Ontario Health Teams: Integrating Health Equity & Community

Alliance for Healthier Communities
Advancing Health Equity in Ontario

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Introduction

Integrated care has been seen as a remedy for traditionally siloed care. Integrated care bridges acute care, primary care, and community and social services (Singer *et al.* 2001) to provide patient-centred, holistic, and cost-effective care to people with complex needs (WHO 2016). Collaborative or integrated health care delivery has proven to be effective for patients with complex medical needs (Ivbijaro *et al.* 2014; Mitchell *et al.* 2015) and is now seen as a necessary innovation to address the challenges associated with medical complexity. Delivering integrated care requires us to coordinate and streamline services across multiple organizations and sectors (Embuldeniya *et al.* 2021; Grone & Barbero-Garcia 2001). Several examples of integrated care exist worldwide. In Ontario, we are aiming to do this through Ontario Health Teams (OHTs).

Despite this trend and ongoing efforts to integrate care, integrated care initiatives across the globe are not achieving the goals intended. Other jurisdictions who are further along in this journey than Ontario have now begun to shift from integrated *health system* care towards integrated *community-based* care. These jurisdictions are seeing success in achieving their intended goals after changing their approach. Ontario's decision-makers and participants in OHTs have an opportunity now to influence the design of OHTs to incorporate community-centered approaches.

Extending the benefits of integrated care to the general population requires combining the scope of integrated care with a *population health approach* (Alderwick *et al*. 2015; Kaene *et al.* 2017; Huynh 2014). This approach to care considers a wide range of factors and interrelated conditions that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to improve the health and well-being of those populations. This approach also commonly shifts the focus to prevention, multiple determinants of health, equity in health, intersectoral action and partnerships, and understanding needs and solutions through community outreach (Huynh, 2014). Despite each OHT having an attributable population based on geography and health care pathways, OHTs also have focused priorities on specific populations. At maturity, OHTs are expected to take a population health approach that includes health promotion, disease prevention and other primary and community supports for the full attributed population, since this is what will keep people healthy.

This document outlines the evidence and rationale for ensuring health equity and community involvement within OHTs. It also includes a Toolkit for Actions, which can help organizations to ensure the goals of OHTs are met. This is a living document; more case studies, tools, and resources will be added over time. For now, examples have been taken from around the world of strong integrated health care models.

Why this? Why now?

Several regions around the world are re-orienting care to ensure that communities are the starting point. This includes health promotion embedded in practice-level interventions and also in broader system change that promotes wellness-oriented health, social, and community care. At the practice level, many initiatives focus on traditional behavioural modification and health-promotion approaches for groups as a key strategy for preventing disease. At the broad system level, it is increasingly common to create new, supportive environments to promote better personal and population health practices for broader populations (Collins 2015; Daniilidou 2003; Farmanova *et al*. 2019). For example, Kaiser Permanente's Community Health programming includes work to improve the conditions for health and equity in the community by addressing the root causes of health, such as economic opportunity, affordable housing, safe and supportive schools, and a healthy environment.

There are examples worldwide that demonstrate this shift to become more equity and community focused. These include:

- Cuban model that ensures family physicians are embedded in every community within Cuba and support transitions and all aspects of health care for their community members. Cuba redesigned their health system in the 1960s and 1970s to ensure that primary care was the foundation along with a strong public health system. This model exemplifies community based primary care and results have indicated increased access, decreased wait times and improved health outcomes. They have created an integrated neighbourhood/home model that ensures primary care clinics are embedded in every neighbourhood and family physicians are community members themselves. This has resulted in equal access to health care and equity in health status. (Swanson *et al.* 1995).
- Integrated Health Systems in the UK are transitioning to Integrated Care Systems (ICSs) and innovators like North West London are focusing on health equity, systemic barriers and community involvement. Some of taken this a step further and have created Integrated Care Communities. This is exemplified in North Cumbria, England which has been divided up into 8 ICCs based on groups of primary care

> **North Cumbria Health Care Partnership**
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> "We know that by offering more intensive health and care services into people's homes and communities that we can prevent them from coming into the hospital in the first place. The development of the Rapid Response will help us to provide care quickly, where it is needed most. This is a big step in joining up our health and care services and it's great news for patients."

practices (networks) and their goal is to work better together to improve the overall health and wellbeing of their community. They explicitly are aiming to do this in a way that provides more care out of the hospital and support people have chronic health conditions and overall improved population health. Each ICC will have a hub which co-ordinates care for the local people. It will provide administrative support and a single point of contact for any professional referring people to ICC services. The hub will coordinate a rapid response when someone's health or care needs deteriorate which sees health and care staff put steps in place to help them avoid a hospital stay and help people get home from hospital sooner.

- Accountable Health Systems in the US are transitioning to Accountable Health Communities which are new models of integrated care being piloted. The Accountable Health Communities Model address a critical gap between clinical care and community services in the current health care delivery system. They are testing whether systematically identifying and addressing the health-related social needs through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. Results to-date have been overwhelmingly positive.

Akron Accountable Care Community

Akron ACC was formed in 2011 and emphasis was on clinical care in tandem with health promotion & disease prevention. Focus on team-based care, diverse community partners & community participation was emphasized given their initial integration attempts were not achieving the desired outcomes. Partners shared in cost savings & reinvested the money saved for future community initiatives. The ACC initially targeted diabetes but focused on improving access to fruit and vegetables as well as increased access to parks. This work resulted in positive diabetes results but also lower health care utilization and costs.

How is this different from what OHTs are already doing?

Many of the integrated care organizations worldwide are failing to deliver on the promise of decreasing costs and improving outcomes. One potential explanation is their predominant focus on health care delivery systems alone, and the subsequent failure to address social determinants of health.

Ontario is poised to learn from other jurisdictions and take bold steps to ensure equity and community is centred in the design and governance of OHTs. This is the right time for Ontario's decision-makers and OHT partners to ensure that a holistic approach is embedded, rather than a provider-focused or health service provider—focused

approach. Ontario can learn from these examples and better address the critical gap between clinical and community services and ensure that social determinants of health, such as stable housing, access to nutritious food, and economic stability are part of the solution. We know that health status is made up of many factors – and that 80% of a person's wellbeing can be linked to factors other than health itself.

How do we emphasize community and health equity within the Ontario Health Team models?

Now is the time for action. There is considerable conversation happening now on the evolution of OHTs. The role of primary health care is recognized and evolving to ensure a strong foundation. Ontario Health and the Ministry of Health recognize the need to prioritize health equity and the lessons learned from other jurisdictions can help us leap forward and capitalize on their learnings and innovation.

Key actions that successful community integration models have implemented are summarized below. You will see many similarities between these and the Models of Health and Wellbeing and Wholistic Health and Wellbeing. Additional details for each of these potential actions are provided in the Toolkit for Actions below.

Potential actions to explore

- Partner with newly forming Primary Care Networks and expand access to TeamCare and Social Prescribing through existing team models
- Understand the characteristics of the population including social, economic and health inequities and continue to collect sociodemographic and race-based data to inform care and service delivery and identify gaps in care and/or disparities in outcomes.
- Involve the community in shaping and improving services by working together
- Ensure an equity driven approach is included and social determinants of health are addressed through working with partners that may not be part of your existing OHT
- Expand community partners and share/merge back office activities to support the future envisioned financial payments and accountabilities
- Ensure to highlight and measure activities/processes that will achieve health outcomes
- Advocate for accountability agreements, funding and OHT guidelines to take a holistic approach and not solely focus on health system design
- Use this PowerPoint Presentation to support conversations about integrated community care with health service providers, OHTs, potential partners, funders and others.

Toolkit for Actions

This Toolkit provides additional detail and outlines tactical approaches to undertaking the actions listed above. It contains detailed descriptions and links to resources for each, as well as case studies that describe successful integration models that highlight community. It is a living document that includes links to resources and key actions that are common within integrated community models. In Appendix A , we provide two studies that illustrate integrated community models in action.

We will update this toolkit and the case studies as resources and more exemplars are identified. As you undertake the actions described in this toolkit, you may discover other tools and resources. Please consider sharing any that you find useful.

1. Partner with newly forming Primary Care Networks and expand access to TeamCare and Social Prescribing through existing team models.

Primary Care Networks (PCNs) have been forming across the province, serving as a vehicle for family physicians to build relationships, have a 'unified voice' for decision making and contribute to OHTs. These networks include all primary care physicians and nurse practitioners and have identified leads (sometimes a board of directors) and are resource hubs for information. The Association of Family Health Teams and the Ontario College of Family Physicians are supporting regions to create networks and are advocating for the Patient Medical Neighbourhood. The Alliance for Healthier communities supports the adoption of PCNs as a methodology for ensuring primary health care is better positioned in Ontario Health Teams

PCNs have been established in Alberta and BC as well as throughout the UK. They are seen as a positive way to bring primary care providers together. However, we know that primary care providers (MDs and NPs) cannot provide the full spectrum of care required within an integrated community health model. People need access to interprofessional teams and access to social and community supports. TeamCare and Social Prescribing are two options that would ensure the entire population would have access to team-based care and social and community supports. Both projects involve co-design, collaboration and partnerships. The Alliance has a social prescribing guidebook for primary care available, and the World Health Organization has recently published a toolkit for implementing social prescribing at the community level. With experience of leading interprofessional teams, our population approach, and the power of social prescribing for social and community supports, we are well positioned to fill this gap.

2. Understand the characteristics of the population, including social, economic, and health inequities.

The characteristics of the attributable population and health inequities must be understood to ensure tailored and appropriate services are provided. Data is currently available through Primary Care Data Reports and the OHT Data Dashboard which will be available soon. These reports include important information on the characteristics of the attributed population including income quintiles, newcomers, measures of deprivation, health status, and measures of health care utilization. These are all fairly typical measures used within integrated care models and are important to understand variations in access, broad characteristics of the population and comparisons with other OHTs. However, integrated community models in other jurisdictions take this a step further by ensuring that they have individual-level data that includes sociodemographic and race-based data, as well as questions about food and income security and self-reported physical and mental health status. Many integrated community models share common screening and intake tools to ensure that people at risk are identified, and tailored service delivery is provided. The Alliance has created a Sociodemographic Toolkit that includes common scripts, intake tools, EMR templates, case studies and workflows to ensure individual sociodemographic data can be collected and used.

All OHTs should ensure that providers, staff, and leadership are familiar with the specific health challenges that certain population groups experience. Consider training providers, staff and leadership on health equity, cultural safety. The Indigenous Primary Health Care has produced several materials and trainings including a toolkit for Creating Safer Environments for Indigenous Peoples and Foundations of Indigenous Cultural Safety, an on-line training course that is designed for health care providers. The French Language Planning Entities have also developed materials to support French Language Services, including the free training on the Active Offer of French Language Health Services geared towards individuals studying or working in health care, developed by the *Réseau du mieux-être francophone du Nord de l'Ontario.*

3. Involve the community in shaping and improving services by working together

All OHTs are encouraging strong community engagement. However, within the integrated community models this is taken a step further and is aligned with the Model of Health and Wellbeing and Model of Wholistic Health and Wellbeing.

The Indigenous Primary Care Council has produced a framework for Indigenous Health System Transformation for OHTs. This framework describes foundational components for Indigenous Health System Transformation and includes important steps including Indigenous health in Indigenous hands (including governance, self-determination and equity); cultural safety; wholistic health; collaborative and reciprocal relationships; and data governance and performance management.

Within the US Accountable Community Care (ACC) model, community engagement is mandatory, and most ACCs incorporate community decision-making through a governing or advisory board. Some challenges that have been identified include ensuring that community members have an equal voice, ensuring members have the tools to understand conversations that contain technical language, and preventing consumer burnout from high expectations of participation. In addition to decision-making, community members help providers guide quality of care and help with other community engagement efforts. You may find it helpful to review Tamarack's webinar series on community engagement.

The integrated community models in the UK have created hubs which co-ordinate resources to ensure that people experience well-planned and coordinated care utilizing local support, knowledge and experience. Each integrated community model has built in methods of co-production that ensures harnessing the ideas and enthusiasm of the community to help identify challenges but also work towards solutions. The North Cumbria Integrated Care Community has created a set of tools that help them work towards their 'co-production pledge'.

4. Ensure an equity-driven approach is included and social and systemic determinants of health are addressed by partnering with organizations, such as municipalities, who may not be part of your existing OHT.

Successful integrated community models worldwide ensure participation from the community. They include diverse partners such as public health; medicine; health systems; mental health and addictions care; academia; and social support services related to food security, housing, and income security. They also include community-specific partners, such as city planners, recreation supports, volunteer organizations, transportation agencies, and schools.

Integrated communities should conduct needs assessments that ensure community involvement in planning decisions and ensuring data is available describing the population. This data should be examined not only to understand the characteristics of the attributable population and the types of services required, but also to determine who *isn't* accessing services. North Muskoka OHT has shared their needs assessment template. It describes an ongoing process and prioritizes the determinants of health. Another useful tool is an asset map - an inventory of community assets and resources.

The NW London Integrated Care System has created an 'Involvement Charter' and engagement framework that was co-created with community members. This publically describes the minimum standards for all involvement and engagement ensuring that community is involved in service design, care decisions and change ideas. In Ontario, we have resources produced by the Black Health Alliance and the Alliance Black Health Committee who have developed a Black Health Strategy. Finally, the Alliance Health Equity Charter may be helpful to adopt and endorse. The Alliance and its Francophone

Advisory Committee has developed a set of principles and resources to advance the health of Francophone communities served by OHTs. By referring to these principles, OHTs can ensure that French language health services are planned, designed, delivered and evaluated while taking into account the diversity and various intersectionalities within Francophone communities in Ontario.

5. Work with community partners and share back office activities to support the future envisioned financial payments and accountabilities.

At maturity, OHTs will receive funding through an integrated funding envelope based on the care needs of their recipient patient population. The integrated funding envelope will be paid to a single fund holder. We understand this to mean that where an OHT is comprised of multiple providers or organizations, one organization will be the recipient of the funding on behalf of the group, or the OHT will incorporate to receive those funds. In addition, OHTs will be clinically and fiscally accountable for meeting all of the health care needs of their patient population. The funding envelope will include population-based funding, as well as activity-based funding for specific episodic care.

Several mature integrated community models have created community-wide coalitions and boards as a structural necessity and are legal entities that enable funding like this and accountability. The coalitions in the US Accountable Care Communities (ACC) model serve as a central organizational node and include broad based community-wide partnerships. This is a mandatory requirement with the rationale and objective of cost containment and improved efficiency. A benefit of the ACC model is that cost savings resulting from programming and interventions are directly put back into the ACC for further community investment.

6. Be sure to highlight and measure activities that will achieve health outcomes but focus on processes that are community-centred.

Robust data collection and metrics were part of all integrated community models examined internationally. This data included screening for risk using a standardized intake tool, patient experience, patient reported outcomes (quality of life) and health system measures (costs, improved value, and utilization).

A key feature of all the integrated community models that distinguishes them from integrated health system models is that they focus on short term process measures, intermediate outcomes measures, and longitudinal measures of impact. This ensures that community members, leaders, and stakeholders understand how outcomes were achieved, and it provides an opportunity to highlight community-based interventions. We are in the process of gathering examples of commonly-used indicators and metrics.

Appendix A: Case Studies

Accountable Care Communities: US Model

Lessons from community-oriented primary care in the United States can offer insights into how we could improve population health by integrating the public health, social service, and health care sectors. Accountable Care Communities (ACCs) or Accountable Communities for Health (ACHs) have been formed in several jurisdictions because the accountable care model was not achieving the planned outcomes.

Unlike traditional Accountable Care Organizations (ACOs) that address population health from a health care perspective, ACCs address health from a community perspective and consider the total investment in health across all sectors. The approach embeds accountable care into a community context where multiple stakeholders come together to share responsibility for tackling multiple determinants of health. The ACC model provide a roadmap for embedding health care in communities in a way that uniquely addresses local social determinants of health.

An ACC is a structured collaboration between healthcare, public health, and a variety of partners outside of the healthcare system. Its mission is to improve health, safety, and equity within a defined geographic area through comprehensive strategies including clinical services, mental health services, social services, community supports, and community-wide efforts to improve community conditions that influence health. This final point – the inclusion of community-wide change – is what makes the ACC model unique and particularly innovative. Models such as the Patient-Centered Medical Home and ACOs have explored the integration of clinical services with mental health and social services, but the ACC model is one of the first frameworks to purposefully integrate public health strategies that address the community-level factors that shape population health.

Through a strong integrated strategy, an ACC is a structure for both primary prevention and enhancing efficacy of secondary and tertiary treatment for those that need it. Several examples exist in the US but we will be describing an ACC in Akron, Ohio.

Akron Accountable Care

The Akron ACC was first envisioned in 2011, when a group of health leaders met to discuss the need for a new model of collaborative health. They established one of the first formal ACCs in the country and have seen positive outcomes and reduced costs as well as healthier communities. A comprehensive framework has been written that highlights this journey but we will summarize a few key activities and outcomes achieved with this model.

After consultation, analysis and assessment of community assets and partnerships, the ACC decided to focus on diabetes care. In their community, the prevalence of diabetes was considerably higher than in other areas, and it was confounded by sociodemographic and race- based factors as well as systemic factors such as population density, poor walkability and access to green spaces. Rather than focus on hospital admissions or outcomes related to complications of diabetes, the ACC focused on prevention and interventions at the individual and population levels, paying specific attention to 'underserved' populations. They focused on four key outcomes related health care costs, decreased 'burden' of disease, and improved quality of life –not only for the people who were in the hospital, but for the entire population.

Some of the innovation was focused on changing the environment through working with city planners and other decision-makers to make decisions that would enable healthy living. For example, in large parts of Akron there were no sidewalks or accessible green spaces. The ACC worked with national parks to make them accessible for public health; this included ensuring accessible transportation to get to the parks. Finally, they ensured greater access to healthy food, including fruit and vegetables, through mobile units and increased access to a range of community health and social supports. They measured all of these activities as well as population health and individual health outcomes. The results were positive and included improved health status, improved diabetes (glucose, weight, obesity, etc) as well as improvements to **all of the 'big dot' indicators** such as ED utilization, hospital visits and overall costs. Akron ACC claims that they are **'healthier by design'.**

Integrated Care Systems and Integrated Care Communities: UK Model

After more than a decade of attempting to integrate care within the NHS, Integrated Care Systems (ICS) are the latest version of integrated care throughout the UK. These were established with the understanding that hospital-based model of care was not the answer to meet rising demand. ICSs are intended to work differently by providing **more care in people's homes and the community** and breaking down barriers between services, including coordinating the work of general practices, community services and hospitals to meet the needs of people requiring care. As of July 2022, the NHS announced that they will be organizing England into 42 ICS regions for full coverage.

A recent paper suggested that OHTs seemed to mimic the partnerships achieved through ICSs, so this is an important model to pay attention to. Every ICS has a 'partnership board' which is drawn from constituency organizations but can make legally binding decisions together; therefore, they claim that all agreements are made in collaborative forums.

Innovation and change has been common in the UK, and a common thread is utilizing the expertise of the voluntary and community sector with engagement from

communities. A few regions of England have taken a step further and are working towards Integrated Care Communities (ICCs). These community-based integrated care models are also being developed in Denmark, Finland and the Netherlands. The NHS has implemented the Pioneer Program in which 25 ICCs have been selected as exemplars in integrated care, improving health equity and building strong communities.

Two examples are provided below.

1. North Cumbria Integrated Care Community (ICC)

North Cumbria is a predominately rural region in England. This region has been divided into eight ICCs based on groups of primary care practices. Each ICC is working with community members to understand the challenges that each area is facing. They are building partnerships with health, community, social and volunteer organizations to improve health and wellbeing for the population. The goals of the ICC are to deal with increasing demand for care within the community and empower people to take control of their health and wellbeing. Each of the eight regions is following a similar approach but has flexibility to tailor service delivery and priorities to meet the needs of the population. All regions in North Cumbria have health profiles that indicate poorer health status and high hospital utilization compared to other regions in the UK.

Each ICC has a hub which coordinates care for the population within their region. This hub provides administrative support and a single point of contact for any professional referring people to ICC services. The hub coordinates a rapid response when someone's health is seen to be deteriorating or extra care is required to help avoid as many hospital stays as possible or to help people get discharged from the hospital sooner.

Each ICC works closely with community and ensures that patients and members of the community help to design services and implement changes and improvements. One region decided to focus on stroke prevention because of risk factors observed in the population data. The aim of their stroke prevention work was to develop an initiative shaped by the community and delivered in partnership with the patients themselves. This ICC worked with community members, volunteer associations, health care providers and patients to develop community events that included blood pressure clinics, access to healthy food, and information about exercise and stroke awareness. Individuals at risk are being identified and proactively managed. Social connections are made and ongoing evaluation is being done to determine impact on hypertension and strokes.

2. North West London Integrated Care System

The North West London ICS started as a pilot that was originally launched in 2011. This integrated network has grown and evolved over time and is highlighted as an innovator within the NHS. NW London is a diverse area with 2.4 million from more than 200 ethnicities and health status, life expectancy, morbidity and hospital utilization are all poorer compared to national averages. People in this area also experience increased challenges due to determinants of health (e.g. poverty, overcrowding, racism, unemployment). This has resulted in considerable health inequity and large variations in health outcomes and health care access.

To accomplish their goals, The NW London ICS has partnered with health systems, academia, community supports, businesses and community members. There are 45 Primary Care Networks in this region. Although it is more like a traditional integrated model, this ICS is embedding community throughout and has included community and health equity outcomes. They have established partnerships with each of the boroughs and have health and wellbeing boards as a statutory body. Each borough ensures community members co-produce services and change ideas that are tailored to their community. The ICS has recently implemented an 'Involvement Charter' with each community that was developed by the community members themselves to ensure that community outreach is embedded in each borough. The ICS works with volunteer organizations, social organizations, and community organizations, and it has worked with additional partners such as city planners, businesses, faith organizations, and schools.

There are massive health inequities in NW London. Insight from community engagement suggests that building equity and trust was required to improve health inequities. The ICS has a 5-year plan to address health inequities, which includes the involvement of communities in determining how to reframe service delivery. The ICS is prioritizing new health and wellbeing programs in community spaces and ensuring that local people are hired to deliver the programs, activities and services. Resources are being given to each community to help them choose sustainable solutions to reduce inequalities. Finally, the ICS is measuring and using data to inform this work. Indicators of success are being determined by community members. Insights and progress will be monitored using quantitative and qualitative insights as well as sense-making through community engagement. A dashboard is planned that will share all insights across all NW London boroughs. With this information, rapid improvement will be embedded.

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