

### Overview

Ontario Health Teams (OHTs) will require a different approach to governance than most OHT partners are used to having. The Ontario government has:

- 1) retained the independent voluntary governance of health organizations that has been a hallmark of the system since its beginning;
- 2) established through the *Connecting Care Act, 2019* a duty for ‘integrated care delivery systems’ (i.e., OHTs) to integrate care that is now being provided by various organizations in various sectors; and
- 3) left the ‘how’ of service integration up to local communities, including the specifics of collaborative governance.

Collaborative governance as a governing arrangement in which leaders from organizations drawn from multiple sectors engage in a collective decision-making process that is deliberative, consensus-oriented, and directed to the achievement of a shared goal (in OHTs’ case, the quadruple aim).

In order for collaborative governance to be self-determined and fit-for-purpose, the board members for each OHT partner, as well as the chief executive officers (or executive directors) who report to them and the staff who support them, will need to:

- 1) understand what it means to have a duty to an integrated local system that serves the patient;
- 2) prioritize steps towards collaborative governance in year 1; and
- 3) consider possible ‘end states’ for collaborative governance.

Choices about end states are not needed now, but knowing that there are many possible end states may reduce anxiety about what the future will look like for each OHT partner. More details about such legal aspects of collaborative governance can be found in the two resources that were drawn upon in preparing this RISE brief (see the first two links under ‘Key resources’).

### A duty to an integrated local system that serves the patient

Section 30 of the *Connecting Care Act, 2019* states “The Agency [i.e., Ontario Health] and each health service provider [i.e., the current and potential future partners in an OHT] and integrated care delivery system [i.e., each OHT] shall separately and in conjunction with each other identify opportunities to integrate the services of the health system to provide appropriate, coordinated, effective and efficient services.” While each organization’s board will need to continue to act in the best interests of the organization and the people it serves (i.e., to discharge their fiduciary duty), the definition of those best interests – fulfilling the organization’s mission, moving towards its vision, adhering to its values, and discharging its accountabilities – can now be understood more broadly than it had been in the past. This is particularly true among the organizations seeking to become partners in an OHT that provides integrated care across many sectors, including home and community care, primary care, specialty care, rehabilitation care, and long-term care, among others.

To meet the broadened definition of best interests, these organizations will want to co-develop a vision that applies to all of the partners in a local OHT, such as the vision of a rapid-learning local health system that continually ‘ups

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

This RISE brief addresses **building block #6**:

- 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**
  - o **collaborative governance (domain 46)**
- 7) funding and incentive structure
- 8) performance measurement, quality improvement, and continuous learning

It is relevant to **section 4** (how will your team work together?) and to a lesser extent **section 6** (implementation planning and risk analysis) in the [OHT full application form](#).

its game' in achieving the quadruple aim of improving care experiences and health outcomes at manageable per capita costs, and with positive provider experiences. Each organization will want to frame its mission at least partly in terms of its specific contributions to the local health system (or a particular service-delivery model) and ensure that its values include building and maintaining trusted partnerships with other partners in its local OHT. These organizations will also want to co-develop the accountabilities of all partners in its local OHT.

## Steps towards collaborative governance in year 1

During the OHT application phase, and again during implementation phase in year 1, boards and their chief executives and support staff can prioritize three steps towards collaborative governance:

- 1) establish a written agreement that addresses the requirements articulated in the ministry's OHT guidance document, including:
  - a) decision-making,
  - b) conflict resolution,
  - c) performance management,
  - d) information sharing (particularly before OHTs become legally recognized data custodians), and
  - e) resource allocation;
- 2) make board-level decisions that position their organization to learn and improve rapidly in contributing to OHT efforts to design each of the eight OHT building blocks, and to harness these building blocks to achieve specific targets related to the care experiences and health outcomes for their year 1 priority populations; and
- 3) organize cross-board processes (and cross-organization processes more generally) that build trusted relationships among partners, which include using joint board retreats and other approaches to come to a shared understanding of what their organizations are trying to achieve together.

In taking these steps, boards and their chief executives and support staff need to recognize that patients are to be involved in the collaborative governance model, that physicians and other clinical leaders are to be involved in the model and/or in the OHT's leadership, and that chief executives are to be held accountable for achieving integration.

## Possible 'end states' for collaborative governance

An OHT's collaborative governance model is likely to evolve over time as trust increases, if new members are added or if collective accountability requirements increase. The ministry's OHT guidance document articulates that it must enable:

- 1) a central brand for the OHT;
- 2) a strategic plan for the OHT;
- 3) coverage of the full continuum of care; and
- 4) a single clinical and fiscal accountability framework (with the latter including strong financial management and controllership).

Many collaborative governance models could meet these requirements. Models 1-3 below reflect increasing interdependence and likely greater ease in achieving a single clinical and fiscal accountability framework:

- 1) collaboration arrangement (i.e., collaboration agreements and joint-venture agreements), which:
  - a) involves a joint decision-making body to oversee joint services,
  - b) involves funds flowing through one organization and then being transferred to other organizations, and
  - c) could involve common directors across boards and/or common senior leaders across organizations;
- 2) organizational alliance, which:
  - a) involves an alliance board that could take the form of a joint executive committee (drawn from the executive committees of each board, each of which has the delegated authority to bind their respective boards, but typically with each board retaining some reserve powers), mirror-image boards or boards meeting as 'one board,'
  - b) involves shared decision-making, including a shared strategic plan (for in-scope services) and shared management of (common) resources,
  - c) involves funds flowing through one organization and then being transferred to other organizations,

- d) typically involves common management (i.e., one management team), and
- e) could involve a common employer;
- 3) one corporation (i.e., amalgamation of organizations with assets transferred to an existing or new organization), which involves one board, one funding recipient, one management team and one employer, although separate sites or programs could use sub-brands (e.g., a primary-care office or hospital site); and
- 4) combinations of models 1-3, which could include a governance corporation with an accountable board overseeing other organizations, some of which:
  - a) have a joint executive committee or joint board,
  - b) are wholly owned subsidiaries, and
  - c) are aligned and funded through a contract like a collaboration agreement (e.g., with a local municipal government that provides housing and broader human services, or with a corporation that provides services across a broader region, the province or the country).

While more detail can be provided about any of these models, the intent here is to highlight only essential points.

Just as with the steps in year 1, all ‘end state’ models of collaborative governance must meaningfully involve a diversity of:

- 1) patients, families and caregivers;
- 2) physicians and other clinical leaders, one part of which is the focus of RISE brief 4 about primary-care provider leadership and engagement; and
- 3) community groups (including community-based agencies), many of which may be sensitive to power imbalances and have concerns about past behaviours, and which is the focus of RISE brief 5 about community engagement.

For organizations working towards an integrated local system, part 2 of the now decade-old toolkit developed by Quigley and colleagues (see ‘Key resources’ below) remains highly relevant (even if part 1, which is focused on the role of LHINs, is not). The Association of Family Health Teams has developed a list of [10 questions that the boards of Family Health Teams should be asking](#) as they approach their role in OHTs. Several membership-based organizations in the province, such as the Ontario Hospital Association and the Ontario Medical Association, are also expanding their support of governance best practices to address OHT-related governance topics. Such resources are likely to go beyond the legal aspects of collaborative governance addressed here, and address topics like the social or relational aspects of collaborative governance, including the importance of skillful facilitation of group processes.

## Key resources

Corbett A, Pessione H, Wakulowsky L. [Governance options: Getting started and evolving towards maturity – Guidance for Ontario health care providers and organizations](#). Toronto, Canada: Borden Ladner Gervais; April 2019.

Corbett A, Wakulowsky L. [Ontario Health Teams: Structuring options](#). Presentation to St. Joseph’s Health Systems Hamilton and partners, Hamilton, ON, Canada, 12 July 2019.

Quigley M, Scott G, Wakulowsky L. [Local Health Integration Network / Health Service Provider Governance resource and toolkit for voluntary integration initiatives](#). Toronto, Canada: Central Local Health Integration Network; 2008.

Lavis JN. RISE brief 3: Collaborative governance. Hamilton, Canada: McMaster Health Forum; 2019.

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