

RISE brief for citizens: Identifying how Ontario Health Teams can meet the needs of rurally based patient and community partners

(Last updated 25 October 2021)

Context and challenges

Approximately 14% of Ontarians live in a rural community.⁽¹⁾ Rural areas

have many benefits, which can include, close-knit communities, greater amounts of space and proximity to nature. However, living in a rural community also comes with its own set of challenges. Across Ontario, rural residents, on average, have a lower health status than urban residents. This includes a lower life expectancy at birth as well as higher all-cause mortality rates that increase with greater levels of remoteness.⁽¹⁾ In particular, health and social systems in Ontario have repeatedly failed to address long-standing issues including:

- inequitable access to care
- insufficient resourcing of service organizations
- large geographic distances between providers
- insufficient transit options and supports for accessing services in urban centres
- lack of culturally and linguistically diverse services
- difficulty sustaining meaningful public participation in health and social services.⁽¹⁾

There are also important differences in population characteristics and health status between rural Ontarians living in the north and south. The northwest of Ontario is home to a greater proportion of Indigenous people (18.3% compared to 11% in the northeast and 2.4% in all of Ontario), while the northeast is home to a higher proportion of the population that identify French as their first language (21.6% compared to 2.8% in northwest and 3.9% in all of Ontario).⁽²⁾ Several indicators suggest that northern rural Ontarians face more intense challenges than southern rural Ontarians, including:

- higher proportion of people living with two or more chronic conditions (25.3% in northwest, 24.5% in northeast compared to 19.7% across Ontario)

What do we mean by rural?

For this panel, we are using the definition of rural included in the Ontario Rural Health Framework, which defines a rural community as “one that has a population of less than 30,000 and is located more than 30 minutes away in travel time from a community of more than 30,000.”⁽¹⁾

We understand that degrees of rurality still exist within this definition and that challenges may differ in southern rural communities from northern rural communities. We encourage you to raise these differences during the panel discussion.

- reduced access to primary care (23.8% and 28.2% of people in northwest and northeast Ontario respectively report being able to see their primary care provider on the same or next day when sick; this is compared to an Ontario average of 43.6%)
- significantly higher potential years of life lost due to avoidable deaths or self-injury/suicide. (2)

Though these challenges vary in their significance depending on the location of the rural community, many organizations have had experience turning these challenges into opportunities to introduce local innovations in health and social care. These include:

- bringing services under a single roof
- creating networks of care centred around the needs of rural patients, such as through rural health hubs
- increasing the use of telehealth and virtual care options to expand the range of services available close to home
- supporting health professionals to work to their full scope of practice.(3; 4)

Despite the efforts of these initiatives, many of the long-standing challenges remain. In addition, the benefits of these initiatives have not been evenly distributed across rural communities, with some having found success while others have not.

Ontario is in the middle of a major health reform that, if implemented with the right supports, could make progress on the long-standing challenges mentioned above. The main piece of the reform is the creation of Ontario Health Teams (OHTs) in which healthcare providers in a given area will work as one coordinated team.(5) To do so, health and social care organizations across the province have been asked to organize themselves into teams to provide care for the residents of a specific geographic area.(5) This is also referred to as the Ontario Health Team's attributed population. Attributed populations for Ontario Health Team's range from 800,000 residents in large urban areas to 50,000 residents in small rural communities.

Under the Ontario Health Team model, patients, families, caregivers and healthcare providers will be collectively responsible for deciding how local care services are delivered and managed.(5) Local health and social care providers who sign on to partner with an Ontario Health Team will work together as a team to manage the health of their attributed populations. This is a different approach from before where individual providers and organizations would make decisions on their own about how to manage care for their patients (see Figure 1). Now, these decisions will be made collectively – involving providers such as primary care providers, hospitals, specialist services, and community care providers. As part of this work, Ontario Health Teams will need to design new models of care that better reach out to their populations and ensure they are receiving the care they

need. Eventually, when this model is fully implemented, each Ontario Health Team will be held accountable, clinically and fiscally, for the health of their attributed population.(5)

Table 1 provides examples of long-standing challenges in rural communities and descriptions of the ways that the Ontario Health Team model may provide solutions.

Figure 1. How traditional care compares to Ontario Health Teams

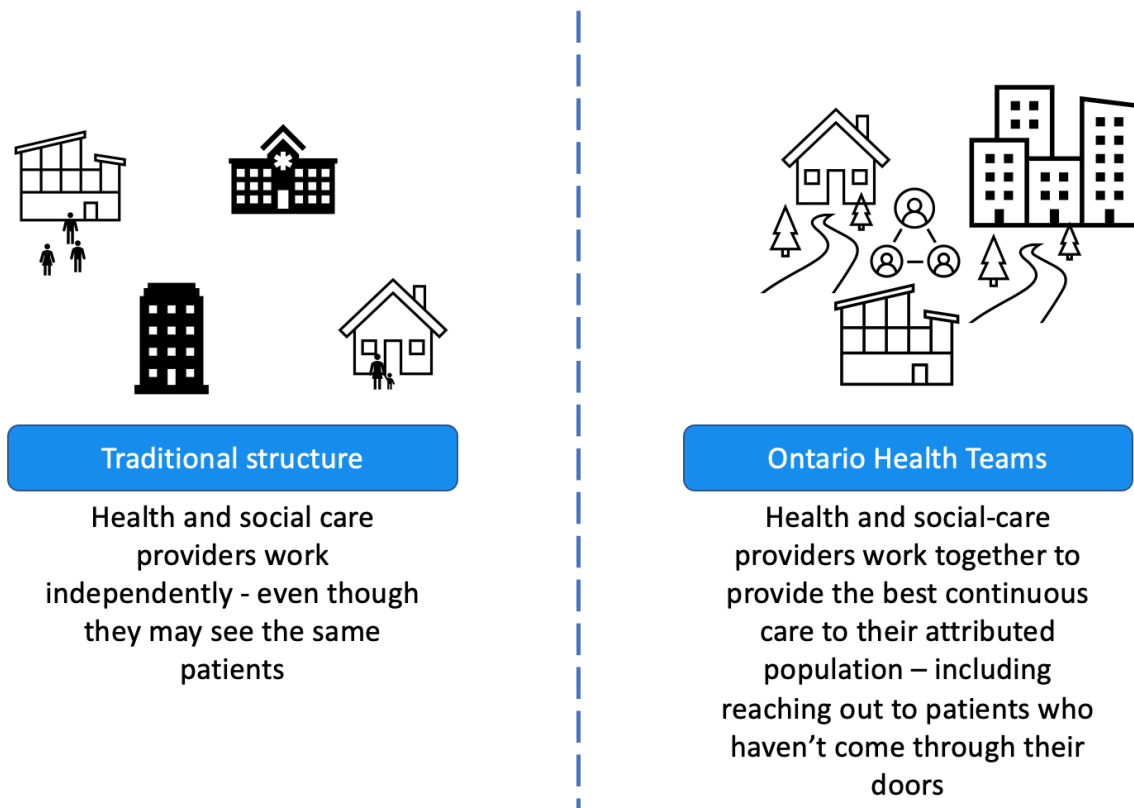


Table 1: How Ontario Health Teams can help to address long-standing challenges in rural communities (5)

Long-standing challenges in rural communities	How Ontario Health Teams can help
<ul style="list-style-type: none"> Challenges accessing services, including specialists 	<ul style="list-style-type: none"> Ontario Health Team model requires partnerships across the entire continuum of care, including specialist services that will work across multiple teams Ontario Health Team model requires that outreach services are put in place, whereby providers reach out to patients instead of

	<p>waiting for them to come through their doors to meet their health needs</p> <ul style="list-style-type: none"> • Performance indicators have been developed by the Ontario Health Teams, many of which include a focus on improving access to care including access to primary care and virtual visits to specialists, among others
<ul style="list-style-type: none"> • Insufficient resourcing of service organizations 	<ul style="list-style-type: none"> • Ontario Health Teams will be provided with implementation funds that can be spent on priority areas among the partners • New funding arrangements between partner organizations within the Ontario Health Teams may allow for improved distribution of resources
<ul style="list-style-type: none"> • Large geographic distances between providers • Insufficient transit options or supports for accessing services in urban centres 	<ul style="list-style-type: none"> • Regional approaches to designing digital solutions and implementation funds from the ministry may help make virtual options more available to connect with services in urban centres • As partner organizations will be collectively responsible for the health of the population, they may explore opportunities to improve transit and transition services or alternative models that could allow patients to be treated closer to home
<ul style="list-style-type: none"> • Lack of culturally or linguistically diverse services 	<ul style="list-style-type: none"> • As part of the process to become an approved Ontario Health Team, partner organizations must demonstrate that they respect the role of Indigenous peoples and Francophone communities in the planning, design, delivery and evaluation of services for these communities • Ontario Health Teams must also demonstrate that they are able to provide culturally safe care for Indigenous peoples in their populations through meaningful partnership with Indigenous communities and service providers • Ontario Health Teams must also find ways to best meet the diverse needs of other populations within their geography
<ul style="list-style-type: none"> • Sustaining meaningful public participation in health and social services 	<ul style="list-style-type: none"> • Ontario Health Teams are expected to meaningfully engage and partner with, and

	be driven by the needs of, patients, families, caregivers and the communities they serve
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In many rural communities, the work of implementing Ontario Health Teams has already begun. This includes Ontario Health Teams whose attributed populations are exclusively in rural communities, as well as teams that have attributed populations in both urban centres and rural communities.

However, it is not only residents of rural communities who face challenges when interacting with the health and social system. We are hearing from organizations partnered with both these types of teams that while the model has potential, they need additional supports and different processes to overcome some of the unique geographic challenges they face. Ontario Health Teams have voiced challenges related to:

- meaningfully engaging patients, families, caregivers, and communities across wide geographies
- inconsistent or unreliable internet access
- long-standing capacity and resource constraints and
- challenges overcoming urban-rural partner dynamics for those teams that have attributed population from both demographics.

We know from the experiences of other initiatives like Ontario Health Teams that the need for tailored supports is not unusual and, at times, can be the key to getting these types of reforms off the ground.

Box 1. Questions related to the context and challenges

- What has been your experience (or the experience of others you may know) getting your health and social care needs met in rural communities?
- What has been your experience, if any, working with organizations trying to better meet the needs of patients and community partners in rural areas?
 - What types of challenges have you seen organizations experience while trying to improve services?
 - What types of challenges have you experienced while engaging and working in partnership with health and social service organizations?
- Given what we have described about Ontario Health Teams and your experiences either with your own care or through supporting organizations trying to address these needs, what would you single out as the biggest challenges facing Ontario Health Teams?

What we heard from citizens, patients and caregivers about the context and challenges

On October 1st, 2021, the McMaster Health Forum and RISE hosted two online citizen panels with a total of 27 residents of mixed urban-rural environments and predominantly rural environments to deliberate about how Ontario Health Teams can best meet the needs of patients and communities in rural areas. Thirteen panel members had been actively engaged as patient, family, and caregiver advisors during the development of Ontario Health Teams (OHTs) and 14 panel members had some experience volunteering in health and social service organizations in their communities but had not been directly involved with their local Ontario Health Teams.

With respect to the context and challenges, citizen-panel participants highlighted:

- **Rural communities lack access to needed care** inclusive of primary, specialty and home and community care
 - Unable to meet needs in rural community, almost always requires travel outside of the community
 - Rural communities face unique needs that affect their overall health and access to care (e.g., higher levels of child poverty, lack of social support services such as housing, public transportation infrastructure)
 - People require greater awareness of available services, both locally and to be able to adapt innovations from elsewhere
- **Patients, families, and caregivers bear the burden of navigating broken systems** as the responsibility to coordinate care has traditionally fallen to them
 - Better coordination is needed between and across care types and systems, particularly for those without strong support networks, without access to transportation or who are otherwise unable to coordinate their own care
 - Added burden works against health and well-being and away from establishing a patient-oriented system
 - Lack of support for and recognition of caregivers and their roles as part of care team
- **Current incentives and organization of health systems contribute to uncoordinated care**
 - Fee-for service incentivises single-issue visits rather than patient-centred comprehensive care
 - Discrepancies in compensation and responsibilities across organizational and jurisdictional boundaries can contribute to gaps and fragmentation in human resources
 - Equal pay for equal work is needed to focus on the best interests of patients (e.g., differences in compensation of personal support workers across municipal boundaries)
- **Digital solutions need to be tailored to rural needs and realities**
 - Lack of mobile phone and internet access remain barriers to effective virtual care, while virtual care not suited for all contexts and/or populations
 - Digital inter-operability is needed across wide-geographies and provider types
- **Hesitancy to increase demands on chronically under-resourced systems and leaders** while ensuring voice and expertise of rural (often smaller) organizations are recognized

What have we learned from the experiences of others?

Ontario is not the first to face the challenges outlined in the previous section. Many other countries as well as provinces and territories in Canada have implemented similar reforms to Ontario Health Teams in rural communities. 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 the supports put in place to meet the needs of patient and community partners. In turn, we can assess whether similar solutions would be right for Ontario or how they may need to be adjusted.

To understand the experience of other jurisdictions, we reviewed available reports and studies describing 5 initiatives similar to Ontario Health Teams. These were implemented in the province of Quebec in Canada, Finland, the United Kingdom (Scotland), the United States. We identified relevant approaches that contributed to success of the initiatives. These are described in Table 2 and organized by key requirements of Ontario Health Teams (sometimes referred to as Ontario Health Team building blocks).

Table 2: Approaches from other initiatives that may be relevant to Ontario Health Teams (6)

Focus area (or building blocks)	Insights from other initiatives
<p>Defined population: a focused population is identified based on how people typically access care</p>	<ul style="list-style-type: none"> ● Initiatives focused on specific populations (such as older adults) or were defined by a specific geography (for example, at a provincial or state-level) ● Population groups in rural areas often have similar care needs (for example, older rural adults often live with more than one chronic condition and have complex care needs)
<p>Services provided: a full and coordinated continuum of care is provided to support health and well-being for individual patients and whole populations</p>	<ul style="list-style-type: none"> ● Including broader human services (for example housing, social support services) in addition to health services ● Including transportation considerations (both access and routing) to support access to services across rural areas and to specialized care in urban areas ● Focus on filling existing gaps in care rather than replacing local systems that are working well
<p>Partnership with patients and communities: patients, family members and caregivers are meaningfully engaged at all levels, from co-designing</p>	<ul style="list-style-type: none"> ● Supporting patient, family and caregiver partnership in service design, governance (for example, participating on leadership boards) and performance management

<p>programs and services to governance structures</p>	<ul style="list-style-type: none"> ● Considering ways in which the re-organization of care models can have broad implications for employment opportunities and decisions about how money flows
<p>Patient care and experience: patients, families and caregivers are offered the highest quality care and the best experience possible</p>	<ul style="list-style-type: none"> ● Improving access to care in rural areas by <ul style="list-style-type: none"> ○ co-locating health and social services ○ using mobile clinics ○ using expanded community partnerships to provide alternative care sites such as libraries, community centres, senior centres and schools ○ expanding skills for health professionals such as nurse practitioners and physician assistants ○ supporting the development of specialized skills required to coordinate care in rural areas (for example, through establishing care coordinators)
<p>Digital solutions: digital information is shared between partners to design, coordinate and deliver care</p>	<ul style="list-style-type: none"> ● Investing in digital health infrastructure to improve connectivity between partners and patients, families and their caregivers ● Investing in training for providers and patients, families and caregivers in how to use digital platforms
<p>Leadership and governance: clinical and financial decisions are made in ways that account for multiple partner perspectives, including providers</p>	<ul style="list-style-type: none"> ● Leveraging regional partnerships to be able to offer a full continuum of services (for example, to access specialized services or reduce administrative burdens for rural service providers) ● Expanding and adapting leadership roles to best suit rural contexts (for example, supporting nurse practitioners and physician assistants to take on primary leadership roles) ● Supporting rural-specific implementation supports (such as rural focused supports and grants)
<p>Financial considerations: resources are aligned with care needs of population</p>	<ul style="list-style-type: none"> ● Providing up-front resources to support the design and adaptation to rural contexts ● Implementing innovative approaches to funding, such as pooling health and social budgets across municipalities
<p>Performance management and continuous learning: best evidence is used and adapted through implementation</p>	<ul style="list-style-type: none"> ● Assessing in real-time issues emerging in implementing new approaches in rural communities

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

- Based on your previous experience, are there additional approaches that you have seen be effective when introducing a new program or initiative in rural environments?
- Based on the list above and the panel discussion so far, what approaches do you think should be prioritized within Ontario Health Teams in rural communities?

What we heard from citizens, patients, and caregivers about the experience of others

In considering what can be learned from initiatives outside of Ontario, citizen panel participants highlighted the follow approaches:

- **Implementing a ‘no wrong door’ policy for patients requires:**
 - shared information systems and coordinated servicing planning
 - greater support for patient navigation through self-management and dedicated care coordinators
 - collective responsibility for patient care across urban and rural services, starting by countering distrust between providers and organizations
 - emphasize kindness as a guiding principle to support necessary culture change
- **Partnership-building requires time and commitment**, particularly among partners that may have strained historical relationships and/or see each other as competitors
 - Build a patient-oriented system inclusive of basic needs, which may include securing access to basic amenities (e.g., electricity, running water) and nutritional, housing and economic stability
 - Equal consideration of structural barriers that disproportionately disadvantage people of colour, LGBTQ people, people with disabilities among others
- **Building on what works while addressing gaps**
 - Sustaining trusting relationships between providers and patients and families
 - Tailoring services and supports for under-served and linguistically and/or culturally specific care (e.g., Francophones, Indigenous, migrant worker populations, Amish and/or German-speaking communities)
 - Building on existing partnerships and delivering care where people already are (e.g., collaborations across agencies to meet care gaps through roaming clinics in under-used municipal buildings or in schools, seniors’ day centres, etc.)
- **Dedicated capacity-building initiatives**
 - Enable close-to-home options for travel-intensive care (e.g., chemotherapy, dialysis), recognizing the mental health impacts of being away from home for extended periods of time
 - Need sustainable solution to increase local long-term capacity (e.g., Northern Ontario School of Medicine rural return-of-service agreements)
- **Expansion of alternative models of care**
 - Examples cited include nurse practitioner led-clinics, social prescribing, community paramedic programs, leveraging existing resources for comprehensive care, such community buildings as outreach centres for group-based care and enabling postal carriers to signal care needs

- Greater formal recognition of caregiver roles (e.g., Caregiver ID programs)
- Learning from the shift to virtual care during COVID-19, particularly to support greater access to specialty care
- **Patient-centred performance measures** to support greater accountability to building patient-oriented system

How could we use this to help Ontario Health Teams?

It is important to consider the barriers and facilitators that could help or hinder the implementation of the approaches from other initiatives to Ontario Health Teams. From those initiatives and from the development of Ontario Health Teams so far, we know that barriers to the implementation of these approaches could include:

- insufficient resources and capacity to implement approaches;
- lack of community engagement, including patients, families and caregivers, in adapting approaches;
- lack of trust between partner organizations; or
- lack of buy-in to the Ontario Health Team model seeing it as “just another pilot project.”

However, we also know that rural communities offer a number of facilitators that can help with the implementation of these approaches. These may include:

- organizations having previous experience working together, particularly when they have established trusting relationships;
- previous experience with innovations and working creatively to make the best use of available resources;
- good knowledge of local health needs and engaged community members; and
- flexibility in the initiative so it can be tailored to the needs of individual communities.(6)

Box 3. Questions related to implementation in Ontario Health Teams

- In your experience either receiving care or when working with organizations on local health or social issues, what barriers or risk factors have come up when introducing a new program or initiative?
- In your experience, what have been successful ways of partnering with local community members?
- In your experience either receiving care or when working with organizations on local health or social issues, what approaches have been successful when introducing a new program or initiative?

What we heard from citizens, patients and caregivers about how to apply these insights to help Ontario Health Teams

Citizen panel participants identified ways they believed OHTs could ‘get further, faster’, including the following considerations:

- **Implementation needs to be tailored to rural communities**, building on existing communication channels (e.g., parent school boards, community service organizations) and networks
 - Use of innovative models of care (e.g., group models of care, hub centres)
 - Early engagement of broader human services, including leveraging municipal resources
 - Focus on trust-building and communication
- **Clear communication around vision for OHTs** with governance and incentives aligned with long-term goals
 - Clear description of advantages and opportunities for more coordinated and comprehensive care
 - Leveraging trusted relationships (e.g., between patients and providers) to address hesitancy to change
- **Streamlined digital care services** for scheduling, virtual care, electronic medical records both within and between OHTs critical to accessibility
 - Requires investments in infrastructure to support digital equity across the province
- **Dedicated funding for leadership** to build and maintain momentum

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