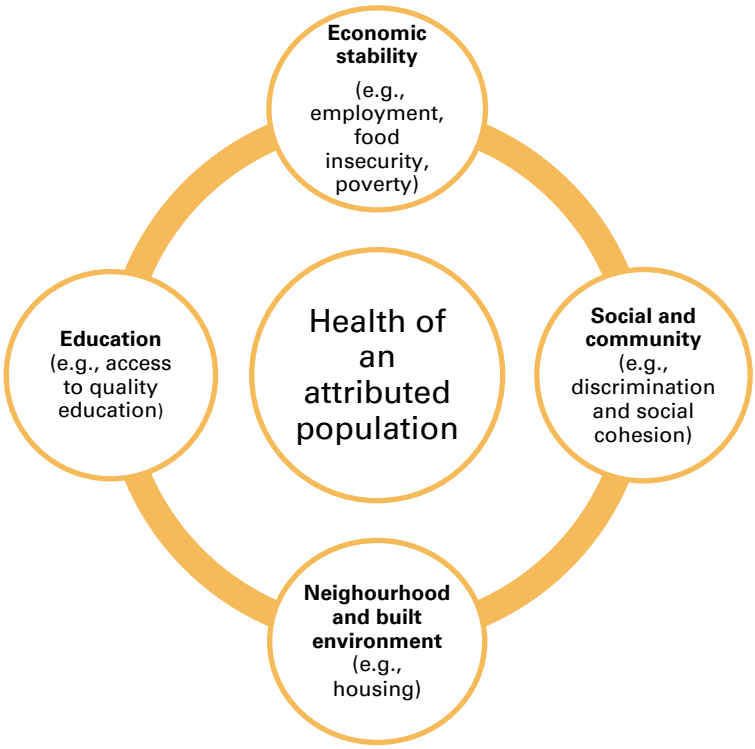
Figure 1. How traditional care compares to Ontario Health Teams



As Ontario Health Teams mature, they will be held accountable for maintaining and improving the health and well-being of their attributed populations. Ontario Health Teams are required to provide a full set of coordinated services, which to date have focused on home and community care (such as personal-support services), primary care, and acute care such as emergency health services and in-hospital care.(1) However, there are many factors beyond healthcare that an individual receives that determine their health. The conditions in which individuals are born, grow, live, work and age have a significant effect on their overall well-being. These are called the 'social determinants of health,' and include factors such as education, housing, income, and job security (see Figure 2). Given the influence of social determinants of health on well-being, some Ontario Health Teams have chosen to partner with organizations that provide broader human services. Some examples could include partnerships with:

- organizations that provide emergency shelter and food services
- organizations that provide advice and supports (such as language teaching and job searching to new immigrants
- municipal governments that plan for childcare supports, employment supports, as well as parks and recreation.

Figure 2. Examples of factors that influence health



While some Ontario Health Teams have already established partnerships with broader human-service providers, there is still a long way to go in figuring out how these services will work together. This includes improving care offered through health and broader human services as well as improving the overall health and well-being of all Ontarians.

Though many Ontarians receive care from both the health system and from providers of broader human services, there are some challenges that affect individuals' ability to benefit from both services. Some of these challenges include:

- historic separation of health and broader human services, including sponsorship by different levels of government and separate budgets
- long-standing differences in access to human and financial resources (with health often having more staff and larger budgets)
- inconsistency in the availability of services between communities
- lack of awareness about what services exist (for example, health providers may not know about what community resources are available)
- differing 'language' and culture between providers in the health system and providers of broader human services
- challenges in sharing patient information due to privacy laws and lack of common digital tools.(2)

The introduction of Ontario Health Teams has the potential to improve some of these challenges. Partnerships already established between healthcare providers and providers of broader human services is an important step. However, the introduction of Ontario Health Teams also presents some new challenges, including:

- lack of defined expectations for which broader human services should be included in the Ontario Health Teams model
- inconsistencies among Ontario Health Teams with respect to the services their partners are able to provide (for example, some Ontario Health Teams have chosen to partner with municipalities while others have not)
- power and resource differences when developing partnerships between large health providers and community-based broader human-service providers (for example, differences between big hospital networks and emergency food banks)
- uncertainty around future funding arrangements for Ontario Health Teams and whether and how this will influence how health and broader human services will work together.(1; 3)

In addition, specific populations within the province, such as rural, Francophone, Indigenous and other under-served populations, face unique challenges accessing the care they need due to historic and current inequities. Issues including lower socio-economic status, language barriers, and care interactions that are not culturally sensitive can result in unfair differences in health outcomes for these populations.

Box 1. Questions related to the context and challenges

- What has been your experience accessing health and broader human services at the same time (for example, rehabilitation services and income supports)?
- Are there additional challenges not mentioned in the list above that you have experienced when receiving care from broader human services?

What have we learned from the experiences of others?

Ontario is not the first jurisdiction to face the challenges outlined in the previous section. Many other countries as well as other provinces and territories in Canada have experience with transformations similar to Ontario Health Teams. Though these examples are not direct parallels to the Ontario Health Team model, they share many common features. By examining the experiences

of other jurisdictions, we can learn about how they plan for and provide broader human services to ensure that patients and families get the care they need, when they need it. We can use these experiences to identify solutions that could be helpful for Ontario and how they may need to be adjusted.

To understand the experiences of other jurisdictions, we reviewed available reports describing how broader human services could intersect with Ontario Health Teams. We identified reports from Quebec, Germany, the Netherlands, New Zealand, the U.K. and the U.S. In the table below, we organized the examples we found into three different models and describe considerations for their use in Ontario. However, for any of these models to work, we know that certain essential elements must be in place, including:

- putting the patient at the centre of care (and their well-being at the centre of all decisions)
- engaging patient, family and caregivers in planning for the intersections between Ontario Health Teams and broader human services (while ensuring equity, diversity and inclusion)
- coordinating between health and broader human services, which could include financing care-coordinator roles and establishing common digital tools.(2)

Box 2. Questions related to what we learned from the experiences of others

- Based on your experience and what you know about Ontario Health Teams, which of the model or model(s) from table 1 could inform the approach to specialty service lines in Ontario?
- Are there specific services that you would prioritize for their inclusion in Ontario Health Teams?
- Based on your experience and the panel discussion so far, what do you think are some additional essential elements to include in the model or model(s) that are put in place?

Table 1. Models for intersections between Ontario Health Teams and broader human services that may be relevant to Ontario Health Teams

Model for intersections between Ontario Health Teams and broader human services	Evidence and considerations
Provider coordinated • Access to broader human services is facilitated by an individual care coordinator/care navigator who is employed by an Ontario Health Team • The care coordinator works with providers of broader human services on an as-needed basis to ensure patients receive the care they need by referring them to the appropriate broader human-service provider	*Evidence* • Care coordination between health and social care has resulted in reductions in patient hospitalization and improved management of chronic conditions, particularly among older and more vulnerable patients (4) • Care coordination has also been found to improve the likelihood that patients attend recommended care and follow-up appointments (5) *Considerations* • This model may be relatively easily put in place as it requires fewer complex governance and financial arrangements • Fragmentation between health and broader human services may continue, particularly for the sharing of patient information, as it is reliant on a single individual • There may be greater variability in the level of coordination received across patients
Organizationally coordinated • An organization that is a member of an Ontario Health Team is responsible for bridging health and broader human services (called a 'bridging organization') • This organization takes a primary role in screening patients, determining their needs, and connecting	*Evidence* • Organization-based coordination between health and social care has resulted in the increased use of screening criteria and acceptance of navigation by patients (6) • Organization-based coordination resulted in some reduction in emergency-department visits (6; 7) *Considerations*

patients with service providers who can meet their needs • This model operates like a 'hub and spoke,' with the bridging organization in the middle (the hub) responsible for ensuring relationships among all partners (the spokes) and following up with patients after referrals • Bridging organizations may be given funds for staffing and infrastructure, but do not pay for services directly	• Determining the 'bridging organization' may be a difficult decision and may, if not properly resourced, significantly increase the administrative workload for that organization • This model may be relatively easily implemented as it does not require significant governance or financial changes, but it is heavily reliant on the goodwill of those participating • Fragmentation may still occur between organizations
Fully integrated • Broader human services would be fully integrated as partners into Ontario Health Teams • This would include sharing of governance and financial arrangements, including a joint budget • This model provides a 'no-wrong-door' approach where people are supported to navigate services based on their needs, often through existing networks of health and broader human-service providers • Priority programming areas may be defined by drawing on population-based data and community-identified priorities • While health services may not be a first place of contact, health services are available as part of a suite of services offered through partnerships with broader human-service providers	*Evidence* • Fully integrated models resulted in a reduced burden on nursing staff, reduced wait times, and improved access to services in hospitals, and improved access to health and broader human services for historically under-served populations (8) • Fully integrated models were also found to support greater resource sharing between health and social government departments (8) *Considerations* • Though this model has the potential to reduce fragmentation, it requires complex governance and financial arrangements that may take time and high levels of trust among partners to establish • This model may require significant changes to legislation to allow for a flexible workforce, information sharing and the integration of health and broader human services, often at the highest levels of governance
Blended approaches • A combination of one or more of any the models above	*Evidence* • We do not know how blended approaches affect the care provided

	Considerations • This model may allow for greater flexibility and tailoring depending on the service type and its need for the Ontario Health Teams' attributed population • This model will require clear definitions of what services are coordinated and provided at what levels • This model may require significant communications efforts to ensure individuals understand differences in how each service type can be accessed

How could we use this to help Ontario Health Teams?

It is important to consider what might help or hinder efforts to put these models into place. From the initiatives described on the previous page and from the development of Ontario Health Teams so far, we know that barriers to putting these approaches into place could include:

- lack of sufficient resources (including people) to support change
- lack of trust among partners, and differences in aims and objectives of working across health and broader human-service providers
- power imbalances among partners
- lack of communication between health and broader human-service providers, which may be a result of differences in 'language'
- lack of information exchange between health and broader human-service partners.

However, we also know that there are also factors that can help with putting these approaches into place. These factors may include:

- partnering across organizations with previous experience working together, particularly when they have established trusting relationships
- clarifying leadership, roles and responsibilities for each partner
- establishing shared values, vision of care, and common understanding
- developing goals in a cooperative and coordinated manner
- adequate resourcing across broader human services
- having supportive policies that encourages innovation and flexibility.(2)

Box 3. Questions related to implementation in Ontario Health Teams

- What do you think are the biggest barriers to establishing intersections between Ontario Health Teams and broader human services?
- What do you think are the biggest opportunities for the Ontario Health Teams and broader human services?

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