



## **Guidance for Ontario Health Teams:**

# **Collaborative Decision-Making Arrangements for a Connected Health Care System**

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**Ontario** 

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## What You Need to Know

- All approved OHTs must establish and document a collaborative decision-making arrangement between members.
  - To be eligible for any future OHT implementation funding opportunities, OHTs will be required to demonstrate they have established a collaborative decision-making arrangement between members addressing, at minimum, the OHT's use of any implementation funding.
  - A checklist is provided at the end of this document, and more information about potential funding opportunities will be provided separately.
  - OHTs' collaborative decision-making arrangements are expected to evolve over time as OHTs mature.
- OHT collaborative decision-making arrangements are to be **self-determined** by members and **fit for purpose**.
- OHT collaborative decision-making arrangements must:
  - be informed in their development by engagements with:
    - local communities
    - patients, families, and caregivers
    - physicians and other clinicians
  - provide for direct participation in decision-making by:
    - patients, families, and caregivers
    - physicians and other clinicians
  - address:
    - resource allocation (including of any implementation funding)
    - information sharing
    - financial management
    - inter-team performance discussion
    - dispute resolution
    - conflicts of interest
    - transparency
    - identifying and measuring impacts on priority populations
    - quality monitoring and improvement
    - expansion to more patients, services, and providers
- Resources to support OHTs in establishing their collaborative decision-making arrangement are available through RISE and include templates, examples, presentations, journal articles, case studies and other published reports, and opportunities to engage directly with experts and peers.

### **A note on COVID-19 and Collaborative Decision-Making Arrangements**

The establishment of a collaborative decision-making arrangement is not only foundational to advancing an OHT's maturation — it can also support shorter-term work as providers prepare for a future wave of COVID-19 and the emergence of seasonal influenza.

Key COVID-19/influenza preparedness and response activities that have been supported by collaborative arrangements during the COVID-19 response include:

- Identifying and supporting vulnerable populations, e.g. in congregate care or living settings
- contributing and deploying staff and other resources where needed
- acquiring and distributing clinical supplies and equipment
- coordinating responses to local capacity pressures
- integrating home care closer to the point of care
- implementing new care pathways and care patterns

## **1. Introduction**

Collaborative decision-making arrangements are arrangements that enable leaders from multiple organizations to successfully engage in deliberative, consensus-oriented, collective decision-making to achieve shared goals, accountabilities, and opportunities for improving patient care.

Establishing effective OHT collaborative decision-making arrangements is foundational to advancing integrated care the levers of integrated funding, integrated accountability structures, and integrated performance management and quality improvement measures. In addition, they have short-term utility as the health system prepares for a future wave of COVID-19 and the simultaneous emergence of seasonal influenza.

OHTs will need to establish collaborative decision-making arrangements as a priority in order to deliver on Year 1 expectations, advance pandemic planning and response and lay the foundation for maturation toward a single framework for fiscal and clinical accountability in future years.

It is expected that collaborative decision-making arrangements will evolve as OHTs develop, expand, and mature to the point of readiness for this shift.

### **1.1. Purpose**

The purpose of this guidance document is to set out expectations and guidance to help providers establish collaborative decision-making arrangements as a team.

This document collects together, affirms, and builds on the information and direction set out in *Ontario Health Teams: Guidance for Health Care Providers and Organizations 2019* ('2019 Guidance') on the essential elements of collaborative decision-making arrangements between OHT members.

This document is also meant to inform and inspire the creative and aspirational organization-to-organization, board-to-board, and leader-to-leader conversations and relationship-building that has been, and will continue to be, foundational to OHT success.

## **1.2. Terminology**

Communications to date from the Ministry of Health (MOH) and other organizations have used the term "governance" when referring to the mechanisms by which a group of providers in an OHT will make decisions about, and oversee, OHT activities.

This document uses the term "collaborative decision-making arrangements" rather than the term "governance" to reflect that OHTs are still in early stages of implementation, including that:

- at this time, patient services continue to be funded and governed by agreements between the funder and each member within an OHT, and not (yet) through an integrated agreement between the funder and the OHT as a whole; and
- OHT members need time to work out the scope of decision-making they assign to the OHT (vs. the scope of decision-making authority retained by individual members).

The use of this term also recognizes that community context differs from region to region, including that providers (including provider organizations and solo practitioners) in different OHTs will take different (and evolving) approaches to defining their roles, responsibilities, and relationships within their OHT.

The intention in using this terminology is to focus on defining the mechanisms through which a foundation for collaborative decision-making can be built to support and enable progress towards a more mature state, including the delivery of integrated patient care services across the OHT.

## **1.3. Disclaimer**

The adoption of a particular collaborative decision-making arrangement can have legal, labour relations, governance, and other implications. This guidance document does not constitute legal or other expert advice. OHT members remain responsible for obtaining expert advice, including legal advice, in determining the most appropriate collaborative decision-making arrangement for their OHT, and in taking the most effective steps for implementation.

## 1.4. Additional Resources

Resources for OHTs on establishing collaborative decision-making arrangements, including templates and examples of documentation of collaborative decision-making arrangements shared by OHTs, guidance and information from experts, are available on the [RISE website](#).

## 2. Key Principles and Elements

As set out in the 2019 Guidance, two principles guide MOH expectations for OHTs' collaborative decision-making arrangements: those arrangements are to be *self-determined*, and they are to *fit for purpose*.

Direction on the application of these two key principles is detailed below. In addition, a summary checklist of minimum expectations for OHT collaborative decision-making arrangements in Year 1 is set out at the end of this document.

### 2.1. Collaborative decision-making arrangements are to be self-determined

As described later in the document, and based on feedback from OHTs, the MOH is identifying minimum expectations ('the what') that applies to all OHTs, with allowance for each OHT to determine the appropriate arrangement based on local circumstance and context ('the how').

#### 2.1.1. OHTs must engage with local communities and providers

The development and establishment of collaborative decision-making arrangements should be informed by OHT members' experiences and engagements with:

- local communities;
- patients, families, and caregivers; and
- physicians and other clinicians.

OHTs should seek to ensure that:

- the design and implementation of collaborative decision-making arrangements appropriately reflect local interests and concerns and are seen as representative, legitimate, and equitable
- appropriate input is obtained by the OHT in the exercise of its collaborative decision-making arrangement, once established
- the OHT operates in a manner consistent with the [Patient Declaration of Values for Ontario](#).

The MOH encourages OHTs to be as broad and inclusive as possible in their engagements.

OHTs should particularly ensure appropriate engagement with French language communities, and ensure adherence to the *French Language Services Act*, as applicable.

OHTs must engage with Indigenous peoples and communities they would serve or partner with.

OHTs are encouraged to leverage available opportunities for engagement with patients, families and caregivers (e.g. member hospitals' patient and family advisory councils; member long-term care home resident councils, etc.) and with physicians and other clinicians (e.g. interprofessional primary care organizations; physician associations, etc.).

OHT are also encouraged to seek out additional opportunities to engage with patients, families, and caregivers, and with physicians and other clinicians, who are *not* currently members of a local representative organization.

### 2.1.2. OHTs determine own legal structures and inter-member relationships

In alignment with the approach of enabling local innovation in each OHT, the MOH is not prescribing or otherwise restricting OHT members to a specific structure or model for their collaborative decision-making arrangements.

Specifically, the MOH *is not requiring* that OHT members:

- establish a new not-for-profit corporation, legal partnership, or other legal entity to constitute the OHT; or
- adopt a particular type of agreement between members, e.g. a joint venture, collaboration, alliance, network, or other type of agreement between organizations that otherwise continue to operate in their own right.

The MOH and its partners (including RISE) will facilitate the sharing of leading examples of agreements as they emerge.

As noted in the 2019 Guidance, establishing collaborative decision-making arrangements between OHT members will take time. These arrangements may evolve as OHTs mature and expand.

All OHTs, but especially OHTs with many members or potential members, will need to develop collaborative decision-making arrangements that appropriately balance agility with representativeness.

One option is to establish different roles and levels or tiers of participation in decision-making for different members, depending on factors including the OHT's priorities, member's capacities, etc.

For example, while some OHTs may wish to adopt a 'single-tier' model (e.g. with all members represented on a 'steering committee', 'collaboration council', 'leadership council', or other central decision-making body), other OHTs may wish to adopt a 'two-

tiered' model (e.g. with a 'strategic/oversight' tier and an 'executive leadership/Implementation' tier).

A further option is a sector or network-based model, e.g., if multiple organizations within the same sector are members of an OHT, those organizations could select a representative to participate most directly in certain OHT decision-making on their behalf.

Additional options, considerations, and examples of different arrangements are available on the RISE website.

In all cases, OHTs are encouraged to include all interested organizations in OHT decision-making in some form, whether as members of a 'core table', as members of an 'advisory body' to the OHT, or some other arrangement.

### **2.1.3. OHTs determine their own membership and entry criteria**

Joining an OHT is voluntary, and OHTs determine their criteria and process for adding members.

OHTs are encouraged to be *inclusive* in their criteria and processes for adding members, in accordance with the OHT's local circumstances and plans for evolving to maturity and in recognition of the range of capacities and resources of different organizations.

For example, OHTs may choose to require incoming organizations to contribute or commit defined resources to the OHT as a condition of new and/or continuing membership – but if they do, they are encouraged to allow organizations to meet that requirement using in-kind or other resources alongside, or rather than, cash contributions. Additionally, OHTs that require defined resource commitments or contributions are encouraged to consider establishing 'sliding scales' or other mechanisms for including organizations with different capacities, resources, and flexibility.

### **2.1.4. OHTs determine how to make decisions on key topics**

OHT members will determine for themselves *how* OHTs will be organized to make decisions, including:

- the 'tables', committees, working groups, etc. doing work to support and inform OHT decision-making;
- how member organizations will be represented within the OHT's collaborative decision-making arrangement (e.g. number of representatives per member and in total, representative's required skills or backgrounds, etc.);
- how to balance decision-making power (e.g. votes) across members with different capacities and funding



- whether (or which types of) OHT decisions must be made by consensus, a simple majority, or other criteria; and
- other structural matters.

#### **2.1.5. Patients, families, and caregivers, and physicians and other clinicians must be included**

OHTs must include patients, families, and caregivers, and physicians and other clinicians in their collaborative decision-making arrangements.

The MOH encourages OHTs to seek to include a *range* of clinicians in their leadership structures and/or collaborative decision-making arrangements, including physicians (primary care physicians and family physicians and other specialists, hospital-based and community-based, etc.), nurse practitioners and other nurses, midwives, rehabilitative care professionals, and others.

#### **2.1.6. OHTs determine decision-making roles of patients, clinicians, etc.**

The MOH is not prescribing *how* patients, families, and caregivers, and physicians and other clinicians, will participate in OHT decision-making, e.g. their roles, authority, or scope of influence in decision-making. Different OHTs, in different local circumstances, may develop different approaches, depending on factors including the OHT's priority populations and the types of organizations within the OHT.

#### **2.1.7. Collaborative decision-making arrangements must address certain matters**

Collaborative decision-making arrangements must, at minimum, address the following:

- resource allocation (including of any implementation funding)
- information sharing
- financial management
- inter-team performance discussions
- dispute resolution
- conflicts of interest (including through requirements and processes for disclosure and management of real or perceived conflicts of interest where OHT spending decisions, e.g. for procurements, that may materially benefit a member)
- transparency
- identifying and measuring impacts on priority populations
- quality monitoring and improvement
- expansion to more patients, services, and providers

These topics have been identified by experts as key to ensuring OHTs can address key collaborative decisions during OHT implementation.

OHTs may choose to address additional matters in written agreements or frameworks based on their local needs.

#### **2.1.8. OHTs must identify a recipient of implementation funding**

OHTs must identify a qualified member who:

- may receive, on behalf of the OHT, any one-time implementation or project support funding;
- will manage that funding in accordance with the OHT's written agreement or framework for collaborative decision-making on the use of such funding;
- has a strong record of financial management
- meets requirements for government funding under the [Transfer Payment and Accountability Directive](#) (TPAD), e.g. dedicated bank account, etc.

It is important to note that the identification of this member, and the establishment of a written agreement or framework governing its use of implementation funds received on behalf of the other OHT members, are only for the purpose of managing initial OHT implementation funding, if available.

Funding currently received by OHT members for service delivery (e.g. through Service Accountability Agreements, Funding Agreements with the MOH, OHIP, etc.) will continue to flow to individual members under their own direct funding arrangements with government, separately from any targeted OHT funding.

There is no immediate expectation that OHT collaborative decision-making arrangements include provisions for sharing or distribution the full range of government funding at this time.

#### **2.1.9. Collaborative decision-making arrangements must be documented and endorsed by members**

OHTs must document their collaborative decision-making arrangements in writing. OHTs may choose their own format, style, and content for this documentation, and examples and templates are (and will be) made available through RISE.

Collaborative decision-making documentation must be endorsed or approved by OHT members in accordance with the process members have agreed upon for this purpose.

### **2.2. Collaborative decision-making arrangements are to be fit for purpose**

In addition to being self-determined, OHT collaborative decision-making arrangements must be 'fit for purpose'. This means that OHT collaborative decision-making arrangements must enable the OHT to meet its goals and accountabilities at a local and system level – and it also means that OHT collaborative decision-making arrangements will almost certainly need to evolve over time.

### **2.2.1. OHTs are intended to create the health care system Ontarians expect**

As set out in the 2019 Guidance, Ontarians expect a health care system that:

- is designed to ensure patients experience seamless transitions across different care providers and settings;
- promotes the active involvement and participation of primary care providers throughout a person's care journey;
- takes care of a person's complete physical and mental health needs, and not just one condition at a time;
- encourages and enables healthy behaviours and activities, and self-care that promote physical and mental health and well-being;
- is interconnected, so that patients don't have to repeat their health history over and over again or take the same test multiple times for different providers;
- is easy to access and provides navigation when patients, families, and caregivers have questions or need assistance;
- provides the appropriate level of care in the appropriate setting, at the right time;
- achieves better value by delivering better quality for the same or lower cost; and
- is built on collaboration, partnership, trust, communication, and mutual respect between patients, families, caregivers, providers, and communities.

OHT collaborative decision-making arrangements should be organized to contribute to these goals, e.g. to ensure there are appropriate tables, resources, and decision-making attention brought to bear on goals relating to transitions, primary care engagement, caring for the complete patient, encouraging healthy behaviours, etc.

### **2.2.2. OHTs should be guided by the quadruple aim and a shared vision and goals**

OHT collaborative decision-making arrangements should support a strategic approach guided by the quadruple aim: better patient and population health outcomes; better patient, family, and caregiver experience; better provider experience; and better value. For example, collaborative decision-making arrangements should ensure appropriate mechanisms are in place for monitoring key performance indicators under the quadruple aim and taking steps to improve the OHT's performance. A standardized provincial performance framework for OHTs aligned to the quadruple aim is in development.

### **2.2.3. Collaborative decision-making arrangements should enable the OHT to complete the 'building blocks' for OHT development**

OHTs should ensure their collaborative decision-making arrangements enable the OHT to meet provincial requirements and expectations in Year 1 and at maturity in relation to each of the eight OHT building blocks, as set out by RISE:

- 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.

#### **2.2.4. Collaborative decision-making must be transparent**

To ensure that OHTs remain responsive to their communities, collaborative decision-making should be appropriately transparent to members and the community. This includes transparency about who is making decisions, the process by which decisions are made, and the decisions themselves.

## Checklist for OHT CDMAs

Each OHT's collaborative decision-making arrangement (CDMA) must:

- Be formalized in writing
- Be informed in its development by engagements with:
  - local communities;
  - patients, families, and caregivers; and
  - physicians and other clinicians
- Include a shared commitment to:
  - achieving the quadruple aim
  - a vision and goals for the OHT
  - working together to fulfill MOH expectations for year 1 and beyond
- Provide for direct participation in OHT decision-making by:
  - patients, families, and caregivers
  - physicians and other clinicians
- Address:
  - resource allocations (including of any implementation funds)
  - information sharing
  - financial management
  - inter-team performance discussions
  - dispute resolution
  - conflicts of interest
  - transparency
  - identifying and measuring impacts on priority populations
  - quality monitoring and improvement
  - expansion to more patients, services, and providers
- Identify a qualified entity who members agree will receive and manage any one-time implementation funds on behalf of the OHT