![RISE — Rapid-Improvement Support and Exchange]

Building block(s)

RISE brief 28: Identifying how Ontario Health Teams can meet the needs of rurally based patients and community partners in mixed urban-rural and predominantly rural environments (Last updated 02 December 2021)

Status of Ontario Health Teams

- The first cohort of 24 OHTs was approved in December of 2019, with an additional five added in July 2020
- Two new cohorts of OHTs approved since then, including 13 in November 2020 and eight in October 2021
- Five in-development teams have been asked to join approved cohort 1 and 2 teams
- Additional work is underway to support in-development teams in the northwest and in the northeast.

Deliberation about OHTs' challenges in meeting the needs of patient and community partners based in rural environments

Box 1: Coverage of OHT building blocks

This RISE brief addresses **all eight** building blocks
1) defined patient population
2) in-scope services
3) patient partnership and community engagement
4) patient care and experience
5) digital health
6) leadership, accountability and governance
7) funding and incentive structure
8) performance measurement, quality improvement, and continuous learning

OHTs operating in mixed urban-rural environments and in predominantly rural environments often face **long-standing challenges** in planning for and delivering care, among others, these include:
- richer demographic mix, with the northwest home to a greater proportion of Indigenous people and the northeast home to a higher proportion of people identifying French as their first language
- northern Ontarians face more significant health challenges (e.g., higher rates of chronic conditions) and healthcare challenges (e.g., lower rates of same-day primary-care access)
- inequitable access to care, particularly specialized services (the subject of a future RISE brief)
- 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 service planning.

In addition, three categories of teams may face **additional challenges:**
- approved OHTs (often more urban) and in-development teams (often more rural) now coming together into a single OHT
- several in-development teams (often more rural) now coming together into a single OHT
- multiple in-development teams working collaboratively across wide geographical areas to adapt the OHT model for a more regional approach.

These three categories of teams are being offered supports to complement their significant existing expertise to:
- establish trusting relationships with new partners
- adjust collaborative decision-making arrangements

- revise the overall vision and strategic directions of the OHT
- understand the needs of their newly attributed population
- determine how partners will work together to collaboratively design and deliver care
- engage a broader set of patients, family members and caregivers to represent the entire attributed population.

Key findings from the citizen panels

Prior to convening this jamboree, RISE hosted two online citizen panels – both on 1 October 2021 – with residents of mixed urban-rural environments and predominantly rural environments to deliberate about these issues. One of the panels consisted of residents who had no affiliation with OHTs, but who had previous experience supporting health and social-care organizations. The other panel consisted of patient, family or caregiver advisors from OHTs at various stages of development. Summary points for each of the three deliberations have been included in this brief.

Citizen panel participants noted that:
- **communication** about OHTs and outreach strategies from OHTs to their communities need to be tailored to rural populations (e.g., building on existing networks and community hubs)
- care-coordination programs need to **account for the additional resources, time and expertise** required for successful implementation in rural areas
- shifts towards virtual care need to be accompanied by significant investments to improve **mobile phone signals and internet access** across the province, while maintaining in-person care for conditions and populations for whom this is most appropriate
- **digital compatibility** within and across OHTs is critical to maintain a patient-centred system, particularly for rural residents who may be more likely to require care from multiple OHTs
- OHTs will have to grapple with both **historical and on-going resource and capacity gaps** in rural areas, while also **building on innovative approaches** to address them.

Key findings from the jamboree

Jamboree participants noted additional challenges, including:
- attributed population of 50,000 is very different in predominantly rural areas as populations are spread across wide geographies (with communities that have varying needs and providers that have varying 'bandwidths' to meet them)
- expectations of partnerships between approved OHTs and in-development teams may challenge their ability to advance at the same pace as other approved OHTs
- provincial data does not always represent the care provided within small geographic areas, particularly at the primary-care level where a family physician typically acts as a 'jack of all trades'
- prescribed models of governance for OHTs in some cases may need to be adapted to better align with existing partnerships and/or Indigenous models of governance
- additional capacity, resources and learning programs are needed to advance the transformation in rural areas, particularly in areas with long-standing resource gaps
- organizations involved in OHTs in rural areas are pulled in many directions and juggling competing priorities, including health-system transformation, COVID-19 recovery, and caring for both populations and providers grappling with the on-going discovery of graves at sites of residential schools across Ontario.

Deliberation about learnings from other jurisdictions with experience implementing supports

By examining the experiences of other jurisdictions, we can learn about the supports put in place to meet the needs of rurally based patients and community partners including from PRISMA in Quebec, ESKOTE in Finland, Te Whiringa in New Zealand, the Lead Agency Model in Scotland, the Advance Payment ACOs and PACE in the U.S., and experiences in Australia.

OHT building blocks	Related insights from other initiatives
Building block #1: Defined patient population (who is covered, and what does 'covered' mean?) → **attributed population**	• **Reduce number of required beneficiaries** in U.S. Medicare ACOs for rural areas (from 15,000 to 5,000), however, in some cases this created sustainability challenges (Advance Payment ACOs) • Recognize differential needs and preferences shaped by linguistic or cultural factors (PRISMA)
Building block #2: In-scope services (what is covered?) → **primary-care centred**	• **In-scope services focused on health and social care equally** (Lead Agency Model and Te Whiringa Ora) • Early involvement of **broader human services**, including housing, sport and recreation, and community councils (Te Whiringa Ora and Australia) • **Transportation included** as an in-scope service to ensure routes included access to nearby health and social-care facilities (Lead Agency Model and PACE) • Care coordination offered in partnership with **community-based, culturally relevant support** (Te Whiringa Ora) • Services oriented around patient-defined goals with objective of supporting greater self-determination (Te Whiringa Ora)
Building block #3: Patient partnership and community engagement (how are patients engaged?) → including **Indigenous peoples and Francophones**	• Local **citizen advisor acts as a member of governing board** (Advance Payment ACO) • Formal mechanisms such as **community councils** to support the identification of local health priorities and the development of implementation strategies and monitoring and improvement plans • Citizen engagement through **regular meetings** of citizen/patient/family volunteers (ESKOTE) • Extended family and community-based web of care involved as **partners in care** (Te Whiringa Ora)
Building block #4: Patient care and experience (how are patient experiences and outcomes measured and supported?) → **population-health management**	• **Co-location** of health and social services (ESKOTE) • **Mobile** primary-care and preventive-care **services** provided in individual homes and community settings (ESKOTE) • Use of **alternative care sites**, typically operated by adult daycare or senior centre organizations to support greater access to services (Advance Payment ACOs and PACE) • Improved transitions and navigation through **case management and care coordination** (PRISMA) • Use of **annual wellness visits** to deliver preventive services and develop preventive-care plans (Advance Payment ACOs) • Emphasis on enabling **self-management** among 65+ (ESKOTE)

	• **Skill expansion for select roles** (e.g., advance practice nurses) to fill human resource gaps (ESKOTE) • **Flexible staffing models** to compensate for workforce shortages (PACE)
Building block #5: Digital health (how are data and digital solutions harnessed?) → **digital tools and data analytics**	• Establishing a **shared digital record** to improve communication between partners (PRISMA, ESKOTE, Te Whiringa Ora and Advance Payment ACOs) • Establishing a **patient portal and/or self-monitoring unit** to support self-management (ESKOTE and Te Whiringa Ora) • **Virtual telehealth supports** both to connect patients to specialists as well as to connect providers with specialty consultations (Advance Payment ACOs)
Building block #6: Leadership, accountability and governance (how are governance and delivery arrangements aligned, and how are providers engaged?) → **collaborative decision-making arrangements** and primary-care leadership	• Expanding and adapting leadership roles to best suit rural contexts, for example, **enabling rural health centres to act as anchor partners** and supporting physicians and advance practice nurses to lead (Advance Payment ACOs and PACE) • Build in **mechanisms** for initiatives **to be accountable to equity-seeking communities** (e.g., through positions on leadership tables, devolution of decision-making) (Australia) • Use of **planning grants** to incentivize organizations with previous collaboration experience to partner together (Advance Payment ACOs and PACE) • **Leveraging regional partnerships** to be able to offer a full continuum of care, such as to access specialized services or reduce administrative burdens for rural service providers (PRISMA, Advance Payment ACOs and PACE) • **Developing local solutions** by leveraging national policy that requires local authorities to offer citizens greater choice in assessment and care delivery (Lead Agency Model) • **Flexibility in implementation processes** and timing to adapt to local and regional contexts (PRISMA, PACE) • Supporting rural-specific implementation supports, such as **rural-focused technical assistance** (Advance Payment ACOs and PACE) • Trust and commitment to initiative strengthened through ongoing and **individualized feedback** from community-based care management supports **to primary-care team** (Te Whiringa Ora) • Investing in staff with **strong cultural competence** and enabling partnerships with those with clinical credibility (Te Whiringa Ora)
Building block #7: Funding and incentive structure (how are financial arrangements aligned?) → (eventually) **integrated funding envelope**	• Implementing innovative funding mechanisms including **pooling budgets** across health and social care and reimbursements based on clinically defined episodes of care (ESKOTE, • **Incentive payments** for additional efforts associated with integrating care in rural communities (PACE) • **Upfront** project **funding**, both fixed and conditional, to cover initial start-up and implementation costs (Advance Payment ACOs and PACE) • **Living wage standard** for independent care-at-home sector (Lead Agency Model)
Building block #8: Performance measurement, quality improvement, and continuous learning (how is **rapid learning and improvement** supported?)	• **Shared business-intelligence model** to facilitate the management of regional indicators to monitor service use and quality improvements (ESKOTE, Finland) • **Accountability measures that speak to** measures of health-system efficiencies and **patient or community-defined goals** (e.g., self-determination in health) (Te Whiringa Ora and Australia) • **Staged performance-measurement targets** to account for significant up-front investment of time and resources to support implementation (Te Whiringa Ora) • Engagement and buy-in supported by **robust performance-management system** able to report on early successes (Te Whiringa Ora)

Key findings from the citizen panels

Citizen panel participants noted that:
• coordination needs to be a **collective responsibility** between disciplines, specialities, and rural and urban providers, and efforts need to be in place to **counteract distrust** between providers and organizations

- care needs to encompass acute health needs as well as address underlying **structural determinants** of accessing care, with **additional supports for under-served and linguistically and/or culturally specific care**; this may include involving broader human services early in the design of OHTs
- OHTs may be able to get farther faster by **building on the long history of successful innovations** led by those in rural areas (e.g., close-to-home capacity for travel-intensive care like chemotherapy and dialysis, nurse practitioner-led clinics, community paramedic programs, and 'layering' services within community hubs).

Key findings from the jamboree

Jamboree participants reflected on the experiences of jurisdictions from outside of Ontario and highlighted several key learnings that could be applied to OHTs, including:
- using a 'tight-loose-tight' approach to implementation, whereby those directing the transformation remain 'tight' around the vision and goals of the transformation, 'loose' or flexible how on it takes place, and 'tight' on measurement and accountability
- creativity in workforce planning and capacity building by focusing on the skills required rather than a specific profession
- investing in information platforms and other supports that allow for ongoing learning, monitoring and evaluation
- being strategic about levels of governance for rural initiatives, including using a regionally networked approach to enhance access to select services, such as hospital care
- nurturing leadership capacity in both health- and social-service systems to ensure one does not dominate the other.

Deliberation about ways to best support the needs of patient and community partners based in rural environments

Address key risk factors, which could include:
- limited **understanding** of specific considerations of rural communities
- insufficient **resources**, including human resources, and capacity to implement approaches
- lack of **community engagement**, including patients, families and caregivers, in adapting approaches
- lack of **engagement of the full range of providers** (e.g., primary care)
- lack of **trust** between partner organizations
- not accounting for historic and on-going **power differentials** between OHT partners
- lack of buy-in to the OHT model from providers and organizations seeing it as '**just another pilot project**.'

Leverage potential success factors, which could include:
- prior **collaboration experience**, such as through informal provider networks that may already be well developed in rural areas where collaboration and interdependence have been a necessity
- explicit **plans to strengthen relationships** between service providers not used to working together
- investments in **relationship building and communication** to establish trust among partners
- approaches to **reduce risk** that allow partners to test out new approaches without significant concern about financial loss
- **flexibility** in the initiative such that it can be tailored to the needs of individual rural communities
- a focus on **filling gaps and building previous efforts into the new initiatives**, including maintaining existing relationships between patients and providers as well as between providers
- **adequate time** for training on new models of care, assessment tools and approaches, relationship building and roles and responsibilities, and staged performance targets
- a **focus on the needs** of local populations rather than on traditional organizational boundaries

- **creativity in meeting workforce requirements** to identify new ways of working, training, or upskilling needs and whether new roles are necessary
- **full-time leadership to adapt the model** to local needs, structures, and cultures, including an on-going investment in relationship building.

Key findings from the citizen panels

Citizen panel participants identified ways they believed OHTs could 'get further, faster', including by:
- building on **existing partnerships** while leveraging momentum to **adapt innovations** from elsewhere
- aligning **governance and incentive structures** with OHT end-goals
- **streamlining digital care services** both within and across OHTs
- **investing** in OHT leadership, partnership-building, and digital equity across the province.

Key findings from the jamboree

Jamboree participants identified numerous next steps to explore, including:
- proactively communicating the long-term vision for OHTs and any specific building-block requirements
- ensuring flexibility in the 'how' of OHT implementation in mixed and predominantly rural environments
- balancing the need for complementary regional and hyper-local approaches to OHT development, including for leadership and governance and for performance measurement and evaluation
- designing additional supports to address capacity gaps for rurally based OHTs, including practice-level coaching and facilitation, tools to support conflict-resolution, opportunities to share information among rurally based OHTs, and learning programs focused on the 'third curve' of population-health management
- recognizing that many rural teams have long-standing resource constraints and may require additional investments and opportunities to test innovations locally to achieve same goals
- focusing on the initial implementation of small but meaningful innovations to build trust among partners.

References

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