

# OMA's Ontario Health Teams White Paper

## Early Learnings and Recommendations for the Evolution of OHTs

October 2020



*OMAThoughts*

This OHT White Paper was produced by staff of the Economics, Policy and Research Department at the Ontario Medical Association (OMA) with the input of OMA legal staff and other partners.

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## Section 1: Executive Summary

In April 2019, the Ontario government introduced significant health-system transformation through Ontario Health Teams (OHTs),<sup>i</sup> which are intended to help improve health-system integration and performance across a range of outcomes linked to the quadruple aim<sup>1,ii,iii</sup>. The movement to integrated care by way of OHTs represents some of the most rapidly evolving health-system reform that Ontario has experienced in more than a decade.

Physicians and their patients have long championed a better and more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more time caring for patients.

This white paper sets out key recommendations as OHTs are developing in Ontario. These recommendations are based on evidence from other jurisdictions and lessons learned. OHTs began forming in 2019 to early 2020. During that time we began to learn and inform how groups can effectively work together to support integration. COVID-19 has introduced significant additional challenges to an already strained system.

We have seen some groups work together effectively to support one another. We have also seen some challenges exacerbated, such as a significant backlog in clinical care resulting from the response to the first wave of the pandemic. The health-care system will need to fundamentally change to deal with the ongoing demand and to address the backlog. This opportunity for change should be used to improve the health-care system — particularly to address such issues as capacity, wait times and hallway medicine — not return to the pre-COVID-19 system. Lessons learned over the past few months and over the coming months should be used to help inform the future state of OHTs.

### Foundational elements and recommendations

Based on evidence and experiences from other jurisdictions, this paper highlights three equally important foundational elements required for successful OHT development and implementation:

#### **Physician leadership in the governance and determination of care delivery**

- OHTs should demonstrate physician leadership in their creation, governance and operation.
- Physicians should be involved in organizational decision-making of OHTs.
- Success of OHTs relies on physician participation and leadership. Formal physician roles within OHTs need to be established. Physician associations within OHTs are a key component to ensuring legitimacy in physician representation and participation in OHTs and should include family physicians and community-based and hospital-based specialists.

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<sup>1</sup> Quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value

## Voluntary physician participation

- Physician participation in OHTs must remain voluntary.

## Primary care at the core/foundation

- OHTs must be designed around primary care and must allow for creativity at the local level, recognizing that what works in one area may not work in another.
- The vision and framework of the Patient’s Medical Home (PMH) and the Patient’s Medical Neighbourhood (PMN) models should be used to facilitate primary care at the centre of OHTs.
- OHTs and family physicians must be supported with appropriate infrastructure, enabling technology and support for connected care, administration and funding.
- All physicians, including family physicians, community-based specialists and hospital specialists must be engaged early in the design of OHT governance to help achieve more seamless integrated care.

To further support primary care as being central to OHTs, the PMH and PMN models are highlighted in the preceding recommendations as keys to success. These are compelling models for change that create a vision that physicians and other providers can rally behind. Incorporation of PMH and PMN frameworks within OHTs will help improve care and patient outcomes, reduce emergency department visits and ultimately help achieve the quadruple aim.

## Enabling factors

To help support the three foundational elements, several enabling factors have been identified that help support the success of the OHT integrated care model and drive physician involvement:

1. Digital health – OHTs must have the necessary digital health supports and tools
2. Governance – Governance structures (including digital governance) within OHTs must include physician leadership in organizational decision-making
3. Patient navigation and care co-ordination – OHT implementation must be supported by the redesign and better utilization of existing patient navigation and care co-ordination resources
4. Metrics and measurement – Key performance metrics must be identified and/or designed to measure OHT success that encompass the quadruple aim.

These enabling factors are discussed in more detail in companion documents to this paper.

## Physician associations

To help ensure and support physician leadership within OHTs, the OMA recommends that physicians within communities form local physician associations. These associations provide a mechanism for physicians to self-organize, come together to elect representatives to the OHT governance board and to discuss and potentially vote on clinical and other issues. The OMA has developed resources and tools to support physicians in developing these associations. During the pandemic, the positive impact on patient care of well-organized physician OHT groups became clear. These physicians (primary care and specialists) came together as a unified group, supported one another, shared information and successfully collaborated on numerous COVID-19 related issues.

The OMA would like to acknowledge the OMA Section on General and Family Practice, the Ontario College of Family Physicians and the Association of Family Health Teams of Ontario for their collaboration in the development of the primary care at the core/foundation section of this paper (see Section 3) and OntarioMD for its contribution to the digital health section of this paper (see Section 4) and its endorsement of this paper.

## Summary and next steps

This white paper provides recommendations related to key foundational elements to help advance system-level change and was informed by early learnings, as the OHT landscape evolves related to digital health, governance, care co-ordination/patient navigation and metrics and measurement. The OMA has been closely monitoring the rapidly evolving landscape, including the impact of the COVID-19 pandemic. The recommendations in this paper are therefore based on both evidence and experience. The OMA will continue to advance and evolve the recommendations in this paper. The OMA looks forward to ongoing co-development of this significant reform with government, Ontario Health, approved Ontario Health Teams and applicants and other health-system partners to share our learnings to support successful health-system integration.

## Section 2: Introduction and Purpose

Early in 2019, the Ontario government introduced its health-system transformation by way of Ontario Health Teams (OHTs). OHTs are intended to help improve health-system integration and performance across a range of outcomes that support the quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value (see Figure 1).<sup>iv</sup>

Figure 1



### Supporting the Quadruple Aim for Health Care

The Ontario Medical Association (OMA) and the physicians it represents have, alongside patients, long advocated for a more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more time caring for patients.

The movement to integrated care by way of OHTs represents some of the most significant, fast-moving and evolving health-system reform that Ontario has experienced in more than a decade. The COVID-19 pandemic has both expedited the need for enhanced integration and exacerbated the challenges the system was facing. The health-care system will need to fundamentally change to deal not only with the ongoing demand, but also address the backlog in clinical care that resulted from responding to the first wave. This opportunity for change should be used to improve the health-care system — particularly to address such issues as capacity, wait times and hallway medicine — not return to the pre-COVID-19 system. Therefore, the need to effectively and efficiently move to an integrated health-care system is more important than ever. To do this successfully requires the leadership and involvement of all



physicians, working alongside policymakers and other key stakeholders, to be ready for the upcoming flu season, future outbreaks of COVID-19 and beyond.

The OMA represents Ontario’s physicians and is a key thought leader in the health-care system, informing policy and developing solutions that improve care delivery in Ontario. With input and advice from OntarioMD, the Ontario College of Family Physicians (OCFP), the OMA Section on General and Family Practice (SGFP) and the Association of Family Health Teams of Ontario (AFHTO), this white paper and its companion documents provide recommendations to help advance system-level change. These recommendations are informed by evidence from other jurisdictions, early learnings in the development of OHTs and lessons learned from our collective experience dealing with COVID-19.

To complement this paper, the OMA continues to provide support to physicians to guide them through the evolving OHT landscape.<sup>2</sup> We look forward to continued collaboration with policymakers to co-develop this important health-system reform.

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<sup>2</sup> This information can be found on the OMA’s dedicated webpage at [www.oma.org/oht](http://www.oma.org/oht). Questions about OHTs may be emailed to [oma\\_oht@oma.org](mailto:oma_oht@oma.org).

## Section 3: Position on Ontario Health Teams

This section outlines three equally important foundational elements required for successful OHT development and implementation.

### Physician leadership in the governance and determination of care delivery

Physician leadership is key to the successful implementation of OHTs. Family physicians, community-based specialists and hospital-based physicians all play a pivotal role in the success of OHTs.

In other countries, such as the United States, studies that focused on accountable care organizations (ACOs) — which have similar aims to OHTs<sup>v</sup> — concluded that they are most successful in terms of cost-savings and quality outcomes when they are physician-led, voluntary and primary-care focused.<sup>vi,vii</sup> ACOs with physicians in leadership roles, e.g., clinical/governance leadership roles, demonstrate cost savings, which can be reinvested in patient care.<sup>viii,ix</sup> For example, cost savings are positively correlated with the proportion of physicians on governing boards of health-care organizations.<sup>x</sup> Physician-led integrated care organizations generate significantly more cost savings per patient while maintaining or improving quality, compared to organizations led by others (average savings of \$474 per patient versus \$169 per patient after three years, respectively).<sup>xi</sup>

Effective performance of ACOs is supported by trusted, long-standing physician leaders focused on improving performance.<sup>xii</sup> Similarly, in the United Kingdom (U.K.), physician-led clinical commissioning groups, another structure that is similar to OHTs, have shown great promise. Evidence continues to emerge that clinical leadership by physicians is an essential component of integrated care delivery systems leading to greater effectiveness and innovation.<sup>xiii</sup> Another extensive literature review (in the U.S., U.K. and Europe) of integrated practice initiatives in Canada demonstrated the importance of strong physician leadership (and support of other clinical groups) as a critical success factor for integrated care.<sup>xiv,xv</sup> Management teams that include physicians enable organizations to implement change more effectively because physicians in leadership positions can connect sectors across the care continuum.<sup>xvi</sup> In addition, physician-led integrated care organizations consistently achieve better patient experience scores.<sup>xvii</sup>

To support effective physician leadership on governing boards within OHTs, the OMA recommends that interested physicians, e.g., family physicians, specialist physicians (including community-based specialist physicians), physicians practising in varied practice models and those in hospitals, etc. form physician associations. Establishing physician associations within communities provides a mechanism by which physicians can self-organize, come together to elect representatives to the OHT governing body and discuss and potentially vote on clinical and other issues related to the OHT. Physician associations lend credibility to physician participation in the broader OHT, as they offer a legitimate mechanism by which physicians represent their peers on any OHT governing board.

### ***What does physician leadership mean in OHTs?***

*Physician leadership means that physicians—primary care-based, community-based and hospital-based specialists—are meaningfully engaged in all aspects of OHTs, from their development to implementation and evaluation. Physicians who choose to be involved in OHTs may represent many areas of practice, with primary care expected to be prominent.*

*Physician leadership can take many forms. For example, physicians may lead the design and structure of a new OHT, shepherd the process of applying to become an OHT, act as administrative leaders, function as clinical leaders within OHTs, develop physician associations and assume formal leadership roles within the governance structure of OHTs as key decision makers.*

## **Learnings from COVID-19**

The COVID-19 pandemic illustrated the critical importance of physician leadership in the health-care system and within OHTs. Many critical issues have emerged during the pandemic, including shortages in personal protective equipment (PPE), the move to virtual care while deferring care, subsequently ramping up deferred care, financial uncertainty and physician mental health.

Through this uncertain period, we have seen the value in effective collaborations with physicians assuming leadership positions. For example, those in physician groups, including those involved in physician associations, mobilized quickly and worked together to address numerous matters related to the pandemic, including:

- Compiling and disseminating provincial guidelines pertaining to COVID-19
- Providing free initial PPE kits for physicians in the local community
- Providing guidance for returning to in-person care
- Creating validation checklists for physicians ordering PPE from different suppliers
- Disseminating resources pertaining to physician wellness during COVID-19
- Disseminating infection control and prevention strategies through the community of practice for primary care
- Participating in bulk purchasing of PPE for primary care physicians.

These experiences further illustrate the importance and value of physician leadership — particularly organized groups of physicians — and their impact within an integrated care system (see Section 4, which discusses governance and the role of physician associations in more detail).

## **Physician engagement**

Building trust and productive working relationships leads to enhanced collaboration and understanding of the perspectives of the partners. Meaningful physician engagement extends beyond informing, educating and consulting and requires true collaboration, partnership and empowerment from the

onset of OHT development.<sup>3</sup> Significant research and work has already been done in Ontario on how to build trust and working relationships and to meaningfully engage physicians.<sup>xviii,xix xx</sup> Research also shows that meaningful physician engagement is important to successful health-system reform and is positively linked to organizational performance, in that the more effective the engagement the better the performance<sup>xxi,xxii</sup> and patient outcomes.<sup>xxiii</sup>

Given the infrastructure and resources available in hospitals, much of OHT development was initially led by hospitals. Moving forward, it is critical that OHTs be co-developed with all physicians involved, including family physicians, community-based specialists and hospital-based physicians. Evidence from the U.S. demonstrates that, in jurisdictions where independent hospitals have led integration (i.e., without including physicians in governance), results have been mixed as compared to physician-led models.<sup>xxiv,xxv</sup> It is vital that hospitals and others leading OHT development meaningfully and actively engage physicians in the process.

## System investment

Investment in physician leadership is critical to the success of OHTs. Physicians want to be involved and to shape this significant health-system transformation in Ontario. Unfortunately, it is simply not feasible for physicians to continue to run their clinical practices while also trying to lead OHTs. System investment in leadership is therefore needed. We have learned that getting physicians to the OHT table to inform the process has been one of the biggest challenges and requires support. For example, it may not be feasible for family physicians to take time away from their clinical duties during the day. Physicians often do not have anyone to cover for them when they are away from their regularly scheduled practice or work in other health-care settings, especially those in rural areas, where resources are already scarce. To enhance success when involving physicians in OHT efforts, it is important to eliminate barriers to their participation, including, where appropriate, physical and financial barriers. In addition, leadership training opportunities should be offered to physicians.

## Recommendations – Physician leadership

1. *OHTs should demonstrate physician leadership in their creation, governance and operation.*
2. *Physicians are encouraged to learn about and become involved in organizational clinical decision-making of OHTs.*
3. *The government should compensate physicians for their leadership in OHT development and implementation.<sup>4</sup>*
4. *Success of OHTs relies on physician participation and leadership. Formal physician roles within OHTs need to be established. Physician associations within OHTs are a key component to ensuring legitimacy in physician representation and participation in OHTs and should include family physicians and community-based and hospital-based specialists.*

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<sup>3</sup> For physician engagement to be effective, it needs to start early and be sustained. Consideration of how to achieve this should include working with medical schools and key partners to better promote engagement long term and to help explain to future physicians that these opportunities will exist when they come into practice.

<sup>4</sup> This includes recognition and value of physician clinical leadership and compensation for time spent by physicians attending meetings, etc., which typically occur during clinic hours.

## Voluntary physician participation<sup>5</sup>

Evidence from other jurisdictions demonstrates that voluntary participation leads to the most efficacious outcomes in systems similar to OHTs. In the U.S., it was found that after three years of voluntary participation, greater shared savings was achieved by physician groups, compared to hospital-integrated groups.<sup>xxvi</sup> The OMA continues to articulate the importance of voluntary participation, while continuing to encourage physicians to learn about OHTs and how they can get involved. We are here to support all physicians, regardless of their level of OHT engagement. The OMA has also developed a non-binding agreement<sup>6</sup> for physicians to participate in an OHT.

### ***What does voluntary physician participation in OHTs mean?***

*Physician participation in OHTs is completely voluntary; participation must not be mandated.*

*Physicians can choose to be involved in an OHT application or to start their own. At this stage in the process, if physicians have been involved in some capacity, they can choose to no longer be involved.*

*Physicians are encouraged to remain engaged and to learn more. Regardless of involvement, there is no impact on physician compensation. The OMA will continue to negotiate physician compensation through the Physician Services Agreement.*

We have learned through past health-system reform experiences in Ontario and elsewhere in Canada that physicians, as self-governing professionals, must be willing participants and an active part of the solution. Voluntary participation and involvement in other integrated models, while building a culture of shared commitment and accountability, leads to improving quality and cost.<sup>xxvii</sup> Senior integration leaders reflecting on their health-system integration experiences in the U.K. have affirmed in a recent report that using a voluntary approach to co-ordinating care is more likely to lead to higher engagement and be more effective than if it was mandated by legislation.<sup>xxviii</sup> Further, legislation does not guarantee a change in behaviour; a voluntary approach to integration, with agreement among the parties involved, may be more successful, despite it being a slower process.<sup>xxix</sup> Physicians are more likely to engage in change when the change is led by physicians and not forced on them and are more likely to buy in and make the necessary changes to their practices as part of health-system transformation.<sup>xxx,xxxi</sup> A recent review of new integration models in the U.K., known as primary care networks, noted that mandatory physician engagement in integrated care models could lead to physician disengagement and resistance.<sup>xxxii</sup> The process to successfully engage physicians to build buy-in and trust by both physicians

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<sup>5</sup> Letter from OMA President regarding compensation – Oct. 8, 2019. Available from: [www.oma.org/oht](http://www.oma.org/oht)

<sup>6</sup> Despite anything set out herein, the intention expressed in this letter is non-binding in nature. The physician and/or group may decline to participate in future agreements and may revoke their participation at any time. Available from: [www.oma.org/oht](http://www.oma.org/oht)

and organizations occurs over time. Physicians must feel valued, respected and trusted and be part of the decisions as opposed to being involved after the fact.<sup>xxxiii</sup>

Physician burnout is becoming increasingly prevalent, with one in four physicians in Canada reporting high levels of burnout and one in three screening positive for depression.<sup>xxxiv</sup> COVID-19 has exacerbated this problem. In the U. S., almost 50 per cent of physicians have high levels of burnout<sup>xxxv</sup> and it is a growing issue worldwide.<sup>xxxvi</sup> Physician burnout results from a variety of factors, including increased workloads and demands on clinical time, growing patient demands, rising costs and the increasing demands of new technology. Therefore, the importance of proper design, development and implementation of any health-system reform must be done with the meaningful involvement and leadership of physicians. Further, to help reduce the burden on physicians, dedicated support and change management tools are required to enable the adoption of new (but often disruptive) technology to improve care to patients.

Physicians, like all professionals, embrace opportunities to engage and innovate to improve the lives of their patients. They will willingly engage with OHTs if appropriate and respectful engagement is offered. If done well, engagement may also improve the health-care provider experience and reduce burnout. A better provider experience — one component of the quadruple aim and an area of focus for OHTs — has more recently been identified as an important element in helping to achieve the other three objectives.”<sup>xxxvii</sup> In other words, without engaged physicians and other health-care providers the objectives of the triple aim may not be fully realized.<sup>xxxviii</sup> An “engaged and productive” workforce is essential to achieving the quadruple aim.<sup>xxxix, xl</sup>

The literature is clear that physicians play a pivotal role in health-care transformation and their voluntary involvement, particularly at decision-making tables, is essential.<sup>xli,xlii,xliii</sup>

## Recommendation – Voluntary participation

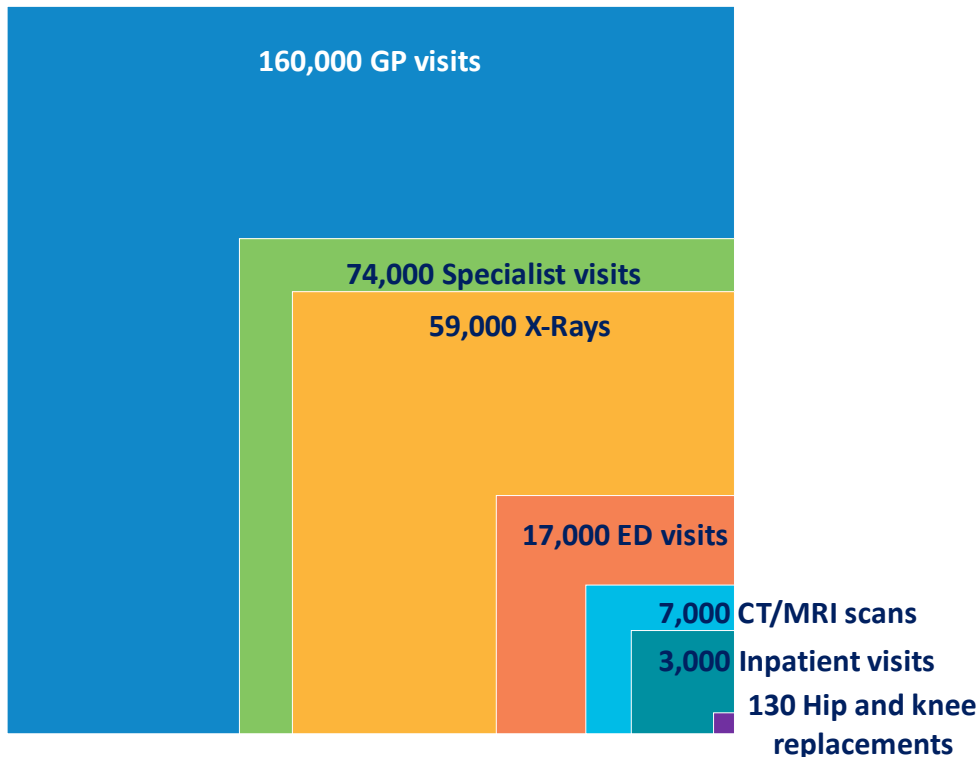
1. *Physician participation in OHTs must remain voluntary.*

### Primary Care at the core/foundation

Successful development and execution of OHTs are predicated upon a high-functioning primary care sector that offers comprehensive, co-ordinated and accessible services based on the continuity of the relationship between the provider and patient. Primary care must be connected with other sectors across the OHT to ensure that individual patient and population needs are met. Other successful high-performing health-care systems, including Australia, the U.K. and the Netherlands, have primary care at their foundation.<sup>xliv,xlv,xlvi</sup> At the core of these successful models of care is a committed focus to enabling and supporting family physicians, whose role and leadership are critical to realizing the vision of OHTs.

## Figure 2 - Average Number\* of Health-Care Services Accessed each Day

Ontario FY2018/19



\* Values rounded to the nearest thousand except for hip and knee replacements, which were rounded to the nearest 10.

Figure 2 – Source: OMA, 2020

Ontario's family physicians serve more than 160,000 people each day (see Figure 2), providing care to patients and families across such settings as patients' homes, family physicians' offices, retirement homes, long-term care homes, hospices, emergency departments and hospitals. Ontario's family physicians have the broad front-line experience and insight to inform how health care and community-based services can be improved in Ontario.

Family physicians provide continuity of care across many settings and throughout the lifetime of their patients. They are essential to helping their patients:

- Navigate the system
- Achieve good health and stay healthy
- Prevent disease by proactively identifying risk factors and co-ordinating and managing chronic disease care for longevity and a better quality of life.

Family physicians are also often the original integrators of care. This is because the family physician-to-patient relationship is the foundation upon which all other relationships within an OHT start from or link to. Many family physicians across Ontario work collaboratively with interprofessional health-care providers as key members of their patients' care teams. Continuity of care between the patient and their physician-led care team has been shown to reduce hospital admissions, decrease system costs and improve patient satisfaction. This is a key line of defense against hallway medicine.

Continuity of care and comprehensive team-based care with family physician leadership are hallmarks of the Patient’s Medical Home (PMH) depicted below (see Figure 3).

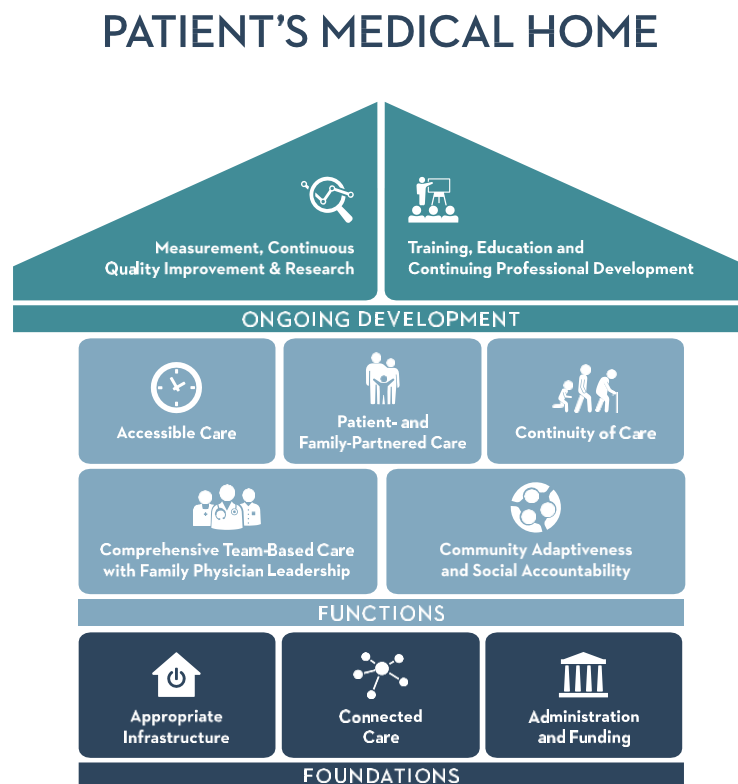


Figure 3 - Source: College of Family Physicians of Canada, 2019

The PMH articulates the foundational elements — appropriate infrastructure, connected care, administration and funding — that are critical to support comprehensive team-based care led by family physicians, care that is socially accountable and adaptive to the community and accessible, patient and family-centred, continuous care. The Patient’s Medical Neighbourhood (PMN) (see Figure 4), an expansion of the PMH, identifies the points of integration and illustrates how an OHT centred around primary care should look.

Given that OHTs will be measured at maturity on their ability to serve an attributed population’s needs and, to the extent possible, keep people out of hospital, family physicians’ capacity should be enhanced to maintain patient continuity at the community level. A PMH regularly evaluates and measures progress, using continuous quality improvement and research. To achieve more seamless and integrated care, it is critical to have family physicians at the core of primary care and the PMH and PMN working collaboratively with community-based and hospital-based specialists, along with other health-care providers.





Figure 4 – Source: College of Family Physicians of Canada, 2019

There are many examples of successful implementation of the PMH in Ontario<sup>xlvii</sup>. SCOPE (seamless care optimizing the patient experience) originated in response to struggles family physicians were facing in developing relationships with consultant specialists and other key health-care providers.<sup>xlviii</sup> The SCOPE program connects registered family physicians virtually, through a single point of access, to an interdisciplinary team that includes local consultant specialists, imaging, nurse navigators and community services. SCOPE helps family physicians serve and, in many instances, co-manage, their patients with complex care needs.<sup>xlix</sup> OntarioMD and other partners have worked closely with SCOPE by providing access to digital tools to facilitate the program.

Another innovative example that exemplifies the PMH model and supports family physicians to deliver quality care is CarePoint Health in Mississauga, which, through expansion of team-based funding, connects solo family practices with interprofessional health-care providers.<sup>1</sup> In this program, the family physician maintains continuity of care and is part of the expanded care team, as opposed to referring the patient to other team-based resources.

### Recommendations – Primary care at the core/foundation

1. OHTs must be designed around primary care and must allow for creativity at the local level, recognizing that what works in one area may not work in another.
2. The vision and framework of the PMH and PMN models should be used to facilitate primary-centred care at the centre of OHTs.
3. OHTs and family physicians must be supported with appropriate infrastructure, enabling technology and support for connected care, administration and funding.
4. Family physicians at the core of primary care in collaboration with community- and hospital-based specialists must be engaged early in the design and implementation of OHTs to help achieve more seamless and integrated care.

## Section 4: Factors to Enable Successful OHTs

Section 3 provided an overview of the three foundational elements required for successful OHT development and implementation, i.e., physician leadership, voluntary participation and primary care at the core of OHTs. These elements must be enabled and supported by the following four key factors for success:

1. Digital health – OHTs must have the necessary digital health supports and tools
2. Governance – Governance structures (including digital governance) within OHTs must include physician leadership in organizational decision-making
3. Patient navigation and care co-ordination – OHT implementation must be supported by the redesign and better utilization of existing patient navigation and care co-ordination resources
4. Metrics and measurement – Key performance metrics must be identified and/or designed to measure OHT success.

Each of these four enabling factors is discussed below and is described in more detail in four companion documents appended to this white paper.

### Digital health

Digital health is defined as “the integration of the electronic collection and compilation of health data, decision-support tools and analytics with the use of audio, video and other technologies to deliver preventive, diagnostic and treatment services that promote patient and population health.”<sup>ii</sup> It is fundamental to achieving and operating a successful integrated care delivery system and is a key component of OHTs. It is essential that OHTs have:

- **Integrated information and sharing systems**, including real-time access to and sharing of data within OHTs to deliver co-ordinated, integrated and high-quality care.
- **Real-time access to digital health tools and assets**, so that providers within an OHT have seamless and real-time access to digital health tools and assets, including the ability to launch digital tools directly from their electronic medical record (EMR).
- **Virtual care**, including equipping providers with the ability and supports they need—including funding support — to provide virtual care.
- **Access to patient-facing digital health tools**, such as patient portals that allow patients to book appointments online and access their medical records.
- **The ability to perform analytics within an OHT**, including using digital health tools to perform analytics for population health and quality improvement purposes.
- **Access to data generated by OHTs** to perform analytics for health-system planning and management and to support delivery of integrated care.

Further details regarding digital health can be found in Appendix A: Digital Health Companion. Below is a summary of the recommendations, which are more fully described in that document.

### Recommendations – Digital health

1. *Physicians are key partners in the development of an integrated information sharing system, which will require legislative and regulatory requirements under the Personal Health Information Privacy*

*Act (PHIPA) and clear data governance and stewardship policies, as well as standards-based integration among different provider digital health systems within an OHT.*

- 2. Providers within an OHT should be equipped with guidance on essential digital tools and assets that are relevant to their clinical workflow, as well as effective change management supports. Physicians participating in an OHT should use an OntarioMD-certified EMR so that they are able to access EMR-integrated provincial digital health assets and tools.*
- 3. The expanded availability of virtual care should continue permanently beyond the pandemic and all modalities of virtual care should be appropriately compensated, including video visits, telephone calls and secure messaging. Providers should have an equivalent choice in the virtual care platform they choose, including the use of non-Ontario Telemedicine Network (OTN) technology. Key principles must be kept in mind to ensure virtual care is developed and delivered appropriately.*
- 4. Patients should have access to patient-facing digital health tools, which will require a framework and standards-based approach, as well as patient education to ensure patients understand the health information they can access.*
- 5. OHTs need to be equipped with digital health technology and supports to perform analytics for population health management and quality improvement purposes.*
- 6. A legislated, multi-stakeholder Data Governance and Stewardship Committee should be convened to facilitate data governance in the system, including the appropriate and ethical use of data by Ontario Health.*

## Governance

The introduction of OHTs in Ontario creates significant challenges and opportunities, including the opportunity to learn from multiple local approaches on various governance structures, organizational structures, information technology (IT) architectures, digital health applications and models of care. In addition, there are several opportunities for designating and deploying province-wide standards for better care, improved system performance, scalability, seamless sharing and data comparability.

The OMA believes that governance of OHTs needs to take place at three levels:

1. The provincial level, to ensure that province-level goals and expected accountabilities are being met and that all OHTs have proper oversight and are tracking to provincial goals
2. The individual OHT level, where physicians may be clinical leaders and hold such key positions as administrators within the OHT governance structure; at this level, physicians would be involved in decision-making that impacts the OHT
3. The physician level, through the establishment of formal physician leadership roles for interested physicians within OHTs and on the governing boards. This can be enabled through physician associations within communities. These associations provide a mechanism for physicians to self-organize and come together to elect representatives to the OHT governance board and to discuss and potentially vote on clinical and other issues related to the OHT. As mentioned previously, these physician associations, along with other physician groups, played a pivotal role in effectively dealing with multiple issues that arose during the COVID-19 pandemic, including shortages of PPE.

Further details regarding governance can be found in Appendix B: Governance Companion. Below is a summary of the recommendations, which are more fully described in that document.

## Recommendations – Governance

1. *The Ministry of Health (MOH) should continue to work with the Physicians Services Committee in relation to OHT implementation.*
2. *Physicians must play a major role on the OHT Health Governance Organizations (HGOs), including a leadership role in clinical and other organizational decision-making.*
3. *Success of OHTs relies on physician participation and leadership. Formal physician roles within OHTs need to be established. Physician contributions and leadership roles within OHTs should be recognized and adequately compensated through negotiations with the OMA.*
4. *The health system needs to support physicians to grow and maintain the necessary skills to effectively lead HGOs to help ensure OHTs roll out properly across the province.*
5. *Physician associations within OHTs are key to ensuring legitimacy in physician representation and participation in OHTs and should include primary care-based physicians and community-based and hospital-based specialists.*
6. *The data and information governance committee is an essential board committee of the OHT HGO and should be established at an early point.*
7. *Regardless of the governance model chosen, it is essential that existing boards be engaged and involved in the establishment of the decision-making framework.*

## Patient navigation and care co-ordination

As discussed in Section 3 of this paper, primary care through family physicians is the foundation of all health care. It is how most people access and receive the majority of their care. It is key to ensuring continuity, comprehensiveness and co-ordinated care,<sup>iii</sup> leading to a better patient experience, which is one of the outcomes of the quadruple aim and an intent of OHTs. Further, savings related to OHTs are intended to go back into supporting patients and making the whole system better.

As set out in the MOH guidance document, OHTs will be expected to “offer patients 24/7 access to co-ordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey.<sup>liiii</sup>” This means that a patient navigator/care co-ordinator function should be available within OHTs.<sup>liiv</sup> This would not mean that physicians are available 24/7.

Ontario’s physicians see tremendous opportunity at this juncture of the government’s vision of greater integration across the health-care system to leverage the vital role of Ontario’s 4,000-plus care co-ordinators (funded through Local Health Integration Networks) and maximize their potential in OHTs. This opportunity has been further leveraged by the recent passage of new home care legislation, which aims to modernize the system and allow for the embedding of care co-ordinators directly in primary care<sup>7</sup>. For optimal results and to strengthen integration where most care happens, care co-ordination in primary care within OHTs ideally should encompass both co-ordination (improving transitions) and patient navigation (better connections) to support continuity in primary care and the follow-up of patients’ holistic and complex needs. Ultimately, the ability to provide more seamless and integrated care within primary care impacts the success of OHTs and would be a key line of defence against hallway medicine.

How we maximize the potential of Ontario’s care co-ordinators comes down to their envisioned role and function to meet the needs of patients and families in getting the most effective care. This will need to

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<sup>7</sup> The OMA advocated for changes to the home care system to maximize the role of care co-ordinators through its submission and deputation to the Standing Committee on Bill 175 in June 2020.

be carefully considered, as a one-size-fits-all approach will not be effective. Co-design with physicians, patients and families will be an essential aspect of a renewed role.

Further details regarding patient navigation and care co-ordination can be found in Appendix C: Patient Navigation and Care Co-ordination Companion. Below is a summary of the recommendations, which are more fully described in that document.

## Recommendations – Patient navigation and care co-ordination

1. *Locate existing care co-ordinators within primary care settings whenever possible on a voluntary basis and with the support of primary care leadership. Additional funding or reimbursement to support overhead costs is an important consideration.*
2. *To optimize results within OHTs, care co-ordination should ideally encompass both co-ordination (improving transitions) and patient/system navigation (better connections) to encompass patient needs and the broader social determinants of health.*
3. *To best maximize the role of care co-ordinators/system navigators and to avoid a one-size-fits-all approach, the role and functions should be co-designed with physicians, patients, families and other health-care providers.*
4. *Establish the necessary IT infrastructure to support patient and family virtual access and information exchange with care co-ordinators.*

## Metrics and measurement

To determine the success of OHTs in achieving the quadruple aim, indicators to measure the success of OHTs based on the aim must be identified and/or developed. To help facilitate this work, the OMA has met frequently with several experts to help identify and develop the parameters surrounding those measures and begin informing their development. These experts have included representatives of government, regulatory bodies, physicians, associations, academic institutions, digital and measurement experts and patient representatives.

The work of this group began before the COVID-19 pandemic and has not yet resumed. The working group has identified several key principles for choosing metrics/indicators. These principles were grouped into two areas, absolute and preferred, as outlined below.

### Absolute

- Cogent/reasonable/meaningful/useful (for whom)
- Reliable/valid
- Actionable/responsive

### Preferred (in approximate order of priority)

- Comprehensive in scope of quadruple aim
- Parsimonious number of measures (i.e., is it essential?)
- Timely
- Consistent with ongoing data collection activity
- Easily available/feasible
- Co-ordinated/comparability across system (source of data, data truth, definitions, able to link among data sources, etc.)
- Encompasses population of interest

Further details regarding metrics and measurement can be found in Appendix D: Metrics and Measurement Companion. Below is a summary of the recommendations, which are more fully described in that document.

### Recommendations – Metrics and measurement

1. *As the system objective of OHTs, the quadruple aim should guide the determination of the domains for metrics.*
2. *The STEEP (safe, timely, effective, efficient, equitable, patient-centred) framework should be used to help guide the determination of metrics.*
3. *The principles for choosing metrics/indicators outlined in this section should be used to guide their identification and development.*

## Section 5: Summary and Next Steps

With the rapid and significant health-system reform to OHTs, the OMA has developed this white paper, with input and advice from other thought leaders — OntarioMD, SGFP, OCFP and AFHTO — to help ensure the future success of OHTs. This includes providing an overview of key elements of the OHT model that are critical to its success — physician leadership, voluntary physician participation and being centered around primary care.

This white paper provides recommendations on these key elements to help advance system-level change, informed by early learnings as the OHT landscape evolves related to digital health, governance, care co-ordination and patient navigation, metrics and measurement and the lessons learned from COVID-19. The OMA has been monitoring the rapidly evolving landscape closely and recommendations are based both on evidence and experience. The OMA is pleased to be a key informant on this major health-system reform and, on behalf of physicians, will advocate for the fundamental importance of meaningful engagement of and collaboration with physicians as key experts in driving effective integration and care delivery in Ontario. Thus, the input of physicians is critical.

### Next steps

The OMA will continue to work to advance the recommendations set out in this paper, including seeking advice from other thought leaders. We will continue to review and learn from this health-system reform and the lessons learned from the COVID-19 pandemic. We will also continue to gain knowledge and information from physicians who are actively engaged in that reform. We will actively communicate with government, Ontario Health, approved OHTs and applicants and other stakeholders to share the learnings from our organizations and physicians to support successful health-system integration.

## Section 6: Appendices

### Appendix A – Digital Health: OMA’s OHT White Paper – Companion Document #1

#### Introduction and purpose

In spring 2019, Ontario launched a rapid and evolving health-system transformation called Ontario Health Teams (OHTs).<sup>iv</sup> These teams are intended to help improve health-system integration and performance across a range of outcomes that support the quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.<sup>lv</sup>

The OMA, physicians and Ontarians have long advocated for a more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more of their time caring for patients. The need to do this appropriately and expeditiously, especially in light of COVID-19 and potential future pandemics, requires the leadership and involvement of all physicians, working alongside policy-makers and other key stakeholders.

The OHT white paper and its four companion documents (*1. Digital health, 2. Governance, 3. Patient navigation and care co-ordination, 4. Metrics and measurement*) were developed to provide recommendations to help advance system-level change. The white paper highlights early learnings and key recommendations for the evolution of OHTs and focuses on three equally important foundational elements required for OHT success. These elements are:

- Physician leadership in the governance and determination of care delivery
- Voluntary physician participation
- Primary care being at the core/foundation.

The companion documents identify key enabling factors in four areas to support these core elements.

This digital health companion document identifies the necessary digital health supports and tools that OHTs must have in place to support their successful development, implementation and evolution over time.

Digital health, defined as “the integration of the electronic collection and compilation of health data, decision-support tools and analytics with the use of audio, video and other technologies to deliver preventive, diagnostic and treatment services that promote patient and population health,”<sup>lvii</sup> is fundamental to achieving and operating a successful integrated care delivery system and is a key component of OHTs.

The COVID-19 pandemic has highlighted the fundamental importance of digital health in the delivery of care and has propelled the development of policy and uptake of digital health tools. For example, as detailed in this companion document, the uptake of virtual care has allowed for the continued provision of care to patients when physical distancing is required. Lessons learned from our experience with the pandemic have also brought into further focus the need to address pre-existing gaps in our digital health system, including access to integrated health information and data governance.



The recommendations below have been informed by the digital health needs for OHTs identified pre-COVID-19 and by learnings from the current pandemic.

## Integrated information sharing system

Real-time access to and sharing of data within OHTs is essential to deliver co-ordinated, integrated and high-quality care. The COVID-19 pandemic has further highlighted the importance of equipping providers with timely access to patient information across the care continuum. A seamless flow and exchange of information across the continuum of patient care will reduce the administrative burden on providers in obtaining patient information. In turn, it will increase efficiency in the delivery of care and reduce burnout. For an integrated care delivery system to operate effectively, an integrated information sharing system is paramount. This will require legislation, regulation and policies and adherence to common technology and information exchange standards.

Entities within an OHT may need to share personal health information (PHI) with each other, regardless of whether they are in the patient's circle of care, e.g., with a social service or community organization that is not a health information custodian (HIC), but is still providing a service to the individual. However, the legislative framework does not now enable information sharing among all providers without express consent beyond the circle of care. This means that, while HIC members within an OHT can share PHI with each other based on implied consent as part of the circle of care, express consent from the patient would be required to share PHI with a non-HIC member in an OHT. This would impede the seamless and efficient exchange of information within an OHT and contribute to the administrative burden on those non-HIC members. The government has taken steps toward enabling information sharing within an OHT by establishing regulation-making authority in the Personal Health Information Protection Act (PHIPA). As these regulations are developed, the structure and information needs of OHTs will need to be considered. Issues such as who is the HIC, who is in the patient's circle of care, how roles and permissions will be managed and the patient masking of information via consent directives will need to be clarified. Clear data governance and stewardship policies are needed and physicians are key partners in their development.

Providers who are integrating as part of a single OHT will each likely have their own individual medical record systems (i.e., an electronic medical record system [EMR] or hospital information system [HIS]) that may not be compatible with others. Information will need to be exchanged among various EMR systems and accessed or exchanged between EMR systems and HISs, to ensure seamless transition and continuity of care. At the community-based practice level, there may be multiple EMR platforms within a sector of a single OHT. An expectation of a single system within a sector may not be suitable for all OHTs, due to the migration efforts and costs for providers switching their EMR or point-of-care system. Many studies have demonstrated that electronic tools are one of the leading contributors to provider burnout.<sup>lviii,lix</sup> Technology should not create a further barrier by adding complexity, unnecessary variation, cost and administrative burden for providers in accessing health information. OntarioMD has been exploring solutions to support and enable data sharing and exchange of information across providers. This is expected to be supported by provincial standards-based integration efforts to establish interoperability between digital health systems, so that providers can seamlessly share information with each other within an OHT using their own system. Any interoperability policy should be designed to support and achieve the quadruple aim and not place further undue burden on providers.

As key users of the system, physicians need to be involved in the design and development of integrated information sharing systems. These systems will also need to address clinical functionality and development efforts will need to be prioritized through a lens of enhancing care to patients. When new technology is introduced at a clinical practice level, change management and resources must be

provided to ensure consistent and repeatable implementations, with attention to administrative burden, work-flow redesign and optimal use of new technology features and functions to support care.

## Real-time access to digital health tools and assets

Providers within an OHT need seamless and real-time access to digital health tools and assets. This includes the ability to launch digital tools directly from their EMR that are fully integrated into their workflow, such as OntarioMD's Insights4Care (i4C) Dashboard and Ontario Health's (formerly Health Quality Ontario's) MyPractice reports. They will also need readily available access to provincial data assets and tools (e.g., Ontario Laboratories Information System, Health Report Manager, eConsult, Digital Health Drug Repository and the Digital Health Immunization Repository). OntarioMD-certified EMRs provide integrated access to these provincial data assets and tools as they are available.

Providers should not be overburdened with requirements to obtain and use digital health tools and assets that are not relevant to their clinical workflow. Providers should also be equipped with effective change management supports so they can understand how to use digital health tools and seamlessly integrate them into their practice workflow, e.g., a provider-tailored digital health playbook and digital health service catalogue.

## Virtual care

Virtual care is defined as “any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care.”<sup>lx</sup> It includes consultation between providers and patients via video, telephone, secure messaging and remote monitoring.

The expanded access to virtual care during the COVID-19 pandemic via temporary billing codes for video visits (including non-Ontario Telemedicine Network [OTN] technology and platforms not specifically designed for medical care, e.g., such commercial videoconferencing tools as Skype and FaceTime) and telephone calls has been successful, with positive uptake by both physicians and patients. A national poll conducted by the Canadian Medical Association (CMA) in May 2020 found almost half of Canadians have had a virtual appointment with a physician, with a 91 per cent satisfaction rate.<sup>lxi</sup> Canadians would like virtual care options to not only be continued after the COVID-19 crisis subsides, but to also be improved and expanded. Half of Canadians believe virtual care could impact the cost of our health-care system, improve access to specialists (45 per cent) and timeliness of test results (41 per cent). Further, a Hamilton Health Team survey found 87 per cent of health-care providers anticipate continuing to provide virtual care beyond the pandemic.<sup>lxii</sup>

Virtual care has become an important component of care delivery, providing a much-needed alternative for patients to see their physicians without compromising quality of care.

Ultimately, providing patients with the ongoing choice of virtual care will require equipping providers with the ability and supports they need — including funding support — to provide virtual care.

The government committed to expanding access to virtual care across the province even before the pandemic. In 2019, a Virtual Care Working Group was struck between the Ministry of Health and the OMA, with participation by OntarioMD and OTN. In November 2019, OTNinvite was officially rolled out across the province, enabling more physicians and patients to hold direct-to-patient video visits using

their own devices via a secure link from OTN. Physicians providing virtual video visits via OTN are paid fees commensurate with clinical activity and equivalent to in-person care. The working group's phased approach to expanding access to all modalities of virtual care was accelerated and partially addressed by the introduction of temporary fee codes for video visits (including non-OTN technology) and telephone calls in response to the pandemic. However, these fee codes are currently temporary and do not include secure messaging.

The expanded availability of virtual care should continue permanently beyond the pandemic and should be enhanced to allow all modalities of virtual care to be billable, including video visits, telephone calls and secure messaging. Providers should have an equivalent choice in the virtual care platform they choose, including the use of non-OTN technology, to ensure it aligns with their technological preferences and capabilities and is seamlessly integrated with their workflow. All modalities of virtual care should be appropriately compensated. This is especially important to ensure that all patients can be reached, particularly those who are often unable to access video visits, such as the elderly, some new immigrant populations, low-income groups rural or remote communities and Indigenous communities. Without allowing choice, certain patients will be disadvantaged. Such expanded access will also enable OHTs to achieve their Year 1 target of delivering a virtual encounter to between two and five per cent of patients.

As virtual care is developed and delivered in Ontario, the following key principles must be kept in mind:

- **Virtual care should not fragment continuity of care.** Virtual care offerings, such as virtual walk-in clinics and apps, have the potential to fragment continuity of care and disturb integrated care delivery by limiting care to episodic provider-patient encounters. Continuity in primary care has been found to be associated with improved patient outcomes and satisfaction, as well as health-care cost savings.<sup>lxiii</sup> In particular, private virtual care offerings that focus on providing convenient and episodic care can greatly fragment continuity of care by providing care to attached patients outside their established provider-patient relationship, further perpetuating the lack of attachment for unattached patients. While virtual walk-in clinics can provide timely care to attached patients who are unable to access their provider and unattached patients who do not have an established primary care relationship, the focus of virtual walk-in clinic models should be on providing continuity of care by establishing attachment for unattached patients, as opposed to providing only episodic care. As detailed in the principle below, integrating virtual care as a component of care delivery in an established provider-patient relationship can also promote continuity of care, so attached patients avoid seeking episodic virtual care from outside providers.
- **Virtual care should be integrated as a component of care delivery.** Learnings from the current pandemic have highlighted that many patients and providers want to continue to use virtual care and that future clinical care will be fundamentally different, comprising of a mix of both in-person and virtual care. However, not all care can be delivered virtually, e.g., immunizations, so in-person care will need to continue. Maintaining an in-person relationship is also crucial to establish trust between the physician and patient and foster the therapeutic relationship. Virtual care should be integrated as a component of how providers deliver care to patients. This will further ensure that care does not become fragmented as described in the principle above.
- **Virtual care should be approached from a clinical-based use lens, not just from a convenience-based use lens.** Solely using a convenience-based lens to develop virtual care has the potential to increase fragmented care, as detailed in the first principle above. While virtual care provides the benefit of convenience and potentially saves patients the associated costs of seeing their

physician in person (e.g., taking public transit, taking time off from work or spending time waiting in the physician’s office), it should not be the only factor informing the development of which virtual care services/offerings. The clinical benefits to patients, ability of providers to fulfill their professional and other obligations and benefit to the system must also be considered. Even though virtual care has enabled many patients to continue to safely seek care during the current pandemic by allowing for physical distancing, not all care can be delivered virtually, as stated in the principle above. It is the physician’s professional obligation, as per the [College of Physicians and Surgeons of Ontario’s telemedicine policy](#), to determine if virtual care is appropriate for the specific patient encounter.

In addition to these key principles, learnings from the expanded access to virtual care during the pandemic should continue to be explored and addressed to improve provision of virtual care in the system and by OHTs. This includes, but is not limited to:

- The impact of virtual care on preventative care and the efficiencies around opportunistic care, given not all care can be delivered virtually (e.g., updating a patient’s immunization while they are in the office for another issue)
- The effective delivery of virtual care in congregate settings such as long-term care and by sectors such as home and community care
- The uptake of virtual care by older and vulnerable patient populations, who may have difficulty using or accessing technology
- The availability of high-speed internet and cellular connection in rural, remote and Indigenous communities
- Ensuring privacy and security of virtual care tools beyond just obtaining patient consent to the potential risk

### Patient-facing digital health tools

Patients should have access to patient-facing digital health tools, including patient portals that allow patients to book appointments online and access their medical records. According to a 2018 survey by Canada Health Infoway, these digital health services are the most in-demand by Canadians and access to such services has been reported to lead to improved patient self-management, timeliness of care and the ability to work in partnership with care providers.<sup>lxiv</sup>

Patient access to data and the development of a patient portal will require a standards-based approach and framework to ensure that patients are provided with a consistent experience in accessing data from multiple providers in an OHT. This is similar to the standards-based integration that is required among providers to allow for an integrated information sharing system.

In addition, patient education is fundamental to ensure patients understand the health information they can access. This will require promotion of digital health literacy, which is defined as “the ability to seek, find, understand and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem.”<sup>lxv</sup>

### Performing analytics within an OHT

OHTs need to be able to use digital health tools to perform analytics within the OHT for population health and quality improvement purposes. Population health is a foundational pillar of OHT care delivery

and the data generated will drive continuous improvement. To perform analytics within an OHT, providers will need to be equipped with technology that allows for appropriate population health and quality improvement data collection and analytics. For example, the i4C Dashboard developed by OntarioMD presents a common indicator set across EMR platforms and allows primary care physicians to view and measure changes in patient data in real-time for population health management. Educational resources and change management supports, such as the i4C Advisory Service, are also essential to ensure that providers within an OHT understand how to analyze their data and use it to improve patient care.

## Access to data by Ontario Health

Ontario Health will require access to data generated by OHTs to perform analytics for health-system planning and management and to support delivery of integrated care. While the OMA supports the use of data analytics to improve population health and research, the amount of identifiable data used should be kept to a minimum to protect and preserve confidentiality, while contributing to system evaluation and/or improvements. Any analytics at the Ontario Health level and system level should be performed only by those who understand health-care provision. Ontarians' privacy must be preserved and, without proper safeguards and consent management processes in place, patients may opt to withhold important information from their providers, which will have unintended consequences on their health care. Ontarians must be aware of the potential uses of their data to preserve confidence in the system and enable successful integration and co-ordination of care. Public trust in the system is especially important during such times as the current pandemic, where sensitivities about privacy and suspicions about government overreach are already raised. Further, any reporting requirements for physicians to provide data to Ontario Health should not be cumbersome or costly.

Data governance is critical to facilitate the appropriate and ethical use of data by Ontario Health. Effective data governance can facilitate the sharing and use of information among providers and health-system stakeholders — and within the system at large — while further preserving patient trust in the providers and the health-care system.

Aligned with the framework of OHTs generally, data governance should be patient-centred and driven by physicians and providers with clearly articulated roles and responsibilities. As the legal custodians and stewards of patients' personal health information, physicians and providers are best positioned to advise on how information should flow. Physicians, patients and other providers should be partners in decision-making processes surrounding digital health governance.

There is a broad need in the system for governance of data, including managing data from the electronic health record (EHR) and the creation of data trusts for pandemic research and planning. An overarching Data Governance and Stewardship Committee is required to meet this need.

Several years ago, under the OMA's leadership, health-system stakeholders considered a legislated, multi-stakeholder Ontario Data Governance and Stewardship Committee. It was proposed that this committee, made up of key health-system stakeholders and patients, would have a mandate to protect the public interest and providers in the development of a digital health governance strategy and would be responsible for (among other things) providing guidance and support around the exchange of personal health information in the digital health environment.

## Recommendations – Digital health

- 1. Physicians are key partners in the development of an integrated information sharing system, which will require establishing enabling legislative and regulatory requirements under PHIPA and clear data governance and stewardship policies, as well as standards-based integration among different provider digital health systems within an OHT.*
- 2. Providers within an OHT should be equipped with guidance on essential digital tools and assets that are relevant to their clinical workflow, as well as effective change management supports. Physicians who are participating within an OHT should use an OntarioMD-certified EMR so that they are able to access EMR-integrated provincial digital health assets and tools.*
- 3. The expanded availability of virtual care should continue permanently beyond the pandemic and all modalities of virtual care should be appropriately compensated, including video visits, telephone calls and secure messaging. Providers should have an equivalent choice in the virtual care platform they choose, including the use of non-OTN technology. Key principles must be kept in mind to ensure virtual care is developed and delivered appropriately.*
- 4. Patients should have access to patient-facing digital health tools, which will require a framework and standards-based approach, as well as patient education to ensure patients understand the health information they can access.*
- 5. OHTs need to be equipped with digital health technology and supports to perform analytics for population health management and quality improvement purposes.*
- 6. A legislated, multi-stakeholder Data Governance and Stewardship Committee should be convened to facilitate data governance in the system, including the appropriate and ethical use of data by Ontario Health.*

## Appendix B – Governance: OMA’s OHT White Paper – Companion Document #2

In spring 2019, Ontario launched a rapid and evolving health-system transformation called Ontario Health Teams (OHTs).<sup>lxvi</sup> These teams are intended to help improve health-system integration and performance across a range of outcomes that support the quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.<sup>lxvii</sup>

The OMA, physicians and Ontarians have long advocated for a more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more of their time caring for patients. The need to do this appropriately and expeditiously, especially in light of COVID-19 and potential future pandemics, requires the leadership and involvement of all physicians, working alongside policy-makers and other key stakeholders.

The OHT white paper and its four companion documents (*1. Digital health, 2. Governance, 3. Patient navigation and care co-ordination, 4. Metrics and measurement*) were developed to provide recommendations to help advance system-level change. The white paper highlights early learnings and key recommendations for the evolution of OHTs and focuses on three equally important foundational elements required for OHT success. These elements are:

- Physician leadership in the governance and determination of care delivery
- Voluntary physician participation
- Primary care being at the core/foundation.

The companion documents identify key enabling factors in four areas to support these core elements.

This governance companion document identifies governance and organizational supports and structures required to support the successful development, implementation and evolution of OHTs.

### Governance

The introduction of OHTs in Ontario creates significant challenges and opportunities, including the opportunity to learn from multiple local approaches on governance structures, organizational structures, information technology (IT) architectures, digital health applications and models of care. In addition, there are several opportunities for designating and deploying province-wide standards for better care, improved system performance, scalability, seamless sharing and data comparability.

We believe that governance of OHTs needs to take place at three levels:

- The provincial level, to ensure that province-level goals and expected accountabilities are being met and that all OHTs have proper oversight and are tracking to provincial goals
- The individual OHT level
- The physician level.

### Levels of governance

At the provincial level, the Ministry of Health (MOH) has committed to working with the Physicians Services Committee in relation to OHT implementation. At the OHT and physician levels, building robust governance models is key to any successful OHT. Physicians and physicians-as-leaders are foundational

to these models and, as noted in the white paper, are essential to helping ensure successful health-system reform.

As noted in Section 3 of the white paper, there are many possible leadership roles that physicians may play within OHTs and in relation to governance structures. For example, physicians may be clinical leaders and hold key positions within the OHT governance structure; at this level they would be involved in decision-making that impacts the OHT. While not required, physicians may also be administrative leaders and manage the day-to-day functions of OHTs. Some physicians have taken on this administrative leadership role in establishing OHTs.

The government did not prescribe a governance model for OHTs. As a result, several models of governance for the new OHTs were articulated by different organizations.<sup>lxviii</sup> These models continue to evolve and change as OHTs are developed and implemented, as more are announced<sup>lxix</sup> and more is learned. In July 2020, the MOH announced that approved OHTs must establish a collaborative decision-making arrangement to be eligible for any future OHT implementation funding opportunities.<sup>lxx</sup> The guidance document includes the requirement that OHTs engage with physicians in the development of the agreement and provide for participation in decision-making.

The OMA believes that OHTs should establish formal physician leadership roles for interested physicians (e.g., family physicians, specialist physicians — including community-based specialist physicians — physicians practising in varied practice models and those in hospitals etc.) within OHTs and on their governing boards. The OMA envisions the best practice model for OHTs at maturity to be a network or alliance model with an overarching health governance organization (HGO). This collaborative body would not, in the short term, replace governance structures of the various groups that have come together to form the OHT (e.g., family health organizations [FHOs], family health teams [FHTs], community health centres, hospitals, etc.) and should include representatives from various groups (physician and non-physicians).

The OMA envisions a model whereby physicians organize within OHTs into self-governing entities, i.e., unincorporated associations or corporations. These physician associations should include primary care physicians and community- and hospital-based specialists. The associations would be responsible for electing or appointing physician representatives to sit on the OHT HGO.

Establishing physician associations within communities provides a mechanism by which physicians can self-organize, coming together to elect representatives to the OHT HGO and to discuss and potentially vote on clinical and other issues related to the OHT. Physician associations lend credibility to physician participation in the broader OHT, as without these associations there is no legitimate mechanism by which physicians represent their peers on any HGO. All OHT models require agreements, contracts, memoranda of understanding (MOUs) and other elements to determine accountability and define structures. For more information about the OMA's proposed governance model see Appendix 1.

During the pandemic, the positive impact of well-organized physician networks, which include primary care and specialists, has become clear. Insights have been gathered from physicians involved in OHT physician associations and we have learned that these groups supported each other, shared information and collaborated on numerous COVID-19-related issues.

Beyond physician associations, other governance models are emerging that promote skills-based boards, where membership on the governing board is based on the skills needed to effectively operate the board and perform its duties, rather than being based on the representation of specific groups. Within these governance models, the importance of physician leadership (primary care and specialist)



and meaningful engagement of physicians needs to be emphasized<sup>8</sup>. Physicians possess important and essential skills for effective OHT implementation, including clinical leadership and change management. We believe that equipping physicians with the necessary skills is a system responsibility and is important to ensuring that OHTs roll out appropriately. Helping to equip physicians with the necessary leadership skills is a role that may be shared among a variety of physician organizations including OMA, SGFP and OCFP.<sup>9</sup>

## Governance requirements

The MOH did not initially prescribe a specific governance model for OHTs, but, as noted above, it has recently stated that approved OHTs must enter into a collaborative decision-making arrangement to be eligible for implementation funding opportunities. The following additional requirements for OHTs are based on available MOH and related materials, such as the MOH guidance document, self-assessment and full applications<sup>lxxi</sup>.

- Three or more health-related services, with preference given to (at a minimum) hospital, primary care and home and community care
- Written agreements among providers
- Patient involvement in the governance model
- Physicians as part of model leadership or governance structure
- A central brand and strategic plan
- Governance agreements containing clauses covering:
  - decision-making
  - conflict resolution
  - performance management
  - information sharing
  - resource allocation.<sup>lxxii</sup>

Depending on the selected HGO structure for the OHT, various contracts should be used to set out accountabilities. The OMA has developed contract templates that support the OMA's HGO proposed structure. These contract templates should be modified, based on the needs of the individual group. A list and description of contracts and accountabilities are described in Appendix 2.

## Board committees

The government's emphasis on technology with respect to OHTs suggests that there will be many potential uses and evaluations of OHT data. Because of the sensitive nature of the personal health information and personal information collected, it is important that all OHTs create a Data and Information Governance Committee (DIGC)<sup>10,11</sup> responsible for decisions around how to protect and use data. This DIGC will be responsible for identifying privacy and ethical issues related to data and will work with OHT staff to determine how to proceed on matters related to security, care, research and analytics

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<sup>8</sup> See Section 3.0 of OMA's OHT white paper for more details on physician engagement.

<sup>9</sup> Supporting physicians to gain and hone these skills needs to start early. Consideration needs to be given to encouraging medical students and early career medical professionals to engage in opportunities that equip them with the skills needed to take on these leadership roles.

<sup>10</sup> <https://www.infogoto.com/information-governance-vs-data-governance-whats-the-difference>

<sup>11</sup> The OMA has developed a draft Data Governance Model, which can be found under OMA Resources and Supports at [www.oma.org/oht](http://www.oma.org/oht).

Other board or governance committees may be set up to support the decision-making of the OHT's HGO, such as finance, human resources and risk committees. There are many resources to support the identification of committees and how they can be set up.

### Other governance models – issues and considerations<sup>12</sup>

Proposed OHT governance models range from a formal, single entity to more informal agreements that:

- Have a single governing corporation act as the OHT
- Work together in the absence of formal agreements
- Collaborate based on multiple contracts between and among parties.

The single governing corporation proposal, which envisions a hospital-style model where all employment and funding is centrally controlled by a hospital-like entity, raises questions about physician participation in strategic planning and other governance-related matters. It also does not properly account for the continuation of current physician funding models within the OHT model, as guaranteed by the MOH. It may also mean the dissolution of other governing structures, if they are part of the new corporation and board. Conflicts of interest may arise if directors are on the organization board and the OHT board, as they would be required to split duty of care and loyalty.

Regarding the other two models, the absence of formal agreements lacks stability and hampers the ability to plan strategically. That being said, this is a new, fast-moving and iterative process of OHT governance development and a looser and less-formal affiliation may be a temporary or transitory solution for some groups.

Similarly, collaborating under the auspices of multiple contracts does not lend itself to stability and may be less optimal when it comes to the integration of services. However, like the second model, it may be an acceptable interim solution for some groups in the earlier stages of OHT development.

### Best practice roles for existing boards

Regardless of the OHT's final governance structure, it is important during the early stages of development of the overarching HGO structure that existing health-care provider boards such as FHTs, FHOs, hospitals, etc., be engaged. This is important, as they will participate in the establishment of the decision-making framework of the OHT.<sup>lxxiii</sup> To help boards work towards the role of OHTs at full maturity to deliver the full continuum of integrated care to target populations, boards should perform five roles<sup>lxxiv</sup>:

- Knowledge and setting the stage with a system perspective
- Demonstrating leadership
- Defining and refining principles for participation
- Engagement

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<sup>12</sup> The OMA is open to considering other models, but will not formally endorse any model that is not optimal from the perspectives of both physician practice and patient care. For example, U.S. evidence on accountable care organization governance endorses a model that is primarily physician-led, not hospital-led as discussed in the white paper.

- Approvals and oversight.

## Recommendations - Governance

1. *The MOH should continue to work with the Physicians Services Committee in relation to OHT implementation.*
2. *Physicians must play a major role on the OHT HGO, including a leadership role in clinical and other organizational decision-making.*
3. *Success of OHTs relies on physician participation and leadership. Formal physician roles within OHTs need to be established. Physician contributions and leadership roles within OHTs should be recognized and adequately compensated through negotiations with the OMA.*
4. *The health system needs to support physicians to grow and maintain the necessary skills to effectively lead HGOs to help ensure OHTs roll out properly across the province.*
5. *Physician associations within OHTs are key to ensuring legitimacy in physician representation and participation in OHTs and should include primary care-based physicians and community-based and hospital-based specialists.*
6. *The data and information governance committee is an essential board committee of the OHT HGO and should be established at an early point.*
7. *Regardless of the governance model chosen, it is essential that existing boards be engaged and involved in the establishment of the decision-making framework.*

## Governance – Appendix 1 – Description of OMA’s Proposed Governance Model

OHT governance models may range from informal arrangements to entities.<sup>13</sup> While the OMA agrees with other stakeholders that there may be some flexibility in the early stages of the OHT’s existence with respect to governance — recognizing that building a model may be an iterative process — the OMA also submits that the best practice model for OHT governance at maturity is a network or alliance model with an overarching HGO. This collaborative governance organization would consist of members of the network including, but not limited to, physician groups, community agencies and hospitals. In the OMA’s proposed HGO structure, physicians whose patients are attributed to an OHT and who voluntarily join would form a separate physician association of primary care providers. This association would consist of physicians from FHTs, FHOs, sole practitioners, etc. Representatives from within the physician association would be elected or appointed (as decided by the group) to join the board or governance committee of the OHT. Depending on the needs of individual groups, community-based specialists could be incorporated into this group as a broader physician association, or they may wish to form their own association.

Physicians will have a major role on the OHT HGO and will take a main leadership role in clinical and other organizational decision-making. The OMA envisions that OHT HGOs could also have physicians as the majority of clinicians on the board. Examples of this model are already emerging in OHT applications.

The OMA proposes that OHT HGO board membership should include:

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<sup>13</sup> For an explanation of the difference between unincorporated and incorporated governance organizations see Appendix 3.

- Various OHT participant groups (to ensure adequate representation of all groups), including physician representation from the physician association
- Patient representatives attributed to and/or from the community served by the OHT, as required by the governing legislation.

The OHT HGO board should also consider inclusion of members with specific skills, e.g., in law, health policy, privacy/data governance, finance and information technology. In the early stages, members of the HGO may be either elected or appointed, depending on how the network groups choose to assign membership. OMA is recommending that physicians be elected to the OHT HGO by the physician association. The number of members may change over time, but the OMA suggests that, for the purposes of effective decision-making and good governance, the number of voting members be kept low. The draft OMA governance model template suggests one possible model<sup>14</sup>.

### Recommendations – OMA proposed governance model

- *The best practice model for OHT governance at maturity is a network or alliance model with an overarching OHT HGO.*
- *Physician associations within OHTs will elect physician representatives to sit on the OHT HGO.*

### Governance – Appendix 2 – Description of contracts and accountabilities

#### *Contract templates<sup>15</sup>*

Depending on the selected HGO structure for the OHT, various contracts should be used to set out accountabilities. Examples of these templates are set out below.

**A contract between the OHT organization and the MOH, as represented by Ontario Health:** This contract would contain high-level accountabilities as outlined in the People’s Health Care Act, IT requirements and governance principles. This agreement would be similar to the FHT Agreement. However, as there is no physician funding, it should be considerably shorter. Typically, the government would draft this agreement and present it to the OHT for negotiation. This is what occurred with the existing FHT Agreement, i.e., the draft was presented to the OMA for review and negotiation.

**Participation agreements between the OHT and the participating entities such as FHTs, hospitals, FHOs, other groups and individual physicians:** The OMA is developing draft templates for these participation agreements, which would include data-sharing agreements to enable the legislation’s IT requirements.

**Agreements to set up secondary governance bodies, including physician associations within a community:** These would be organizations representing the physicians to the HGO, including serving an electoral function. The OMA is developing draft templates for physician association agreements.

**An agreement to establish the governance organization:** This would occur in the absence of an incorporated entity. This contract would set out the terms and principles of the HGO, including

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<sup>14</sup> The template can be found under OMA Resources and supports at [www.oma.org/oht](http://www.oma.org/oht).

<sup>15</sup> The contract templates can be found under OMA Resources and supports at [www.oma.org/oht](http://www.oma.org/oht)

processes and procedures for decision-making. The OMA has a template for this agreement and believes it could be converted to by-laws for an incorporated group.

## Governance – Appendix 3 – Unincorporated versus incorporated governance organizations

### *Unincorporated or incorporated*

The OHT governance organization (GO) board may be either an incorporated entity similar to a FHT with a board of directors, or an unincorporated entity similar to the governance organizations established and operated under the Academic Alternative Funding Plan. The network groups and the OHT GO would need to decide what model works best. The model may change over time as the OHT GO matures. Individual OHTs will need to obtain independent legal and accounting advice on what best suits their needs.

### *Unincorporated association or entity*

Generally speaking, it is simpler to not incorporate. Therefore, creating an unincorporated association or entity via contract to serve as an overarching OHT GO can be an option for groups coming together that wish to avoid incorporation for legal or financial reasons. Such a contractual agreement leaves the group with more freedom, but preserves the legal responsibilities and accountabilities to govern the OHT. Liabilities and indemnifications among the different groups would be contractual, as set out in the participation agreements with the various providers.

### *Incorporated governance organization: Corporate structure with a board of directors*

The OHT may choose to incorporate under the Corporations Act as a not-for-profit corporation and establish a board of directors and bylaws pursuant to that legislation. The structure anticipated by this model would presumably be similar to the incorporated community-sponsored FHTs. As with much of the work being carried out with respect to OHTs, the benefits and risks of incorporation will need to be continually re-examined, as more information becomes available and as OHTs evolve. Some of the important benefits of incorporation are related to the management of liability and indemnification issues, including securing insurance for the board.

The OMA sees OHT governance as an iterative process, so a group could initially choose to form an unincorporated association before proceeding to incorporate. The OMA suggests that this may be preferable. However, each group's situation is unique and each will need to evaluate its current and anticipated needs to decide on an initial structure.

## Appendix C – Patient Navigation and Care Co-ordination: OMA’s OHT White Paper – Companion Document #3

In spring 2019, Ontario launched a rapid and evolving health-system transformation called Ontario Health Teams (OHTs).<sup>lxxv</sup> These teams are intended to help improve health-system integration and performance across a range of outcomes that support the quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.<sup>lxxvi</sup>

The OMA, physicians and Ontarians have long advocated for a more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more of their time caring for patients. The need to do this appropriately and expeditiously, especially in light of COVID-19 and potential future pandemics, requires the leadership and involvement of all physicians, working alongside policy-makers and other key stakeholders.

The OHT white paper and its four companion documents (*1. Digital health, 2. Governance, 3. Patient navigation and care co-ordination, 4. Metrics and measurement*) were developed to provide recommendations to help advance system-level change. The white paper highlights early learnings and key recommendations for the evolution of OHTs and focuses on three equally important foundational elements required for OHT success. These elements are:

- Physician leadership in the governance and determination of care delivery
- Voluntary physician participation
- Primary care being at the core/foundation.

The companion documents identify key enabling factors in four areas to support these core elements.

This patient navigation and care co-ordination companion document highlights the importance of access to comprehensive and co-ordinated primary care and how to best achieve this within OHTs.

### Patient navigation and care co-ordination

Primary care through family physicians is the foundation of all health care. It is how most people access and receive the majority of their care. It is key to ensuring continuity, comprehensiveness and co-ordinated care,<sup>lxxvii</sup> leading to a better patient experience, which is one of the outcomes of the quadruple aim and an intent of OHTs. Further, savings related to OHTs are intended to go back into supporting patients and improving the system.

As set out in the Ministry of Health (MOH) guidance document, OHTs will be expected to “offer patients 24/7 access to co-ordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey.”<sup>lxxviii</sup> This means that there should be available a patient navigator/care co-ordinator function required within OHTs.<sup>lxxix</sup> This would not mean that physicians are available 24/7.

### Care co-ordination defined

Care co-ordination is defined as “... the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health-care services. Organizing care involves the marshalling of personnel and other resources

needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”<sup>lxxx</sup> Care co-ordination is one of Dr. Barbara Starfield’s key pillars of primary care.<sup>lxxxi</sup> It is also considered a building block of high-performing primary care.<sup>lxxxii</sup> Effective care co-ordination promotes a more connected journey for the patient; a more integrated health-care system and is consistent with the quadruple aim.

## Care co-ordination and OHTs

Ontario’s physicians see tremendous opportunity in the government’s vision of greater integration across the health-care system to leverage the vital role of Ontario’s 4,000-plus care co-ordinators (funded through Local Health Integration Networks [LHINs]) and maximize their potential in OHTs. This opportunity has been leveraged by the recent passage of new home care legislation, which aims to modernize the system and allow for the embedding of care co-ordinators directly in primary care.<sup>16</sup> We know that, at a mature state, OHTs are intended to offer patients round-the-clock access to care co-ordination and system navigation services. We recognize this reality is several years away and welcome the opportunity to co-design how Ontario’s vision can be strengthened, as these providers are transitioned from the LHINs and develop their role in a renewed health-care system.

Ontario’s physicians value the role of our province’s care co-ordinators. Care co-ordinators are viewed as more than simply brokers of care services. They often assist patients in their navigation of the current system and, together with physicians, frequently and tirelessly advocate for their patients’ needs. Given that primary care is the most recognized hub of care co-ordination (family physicians and primary care teams provide the bulk of care co-ordination), it may make sense to locate care co-ordinators within primary care settings whenever possible. Doing so provides an element of medical oversight, promotes continuity of care, supports communication among the health-care team and makes care co-ordinators accessible to patients and providers in their communities. However, relocation to primary care should be accomplished on a voluntary basis and with the support of primary care leadership. Attention to the availability of space and appropriate reimbursement for overhead (e.g., rent for occupied space) will be required. It should be noted that family physicians do not envision themselves employing care co-ordinators. However, this may be the purview of the lead organization within an OHT. Where co-location is not possible or feasible, OHTs may wish to consider using virtual technologies to connect patients with care co-ordinators from either the primary care clinic or from the patient’s home.

For optimal results and to strengthen integration where most care happens, care co-ordination in primary care within OHTs should ideally encompass both co-ordination (improving transitions) as well as patient navigation (better connections) to support continuity in primary care and follow-up of patients’ holistic and complex needs. This could include access to physiotherapy, rehabilitation, mental health and addictions, specialist referrals, agencies and other needs related to the social determinants of health (e.g., income and housing supports) requiring broader system navigation. Ultimately, the ability to provide more seamless and integrated care within primary care impacts the success of OHTs and would be a key line of defense against hallway medicine.

How we maximize the potential of Ontario’s care co-ordinators comes down to their envisioned role and function to meet the needs of patients and families seeking the most effective care. This will need to be

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<sup>16</sup> The OMA presented at the June 16, 2020, Standing Committee on the Legislative Assembly reviewing Bill 175 and advocated for changes to the home care system to maximize the role of care co-ordinators. The Hansard transcript can be accessed at: [https://www.ola.org/en/legislative-business/committees/legislative-assembly/parliament-42/transcripts/committee-transcript-2020-jun-16#P1117\\_292569](https://www.ola.org/en/legislative-business/committees/legislative-assembly/parliament-42/transcripts/committee-transcript-2020-jun-16#P1117_292569)

carefully considered, as a one-size-fits-all approach will not be effective. Co-design with physicians, patients and families will be an essential aspect of a renewed role.

Moving forward, it will be critical to facilitate communication and information exchange between care co-ordinators, family physicians and other care providers. Important elements of this include:

- Accessibility of care co-ordinators throughout the week, including setting up a system to address information exchange after hours
- Providing electronic exchanges of information whenever possible
- Providing clear and succinct updates with relevant patient information on a regular basis
- Minimizing paperwork, forms and other red tape that get in the way of patients and families obtaining timely access to needed services and supports.

At the minimum, care co-ordinators should be made available virtually to the care team. A key enabler of this is having information technology (IT) infrastructures that can connect and facilitate the exchange of information between care co-ordinators and all relevant care providers involved in the patient's health-care journey.

### Recommendations – Patient navigation and care co-ordination

1. *Locate existing care co-ordinators within primary care settings whenever possible on a voluntary basis and with the support of primary care leadership. Additional funding or reimbursement to support overhead costs is an important consideration.*
2. *To optimize results within OHTs, care co-ordination should ideally encompass both co-ordination (improving transitions) and patient/system navigation (better connections) to encompass patient needs and the broader social determinants of health.*
3. *To best maximize the role of care co-ordinators/system navigators and to avoid a one-size-fits-all approach, the role and functions should be co-designed with physicians, patients, families and other health-care providers.*
4. *Establish the necessary IT infrastructure to support patient and family virtual access and information exchange with care co-ordinators.*



## Appendix D – Metrics and Measurement: OMA’s OHT White Paper – Companion Document #4

In spring 2019, Ontario launched a rapid and evolving health-system transformation called Ontario Health Teams (OHTs).<sup>lxxxiii</sup> These teams are intended to help improve health-system integration and performance across a range of outcomes that support the quadruple aim: Better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.<sup>lxxxiv</sup>

The OMA, physicians and Ontarians have long advocated for a more integrated health-care system. If implemented effectively, OHTs have the potential to improve care delivery and increase efficiencies to allow physicians to spend more of their time caring for patients. The need to do this appropriately and expeditiously, especially in light of COVID-19 and potential future pandemics, requires the leadership and involvement of all physicians, working alongside policy-makers and other key stakeholders.

The OHT white paper and its four companion documents (*1. Digital health, 2. Governance, 3. Patient navigation and care co-ordination, 4. Metrics and measurement*) were developed to provide recommendations to help advance system-level change. The white paper highlights early learnings and key recommendations for the evolution of OHTs and focuses on three equally important foundational elements required for OHT success. These elements are:

- Physician leadership in the governance and determination of care delivery
- Voluntary physician participation
- Primary care being at the core/foundation.

The companion documents identify key enabling factors in four areas to support these core elements.

This metrics and measurement companion document describes the early work that has been completed to identify indicators to measure the success of OHTs to meet the quadruple aim. This initial work was completed prior to the COVID-19 pandemic.

### Metrics and measurement

To determine the success of OHTs in achieving the quadruple aim, indicators based on the aim must be identified and/or developed. To help facilitate this work, the OMA has met frequently with several experts to help identify and develop the parameters surrounding those measures and begin informing their development. These experts have included representatives of government, regulatory bodies, physicians, associations, academic institutions, digital and measurement experts and patient representatives.

This working group is intended to support a common interest, it is not a decision-making body. Further, it is recognized among the members that there will be differences in opinion. Information and advice generated about measures will be shared among members to support the collective interest in measurement.

Achieving the quadruple aim is the system objective of OHTs and the OMA therefore believes it should be used to guide the determination of the domains for metrics: Population health; patient experience; efficiency; and provider experience. These domains also align with those used to develop measures in the United States associated with accountable care organizations. Given the increasing levels of burnout

in the profession and the fundamental importance of physician health for driving patient experience and outcomes and system efficiencies, the evaluation of provider experience within the OHT model is of particular interest.

In addition, the working group identified the Institute of Medicine's Quality of Care Measures or the STEEP framework as another domain to help guide the determination of metrics. STEEP refers to:

- Safe: Avoiding harm to patients from the care that is intended to help them
- Timely: Reducing waits and sometimes-harmful delays for both those who receive and those who give care
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively)
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas and energy
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status
- Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

Further, the working group identified several key principles for choosing metrics/indicators. These principles were grouped into two areas, absolute and preferred.

#### **Absolute**

- Cogent/reasonable/meaningful/useful (for whom)
- Reliable/valid
- Actionable/responsive

#### **Preferred (in approximate order of priority)**

- Comprehensive in scope of quadruple aim
- Parsimonious number of measures (i.e., is it essential?)
- Timely
- Consistent with ongoing data collection activity
- Easily available/feasible
- Co-ordinated/comparability across system (source of data, data truth, definitions, able to link among data sources, etc.)
- Encompasses population of interest.

As the work related to metrics is in the early stages of development, the group also identified several other issues and considerations when choosing metrics. These include:

- Internal use versus public reporting versus accountability will influence principles used to select the measure
- Tolerance of imprecision will depend on the purpose of the measure
- Trade-offs on principles (circumstances determine relative importance of principles)
- Individuals versus trusted entities (i.e., some measures will be for groups and others will be for individuals)
- The need to consider what is not being measured and/or unintended consequences

- Enterprise system for unified provincial collecting/reporting ideal.

## Recommendations – Metrics and measurement

1. *As the system objective of OHTs, the quadruple aim should guide the determination of the domains for metrics.*
2. *The STEEP framework should be used to help guide the determination of metrics.*
3. *The principles for choosing metrics indicators outlined in this document should be used to guide their identification and development.*

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