

### RISE brief 29: Examining intersections between Ontario Health Teams and specialty service lines (Last updated 22 March 2022)

#### Overview and challenges

Ontario's health system is undergoing a transformation to enable population-health management through the creation of Ontario Health Teams (OHTs). First announced in February 2019, OHTs are cross-sectoral networks of healthcare organizations (and, in some cases, public health and social services) that at maturity will be held clinically and fiscally accountable for the health of their attributed population. OHTs are expected to provide a complete continuum of care to their populations through their networks. To be approved as an OHT, membership has to include, at minimum, primary, home and community and hospital-based care. OHTs are not expected to provide highly specialized services (herein called specialty service lines), though fulfilling the objective of population-health management for an OHT's attributed population will require them to establish intersections with specialty service lines.

#### Box 1: Coverage of OHT building blocks

This RISE brief addresses **all eight** building blocks

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

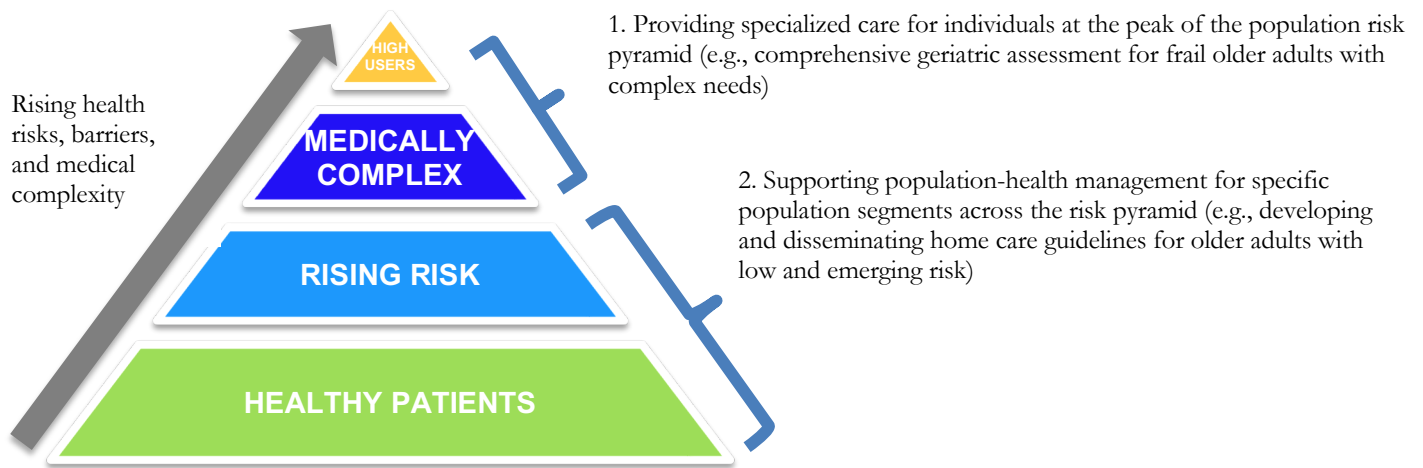
We use the phrase 'specialty service lines' to highlight that these services are structured and coordinated programs of care (rather than a single intervention or the work of an individual specialist). Specialty service lines have several unique characteristics. The Ontario Hospital Association (OHA) defined these as services requiring:

- focused expertise and extensive resources
- an adequate volume of patients to maintain quality and subspecialty clinical expertise
- regional or jurisdictional planning to address economies of scale
- interdependencies with other services.(1)

Some specialty service lines may focus on conditions that are primarily acute and/or episodic, as is the case for complex cardiac and stroke care, and solid-organ transplant services. Others address complex or rare presentations of conditions requiring longitudinal or life-long care, as in care for children and adults with severe neurodevelopmental conditions, care for people needing hemodialysis, and care for some people with severe and persistent mental illness.

Specialty service lines have two important functions in a population-health management approach, as illustrated in Figure 1 below. The first function is to provide care for individuals at the top of the population-health management risk pyramid (i.e., the small proportion of individuals facing the most complex health concerns or with resource-intensive focused needs).(2) These are the services that require extensive resources, focused expertise, and adequate patient volumes to concentrate needed subspecialty expertise. The second function of specialty service lines extends beyond providing care, to instead supporting providers working at other levels of the population-health risk pyramid. For instance, specialty service lines may support the development and implementation of condition-specific care pathways, or patient self-management supports, that span the continuum from preventive and primary care to highly specialized care.(3)

**Figure 1: Role of specialty service lines in a population-health management approach**



At present, individuals seeking care from specialty service lines in Ontario may face challenges including:

- long wait times
- lack of coordination with primary care, home care, rehabilitation, or hospital care
- gaps in coverage (often including for pharmaceuticals or assists for daily living)
- inadequate psychosocial support to ‘wrap-around’ specialty service lines for patients and families (4-8)
- inequities in access to and experiences with specialty service lines for populations including rural and Northern communities, Indigenous peoples, racialized populations, Francophone populations. (9-11)

Building connections between OHTs and specialty service lines presents an opportunity to address some of these issues but will also pose a new set of challenges. OHTs vary in the scope of services that they cover, and there is no defined list of services that OHTs must include. Some OHTs already include some specialty service lines, especially large teams in urban centres that include tertiary-care hospitals and other highly specialized tertiary-care providers among their partners. Other OHTs may exclusively provide primary and secondary care.

Specialty service lines may also vary in their capacity to fulfil the second function (i.e., to support providers along the population-health management pyramid). Some specialty service lines in Ontario have well-developed partnerships, infrastructure, and processes for supporting population-health management, such as complex case management or care coordination-personnel. Other specialty service lines may lack critical components such as data and information technology or may have unevenly developed networks of partnerships across the province. This has implications for the capacity of specialty service lines to support OHTs’ population-health management efforts.

### Key findings from the citizen panel

We hosted two citizen panels on 14 January 2022, to elicit perspectives on these issues. Participants included patients and caregivers who have experience accessing specialty service lines, for both acute and ongoing complex needs. Panels included a mix of individuals with and without direct experience of supporting OHTs or other health organizations in advisory roles.

Participants in the citizen panels highlighted challenges affecting their experiences with specialty service lines, including:

- lack of care coordination
  - communication among providers is fragmented owing, in part, to a lack of shared records
  - dependence on individual providers’ knowledge of the system and willingness to coordinate care, rather than a systematic approach, resulting in variable experiences

- caregivers take on a care coordinator role in the absence of formal supports and experience barriers to communicating with care teams
- lack of coverage for a full continuum of care
  - some components of specialty care such as outpatient medications and rehabilitation services are not covered by OHIP
  - individuals with rare conditions may struggle to find appropriate social supports
- access challenges in Northern communities
  - travelling long distances for highly specialized care can result in lost income and prolonged time away from home communities,
  - high costs of travel are not fully covered and are reimbursed rather than being covered up front,
  - internet connectivity can present a barrier to virtual care
- insufficiency of system resources, including human resources and funding.

### Key findings from the jamboree

In addition to agreeing with the list above, jamboree participants highlighted challenges for establishing intersections for providing care to those at the peak of the population risk pyramid, including:

- lack of accountability for transitions and care coordination
- need to engage specialty service providers in planning.

Participants further noted challenges for engaging specialty service lines in supporting population-health management, including:

- the need to strike a balance between building supports for specific populations and conditions and the need to reduce silos to manage multimorbidity
- the need for shared and standardized data systems to understand population needs and to enable benchmarking
- overall system capacity strained by health-human resource shortfalls and COVID recovery.

## **What have we learned from the experiences of others?**

Other jurisdictions that have adopted population-health management approaches have grappled with similar questions around the role of specialty service lines and their intersections with local networks of care. We conducted key informant interviews and targeted database and internet searches to identify how other health systems have approached this issue. We focused on initiatives that:

- addressed the role of specialty service lines, as defined above
- addressed this role in relation to local networks of care
- crossed multiple OHT building blocks (i.e., were a package of interventions, rather than a single intervention such as virtual consultation).

We identified five models for how specialty service lines interact with health systems serving general populations. The table below describes these models and provides examples, what we know from effectiveness studies of similar initiatives, and considerations specific to the Ontario context. In addition to the considerations in Table 1, any model will require:

- robust patient, family and caregiver engagement related to the both the specialty service lines and their intersections with Ontario Health Teams
- seamless coordination between Ontario Health Teams and those organizations providing specialty service lines
- common digital health tools that allow for the safe and efficient sharing of patient information
- careful attention to equity implications, including differential effects of each model for specific populations.

**Table 1: Models for the role of specialty service lines in a population-health management approach**

Model and examples	Findings from effectiveness studies	Considerations for the Ontario context
<p><i>Population-specific accountable-care organizations</i> (ACOs) directly provide a complete continuum of care to individuals with high-cost conditions or at risk of high-cost use, and include organizations able to provide specialty services and high-touch care management (e.g., end-stage renal disease ACOs, pediatric ACOs, ACOs for cancer care).</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>• ESRD Seamless Care Organizations (ESCOs) [U.S.]: specialty accountable care organizations organized around dialysis facilities and nephrologists instead of primary care</li> <li>• Ambulatory Intensive Care Unit [U.S.]: an approach to serving high-needs, high-cost patients that has been adopted in some ACOs</li> </ul>	<p>ESCOs</p> <ul style="list-style-type: none"> <li>• Associated with decreased costs, decreased hospitalizations and 0.3% increase in patient survival over a one-year period (12; 13)</li> </ul> <p>Ambulatory Intensive Care Units</p> <ul style="list-style-type: none"> <li>• Generally does not affect emergency department use or mortality, and effectiveness in reducing hospitalization varied (14)</li> </ul>	<ul style="list-style-type: none"> <li>• It may be difficult to coordinate across large geographic areas with smaller populations (14)</li> <li>• Context for achieving savings from this model occurred in financial arrangements that differ from Ontario’s</li> </ul>
<p><i>Contractual arrangements</i> enable local health systems, like OHTs, to contract with specialty service lines for specific services in instances where partners are unable or do not provide these types of care.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>• Carve outs [U.S.]: accountable-care organizations may ‘carve out’ (i.e., contract for) unavoidable high-cost services like trauma surgery, or individuals with extreme healthcare costs</li> <li>• Care compact [U.S.]: healthcare providers and health systems may also enter a non-binding ‘care compact’ with specialty services lines, which specifies expectations of each party</li> <li>• Clinical commissioning groups [U.K.]: groups of primary care practices and other stakeholders that plan and procure services within their local area, including specialty service lines</li> </ul>	<ul style="list-style-type: none"> <li>• Carve-outs</li> <li>• No difference in access to care for individuals with serious mental illness, and reduced access to care for individuals with mild/moderate mental illness in Oregon coordinated care organizations with behavioural health carve-outs(15)</li> <li>• Increased accuracy of estimates of savings in New Jersey Medicaid ACOs(16)</li> </ul>	<ul style="list-style-type: none"> <li>• There is a risk of fragmentation in care for patients transitioning between their OHT and contracted service providers</li> <li>• Drafting and managing contracts for specialty service lines would require expertise and human resource capacity for Ontario Health Teams</li> </ul>
<p><i>Regional networks</i> are formed by specialty service providers within a region, organized around a specific condition or population. Regional networks standardize pathways into and within specialty service lines and work together to increase flexibility and achieve economies of scale. Regional networks also support care for specific population segments at a regional level by interfacing with multiple regional or local care organizations to provide support with planning, evaluation, and other functions.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>• Provider collaboratives [U.K.]: groups of acute care providers that coordinate to reduce variation in care while engaging with local levels of care to support planning</li> </ul>	<p>Provider collaboratives:</p> <ul style="list-style-type: none"> <li>• Most sites in an early pilot supported patients to receive care closer to home, but existing data did not allow for analysis of quality or other outcomes (17)</li> </ul>	<ul style="list-style-type: none"> <li>• Networks would each need to coordinate with multiple OHTs within their region</li> <li>• OHTs would need to coordinate with multiple networks addressing different specialty service lines</li> <li>• Networks may require structures tailored for different conditions and</li> </ul>

Model and examples	Findings from effectiveness studies	Considerations for the Ontario context
<ul style="list-style-type: none"> <li>• Regional networks support multiple OHTs in providing care for specific populations, examples include               <ul style="list-style-type: none"> <li>○ Kids Come First Health Team, with a focus on children and youth</li> <li>○ Central Ontario Health Network for Specialized Populations with a focus on people with complex mental health or substance use needs</li> </ul> </li> </ul>		<p>different regions, rather than following a single template</p>
<p><i>Provincial programs</i> directly provide specialty service lines in a small number of facilities, under central oversight. Provincial programs also provide clinical leadership and performance monitoring of care for specific population segments at a provincial level, often with a regional layer of support for implementation.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>• Provincial programs [Ontario]: Cancer Care Ontario, CorHealth, Provincial Geriatric Leadership Ontario (PGLO), and Trillium Gift of Life</li> <li>• Provincial Health Services Authority (PHSA) [B.C.]: responsible for provincial clinical policy and oversight in several areas including cancer, children’s health, renal care, and others</li> </ul>	<p>No effectiveness studies found</p>	<ul style="list-style-type: none"> <li>• Ontario already has several provincial programs</li> <li>• Each provincial program would need to coordinate with all OHTs</li> </ul>
<p><i>Blended approaches</i> involve partnerships across levels of governance that bring together two or more of the approaches above.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>• Integrated care systems [U.K.] bring together providers and commissioners of NHS services across geographic areas at three different levels, including:               <ul style="list-style-type: none"> <li>○ ‘Neighbourhoods’ (populations of around 30,000 to 50,000 people) served by groups of GP practices, NHS community services, and social-care and other providers</li> <li>○ ‘Places’ (populations of around 250,000 to 500,000 people) connecting primary care networks to local councils, community hospitals and voluntary organizations</li> <li>○ ‘Systems’ (populations of around 1 million to 3 million people) bringing together health and care partners in different sectors to set strategic direction and develop economies of scale with specialty service lines</li> </ul> </li> </ul>	<p>No effectiveness studies found</p>	<ul style="list-style-type: none"> <li>• Blended approaches would require clear definitions of what services are coordinated and provided at what level</li> <li>• Blended programs would require addition layers of governance and administration than have been envisioned for OHTs</li> </ul>

## Findings from citizen panels

Participants in citizen panels were generally supportive of blended approaches taking the most applicable elements of each model, particularly regional networks and provincial programs. Comments on specific models included:

- concerns that contractual models could incentivize ‘cherry picking’ of patients and profit-motivated care
- concerns that regional-defined networks would need to have the appropriate human resources
- support for provincial programs given past positive experiences with Cancer Care Ontario, but worried about transitions between primary care and specialty cancer services.

Additional elements that participants believed should be part of any model include:

- holistic approaches, particularly for life-long conditions, which recognize that a large proportion of individuals experience multiple concurrent health concerns including both physical and mental health issues
- shared electronic health records
- involvement of and communication with patients and their caregivers
- consistent standards of care
- care coordination and interpersonal continuity, including ongoing support after exiting specialty care, such as in cancer survivorship.

## Key findings from the jamboree

Jamboree participants added the following reflections on learning from other jurisdictions:

- regional specialty services, regional non-specialty services, and provincial services will all require distinct approaches to planning
- Ontario lacks the incentives for care coordination that exist in other jurisdictions, namely within the ACO-model from the U.S., and the support infrastructure that exists in the U.K.
- while carving out funding for cancer and renal care has been successful in Ontario, carve outs can also be problematic because many health issues cannot be addressed in isolation
- some success has been achieved in Northern areas to address health-human resource issues across large geographic areas, but these networks require dedicated funding to continue.

## **How could this be used to support OHTs?**

Adopting any elements of the above models across the province will require thoughtful and matrixed implementation. Barriers to implementation of new models for linking OHTs and specialty service lines may include:

- the need for flexibility in planning to address variations across populations, geographic areas, and condition-specific organizations
- the lack of interoperability of electronic record systems across OHTs and specialty service lines, as well as direct access for patients and their caregivers
- the lack of widely available data for some conditions, particularly for rare conditions
- the lack of defined accountabilities (including financial accountabilities) between specialty service lines and OHTs
- the additional administrative demands to coordinate care between OHTs and specialty service lines
- the potential for instability when introducing new financial arrangements between OHTs and specialty service lines.

Factors that may support implementation include:

- previous and ongoing experience with provincial programs that are now part of Ontario Health (such as Cancer Care Ontario, CorHealth, and Trillium Gift of Life, among others), regional networks (including Kids Come First Health Team and the Central Ontario Health Network for Specialized Populations) and condition-specific

organizations that provide system supports (such as the Provincial Council of Child and Maternal Health, the Provincial System Support Program at CAMH, and others)

- commitment and expertise of specialty-service-line providers that can be leveraged both to care for patients with complex needs and to support population-health management approaches along the population-health risk pyramid.

#### Key findings from the citizen panel

Participants in the citizen panel identified the following implementation barriers:

- limited information sharing across digital platforms
- barriers to digital access in the North
- additional work in developing and administering new models
- insufficient health human resources and inadequate hospital capacity post-pandemic
- delays due to political factors.

Participants identified the following implementation facilitators:

- learning from Cancer Care Ontario and other success stories within the province
- building on momentum in digital care that emerged during the pandemic
- talent and expertise within the province, which needs to be leveraged in an equitable way.

#### Key findings from the jamboree

Jamboree participants agreed with the above implementation barriers and identified the following additional concerns:

- limited acknowledgment and supports for regional models
- lack of supports, such as for data, that extend beyond OHTs to facilitate intersections.

Jamboree participants identified the following next steps:

- develop a matrix for planning for the intersections between specialty service lines and OHTs and for the types of conditions and populations for which greater integration between specialty service lines and OHTs is necessary
- use the matrix to prioritize a small number of conditions to begin planning for the intersections with OHTs (e.g., frailty, specific mental health and addictions conditions, surgical backlog, adults with developmental conditions), considering factors such as population needs and potential for impact
  - co-design a matrix and establish the terms of engagement with the groups willing to pilot a new approach
  - co-design a new approach for select types of select specialized lines of services (ideally with some variation as to whether they are provincially, regionally or locally planned)
  - co-design a governance structure that would support collaboration within (and across) specialized lines of service
  - establish a repository of care models and care pathways within (and across) specialized lines of service
- expand the role that OHT Impact Fellows hold to support documenting and evaluating new approaches within OHTs and with innovative regional models to support cross-regional learnings
- creating provincial standards for intersections between OHTs and specialty service lines (rather than solely relying on guidelines or other discretionary measures).



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Evans C, Waddell K, Bain T, Reid R, Lavis JN. RISE Brief 29: Examining intersections between Ontario Health Teams and specialty service lines. Hamilton: McMaster Health Forum; 2022.

RISE prepares both its own resources (like this RISE brief) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results, and conclusions are those of RISE and are independent of the ministry. No endorsement by the ministry is intended or should be inferred.

ISSN: 2562-7309 (online)