RISE
Rapid-Improvement Support and Exchange

RISE brief 1: OHT building blocks (Last updated 7 August 2019)

Overview

Ontario Health Teams (OHTs) will initially need to learn and improve rapidly in the design of each of the eight OHT building blocks (which were called 'OHT requirements' in the ministry's original guidance document). Designing these building blocks will require strategic choices in 58 domains, with some of these decisions needing to be made in year 1 and others coming later.

OHTs will also need to learn and improve rapidly in harnessing the building blocks to achieve specific targets related to the care experiences and health outcomes for their year 1 priority populations. They can then build on these experiences in steadily expanding their priority populations in later years, with the goal of eventually optimizing care experiences and health outcomes for the entire population for which they're accountable.

Box 1: Coverage of OHT building blocks & relevance to sections in the OHT full application form

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

It is relevant to **all sections** in the OHT full application form, and the accompanying Excel file includes links between building blocks and sections or questions in the application form.

A key priority in year 1 will be to document processes so they can be easily spread to the design of other building blocks and scaled to the entire population in later years. In RISE brief 2, we introduce a sample work plan in Excel that can be used to document processes (and track progress) over time.

OHT building blocks and related domains

RISE drew on the ministry's guidance document and readiness assessment to develop a list of the mutually exclusive and collectively exhaustive domains where OHTs will need to make strategic choices (see Table 1). In doing so, RISE:

1) re-ordered the building blocks to improve flow and numbered them from #1 to #8;
2) provided both a brief phrase to describe each building block and a question that will need to be answered in designing a building block (see bolded text in column 1);
3) summarized the ministry's expectations with respect to each building block in year 1 and at maturity (see text that follows the italicized and underlined text in column 1);
4) identified each unique domain where strategic choices will need to be made in designing each building block, and numbered them from 1 to 58 (see column 2 with the column header D for domain);
5) provided a brief description of each domain (see column 3);
6) identified any considerations specific to a domain (e.g., some domains are targets that may be best considered within building block #8 (performance measurement, quality improvement, and continuous learning) – see column 4); and
7) identified links to the seven characteristics of a rapid-learning health system (see bolded text at the bottom of relevant cells in column 1), which is a framework that helps to guide the work of RISE (and is the focus of RISE brief 10).

One way to think of the year 1 expectations of OHTs is that:

1) for each priority population they are making strategic choices related to building block #4 (patient care and experience); and
2) they are simultaneously designing the other building blocks in ways that support the work on each priority population and set the stage to scale up and spread this work to other priority populations (and eventually to the entire population for which they're accountable).

An Excel version of this table is available here. The Excel version includes an additional column with links between building blocks (or domains) and sections of (or questions in) the OHT full application form (see last column).

Table 1: Building blocks and related domains

Building blocks	D	Domain descriptions	Notes
Building block #1: Defined patient population (who is covered, and what does 'covered' mean?): Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1. *Year 1 expectations*: Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population. *At maturity*: Teams will be responsible for the health outcomes of the population within a geographic area that is defined based on local factors and how patients typically access care.	1	Target-population definitions (e.g., based on Family Health Team enrolment, hospital admission, long-term care resident) and their characteristics, healthcare use (including costs), experiences and outcomes	
	2	Geographic-area definitions (e.g., based on local factors, referral/utilization patterns)	
	3	Patient-access targets	Intersects with building block #8
	4	Service-delivery (volume) targets	
	5	Sustained care-relationship targets	
Building block #2: In-scope services (what is covered?): Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in the full continuum of care and include or expand primary care services. *Year 1 expectations*: Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary care coverage for a significant portion of the population. *At maturity*: Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.	6	Service-inclusion definitions - e.g., by health sector (i.e., home and community care, primary care, specialty/hospital care (including emergency services), rehabilitation care, long-term care, and public health) and non-health sector (e.g., social services and housing) - e.g., by category of conditions (e.g., mental health and addictions, work-related, cancer, and end-of-life) - e.g., by category of treatments (e.g., prescription drugs, complementary and alternative therapies, and dental services) - e.g., by population (e.g., francophones, Indigenous peoples)	Must include 3+ sectors (with preference given to home and community care, primary care, specialty/hospital care) and 'services' includes 'technologies' like drugs, devices, diagnostics and surgery Includes individual-level interventions on the social determinants of health (population-level interventions are addressed below)
	7	Service-exclusion definitions (e.g., highly specialized treatments)	
	8	Service site decisions (e.g., 'focused factories' for healthcare and supportive housing as an alternative to healthcare settings)	

Building blocks	D	Domain descriptions	Notes
Building block #3: Patient partnership and community engagement (how are patients engaged?) - Demonstrated history of meaningful patient, family and caregiver engagement, and support from First Nations communities where applicable. Plan in place to include patients, families and caregivers in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient engagement framework and patient relations process. Adherence to the *French Language Services Act,* as applicable. *Year 1 expectations*: Patient declaration of values is in place. Patients, families and caregivers are included in governance structure(s) and patient leadership established. Patient engagement framework, patient relations process, and community engagement plan are in place. *At maturity*: Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers and the communities they service. **→ Aligns with rapid-learning health systems (RLHS) characteristic 1: Engaged patients**	9	Proactive patient and public engagement (including related training and feedback) at all levels - service or program (includes patient advisors/partners and co-design) - organization (includes advisory councils, leadership and governance) - local system (includes advisory councils, leadership and governance, as well as patient advocacy for system-level change)	Patient includes patients, caregivers and family members, whereas public includes all citizens regardless of whether they access services, have formal immigration status or pay taxes
	10	Responsive patient relations (includes complaints and other types of unstructured feedback)	For structured feedback, see PREMs in building block #4
	11	Patient values (includes declaration of values alone or as part of a patient-engagement framework)	
	12	Community engagement	
	13	Indigenous peoples engagement	
	14	Cultural sensitivity	
Building block #4: Patient care and experience (how are patient experiences and outcomes measured and supported?): Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care. *Year 1 expectations*: Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the Team's services are in place. Expanded virtual-care offerings and availability of digital access to health information. *At maturity*: Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it,	15	Proactive patient identification	
	16	Individualized care planning	
	17	Care pathways	
	18	Health literacy support	
	19	Digital access to health information	Digital access intersects with the patient portal in building block #5
	20	Shared decision-making	
	21	Self-management planning and support (including digital self-care)	Digital access intersects with the patient portal and digital health tools in building block #5
	22	Virtual-care services	Digital self-care intersects with the e-consultations for patients in building block #5
	23	Proactive chronic-disease management	
	24	Population-based health promotion and disease prevention	Includes population-based interventions on the social determinants of health

Building blocks	D	Domain descriptions	Notes
including digitally, and transitions will be seamless. **→ Aligns with RLHS characteristics 1 (engaged patients) and 2 (digital capture, linkage and timely sharing of relevant data)**	25	Integrated-care models	Includes primary-care home and shared-care models (including the appropriate engagement of provincial assets like mental health facilities)
	26	Coordination services, including interprofessional teams and sustained care relationships	Includes 24/7 access to such services
	27	Transition services	Includes no cold hand-offs
	28	System-navigation services	
	29	Patient-reported experience measures (PREMs)	
	30	Patient-reported outcome measures (PROMs)	
	31	Integration measures (e.g., coordination, transition and system navigation measures)	
	32	Public-facing website describing above services (and one number to call for advice)	
Building block #5: Digital health (how are data and digital solutions harnessed?): Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners. *Year 1 expectations*: Harmonized information-management plan in place. Increased adoption of digital health tools. Plans in place to streamline and integrate point-of-service systems and use data to support patient care and population-health management. *At maturity*: Teams will use digital health solutions to support effective healthcare delivery, ongoing quality and performance improvement, and better patient experience. **→ Aligns with RLHS characteristics 2 (digital capture, linkage and timely sharing of relevant data) and 4 (appropriate decision supports)**	33	Patient portal	Patient 'owned' record
	34	Electronic medical record	Provider 'owned' record
	35	Electronic health record	System 'owned' record (including clinical viewers, etc.) accessible to all partners (under the terms of a harmonized information-management plan)
	36	Digital health tools, including their selection and implementation	Includes decision supports and can be included in the above portals/records; a generic digital tool-evaluation template would be useful
	37	E-consultations for patients	Includes telemedicine/ telehealth
	38	E-consultations among providers	
	39	Data privacy and security	Includes data sharing within 'circle of care'
	40	Data harmonization across organizations, sectors and systems	
	41	Data modelling and analysis	

Building blocks	D	Domain descriptions	Notes
	42	Data sharing and use - in patient care (at point of service) - in rapid learning about and improvement in patient experiences and outcomes - in population-health, financial-risk and other performance management	
	43	Single point of contact for digital-health activities	
Building block #6: Leadership, accountability and governance (how are governance and delivery arrangements aligned, and how are providers engaged?): Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for the team, reflecting a central brand, and where applicable, putting in place formal agreements between team members. *Year 1 expectations*: Agreements with ministry and between team members (where applicable) in place. Existing accountabilities continue to be met. Strategic plan for the team and central brand in place. Physician and clinical engagement plan implemented. *At maturity*: Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls. **→ Aligns with RLHS characteristics 5 (aligned governance, financial and delivery arrangements), 6 (culture for rapid learning and improvement), and 7 (competencies for rapid learning and improvement)**	44	Distributed cross-sectoral leadership capabilities of all five major types - Lead self (e.g., demonstrate character) - Engage others (e.g., communicate effectively and build teams) - Achieve results (e.g., strategic planning and rapid learning and improvement) - Develop coalitions (e.g., build partnerships and navigate socio-political environments) - Transform systems (e.g., champion and orchestrate change)	
	45	Accountable-care organizations, including clinical and financial accountability frameworks	
	46	Collaborative governance	
	47	Proactive provider engagement at all levels - service or program (includes dyad leadership) - organization (includes leadership and governance) - local system (includes advisory councils, leadership and governance) - provincial system (see local system)	
	48	Culture of teamwork, collaboration and adaptability	
Building block #7: Funding and incentive structure (how are financial arrangements aligned?): Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fundholder, and reinvesting savings to improve patient care. *Year 1 expectations*: Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data. *At maturity*: Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient	49	Population costs and cost drivers	
	50	Integrated fund holding, including case-mix-adjusted bundled payments as a transition step	
	51	Contracts, including gain- and risk-sharing contracts	
	52	Re-investments of savings	

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populations. **→ Aligns with RLHS characteristic 5 (aligned governance, financial and delivery arrangements)**			
Building block #8: Performance measurement, quality improvement, and continuous learning (how is rapid learning and improvement supported?): Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality-improvement activities, engage in continuous learning, and champion integrated care. *Year 1 expectations*: Integrated quality-improvement plan in place for the following fiscal year. Progress made to reduce variation and implement clinical standards and best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative *At maturity*: Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the quadruple aim will measure performance and evaluate the extent to which Ontario Health Teams are providing integrated care, and performance will be reported. **→ Aligns with RLHS characteristics 2 (digital capture, linkage and timely sharing of relevant data), 3 (timely production of research evidence) and 7 (competencies for rapid learning and improvement)**	53	Performance measurement across the quadruple aim and across sectors, including detection of inappropriate variation, provider feedback, and public reporting	
	54	Guidelines (including living guidelines) and other sources of best evidence	
	55	Local area- (OHT-) focused rapid learning and improvement, including annual plans/ priorities and behaviour-change support	
	56	Problem-focused rapid learning and improvement, including understanding how data and evidence add value in different stages of a rapid learning and improvement cycle, participating in Ontario Health-directed initiatives, and participating in implementation trials	
	57	Rapid learning and improvement collaboratives	
	58	Rapid learning and improvement competencies	Beyond leadership capabilities covered in building block #6

Key resources

Ministry of Health. Ontario Health Team self-assessment form. Toronto, Canada: Government of Ontario; 2019.

Ministry of Health. Ontario Health Teams: Guidance for health care providers and organizations. Toronto, Canada: Government of Ontario, 2019.

Lavis JN. RISE brief 1: OHT building blocks. Hamilton, Canada: McMaster Health Forum; 2019.

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.

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>>Contact us
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
rise@mcmaster.ca