



Ontario Health Teams **UPDATE** | April 2019

Governance Options: **Getting Started and Evolving Towards Maturity**

Guidance for Ontario Health Care
Providers and Organizations

This is the first in a series of BLG publications to assist Ontario health care providers and organizations to understand and develop governance options as they work toward Ontario Health Team implementation.

More detail and insight on the OHT governance structures and options outlined in this publication will be provided in upcoming BLG publications, seminars and other communications: stay tuned!



Ontario Health Team Governance Options: **Getting Started**

Guidance for Ontario Health Care
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The newly enacted *Connecting Care Act, 2019 (CCA)* enables the designation by the Minister of Health and Long-Term Care (**Minister**) of integrated care delivery systems called Ontario Health Teams (**OHTs**).

While the Ministry has provided guidance on minimum governance requirements for OHTs, it makes clear that **governance arrangements for OHTs will be “self-determined and fit for purpose”**.

There are many options for OHT governance and each has pros and cons depending on the circumstances. There is no one-size-fits all answer. The right fit will depend on many different factors.

OHTs may start with one model and evolve to greater governance integration as trust increases and as new members are added.

What is an Ontario Health Team?

An OHT is a person or group of persons or entities designated by the Minister. To be designated, the person, entity or group must meet any prescribed conditions or requirements set out in regulations (to be established) and have the ability to deliver, in an integrated and co-ordinated manner, **at least three** of the following services:

- Hospital services
- Primary care services
- Mental health or addictions services
- Home care or community care services
- Long-term care home services
- Palliative care services
- Other prescribed services

Becoming an OHT

The Ministry Guidance also outlines a **process and timeline** for the Ministry's open invitation to providers to become OHTs, including:

- Required components of the OHT model
- Expectations for OHTs at maturity
- Readiness criteria and year one expectations
- Assessment process that recognizes a continuum of readiness which includes "Ready" (OHT Candidates), and "In Discovery" and "In Development" states

The assessment process is expected to continue in phases until full provincial coverage of OHTs is achieved. The timeline for the first round of assessments, as well as other information, resources, and updates is available at: <http://health.gov.on.ca/en/pro/programs/connectedcare/oht/>

Preference will be given to submissions that include a minimum of **hospital, home care, community care and primary care** (inter-professional primary care models and physicians). Physician participation is voluntary, but the Ministry's vision is for physicians to play leadership roles and function as core members of OHTs. The current vision is for OHTs to be built on existing physician remuneration models.

OHT Governance

The CCA does not prescribe any governance model for OHTs. The Ministry Guidance makes it clear that there is no specified model, OHTs "are free to determine the governance model that works for them," and that governance arrangements are to be "self determined and fit for purpose". However, the Ministry Guidance does specify some minimum governance requirements for OHTs, from readiness through maturity:

- Governance structures will include patients
- Physician and clinical leaders are to be included as part of the leadership and/or governance structure
- Governance model must be conducive to coordinated care delivery, support achievement of performance targets, and enable achievement of accountability objectives
- Must demonstrate strong financial management and controllership to oversee integrated funding envelope
- Must reflect a central brand
- If OHT consists of multiple providers there must be formal agreement(s) and reporting obligations

The following matters are also identified in the Ministry Guidance:

- There will be an agreement with the Ministry and the OHT outlining service delivery and performance obligations
- Existing funding and service agreements with the Ministry will remain in place initially (and possibly beyond), but funding obligations may be reviewed to determine what should continue and what may be revisited, with a view to reducing reporting obligations
- Physician and clinical engagement plan is required to be implemented
- There is to be a strategic plan or strategic direction for the OHT consistent with the central vision and target outcomes for the OHT

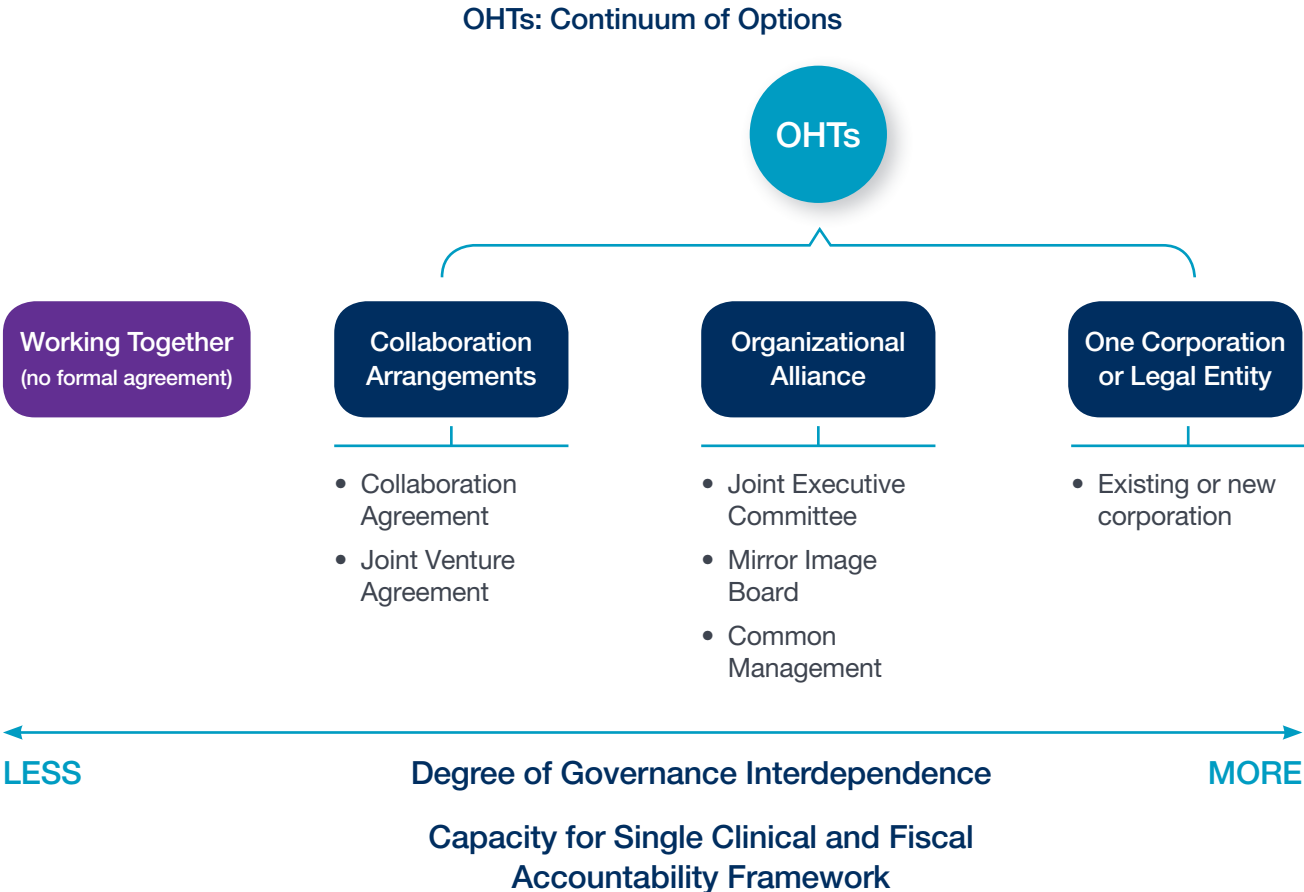
A summary checklist of the required elements for OHT governance is attached.

Continuum of Governance Options

Governance options for OHTs to fulfil the Ministry’s requirements fit along a continuum, as illustrated below. An OHT can be a single entity or comprised of multiple entities, as long as it provides three or more of the specified services.

While an informal arrangement among two or more providers (e.g., undocumented or documented with a non-binding Memorandum of Understanding) may otherwise allow for service integration/coordination, it will not likely meet the Ministry’s required structure to be treated as an OHT.

The Ministry Guidance is clear that a written agreement will be required if two or more entities are involved in forming an OHT; however, there is a spectrum of different arrangements, from less interdependent to more interdependent, which will fulfill this requirement. Each will have pros and cons and may be more or less suitable depending on the circumstances.





Options for Structuring Ontario Health Teams

The governance structure of OHTs will evolve over time and the structure at maturity may be very different than the initial structure. At a macro level, there are two approaches to structuring OHTs in the initial phase:

- 1** Maintaining the separate legal existence of two or more existing entities
- 2** One single accountable legal entity, either newly created, existing or as a result of an integration of two or more entities

As noted, an informal collaboration between entities, which we refer to as “Working Together,” will likely not meet the Ministry’s OHT criteria, but may be an important first step in the process for forming an OHT.

There are a number of different ways of approaching the initial governance structure of an OHT, with the possibility of some providers within an OHT becoming more formally linked than others. It is likely that governance structures will evolve from less interdependence to more over time.

To the extent possible, OHT candidates should prioritize initial arrangements which allow for a process to evolve to greater interdependence over time. While the government will retain power to integrate health service providers, organizations and individuals will be best positioned if they are proactive in establishing a plan independently which meets the governments objectives.

The ability to work towards a single clinical and fiscal accountability framework (i.e., to deliver the full continuum of integrated and co-ordinated care with a single funding agreement) will be optimized by a governance model with:

- A high degree of governance interdependence
- The capacity for one strategic plan
- Mechanisms to ensure accountability and performance compliance from entities that may need to remain independent
- The ability to add others and work in alignment with important players that may not be able to integrate (such as local government)

This is an end state: how quickly and successfully health providers will get there will be influenced by the trust among the parties and the degree to which initial governance models enable the ability to evolve and to add others.

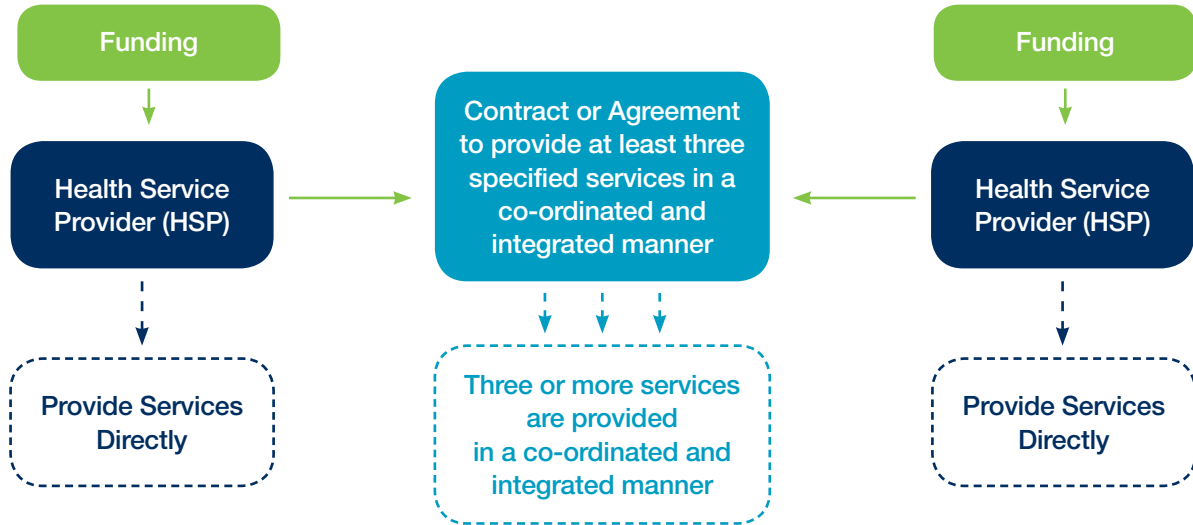
OPTION 1: Separate Legal Entities

On the less interdependent end of the OHT governance continuum are arrangements which allow two or more existing entities to maintain their separate legal existence and collaborate by way of agreement.

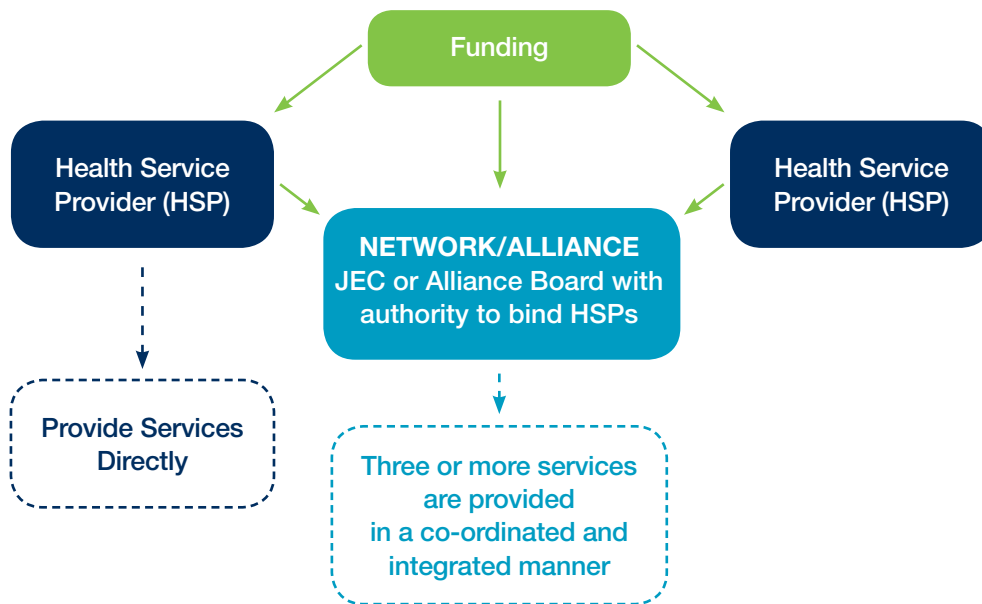
- **Collaboration and joint venture agreements** are a way for two or more entities to agree to integrate and co-manage delivery of certain services while otherwise maintaining separate legal entities and decision-making authority.
- **Networks/Alliances**, on the other hand, involve an agreement between two or more entities to delegate certain powers to a common decision-making body.

	Collaborations and Joint Venture Agreements	Organizational Network/Alliance
Attributes	<ul style="list-style-type: none"> • No new entity created: maintains separate legal existence (two or more corporations) • Agreement to co-manage with a view to integration of delivery of specific services (e.g., front line and potentially back office) • Some “joint committee” or governance structure required to oversee joint services: could involve overlapping directors or common senior leadership team or “project” governance • Separate employers • Typically initial stages would involve limited integration of services, staff, facilities or equipment • Parties’ expectation would be that arrangement is ongoing but with termination provisions 	<ul style="list-style-type: none"> • No new entity created: maintains separate legal existence (two or more corporations) • Broader agreement to share and/or collaborate • Agreement to formal governance arrangement: common (mirror image) board or boards meet as “one board” or joint executive committee with delegated power • May create common employer and allows for more significant operational integration • May evolve to one management team • Provide decision-making authority to shared governance entity to manage shared resources and strategic planning for a scope of services • Typically escape clauses or process to unwind
Implications	<ul style="list-style-type: none"> • Patients/clients and funding still separate although funds could flow through one entity to meet requirements of OHT • Harder to create a central brand but not impossible: brand would be specific to services delivered and not entities • Strategic planning, funding and branding would relate only to the shared services with parties still providing other services directly • Capacity for other providers to join with relative ease 	<ul style="list-style-type: none"> • More easily enables one funding agreement • Enables common strategic planning and central brand for the Network/Alliance • Major issues require individual agreement (reserve powers) which can create instability • Scope for health care providers to provide health care services separately but intent for Network/Alliance to “own” and operate services within an agreed scope • Relatively easy to move additional services from current health care provider participants to the Network/Alliance; therefore, easy to expand mandate • More difficult to add other providers, particularly if there is common management: governance model may require restructuring to allow new providers to participate in decision making

Sample Structure: Collaboration or Joint Venture Agreement



Sample Structure: Network/Alliance



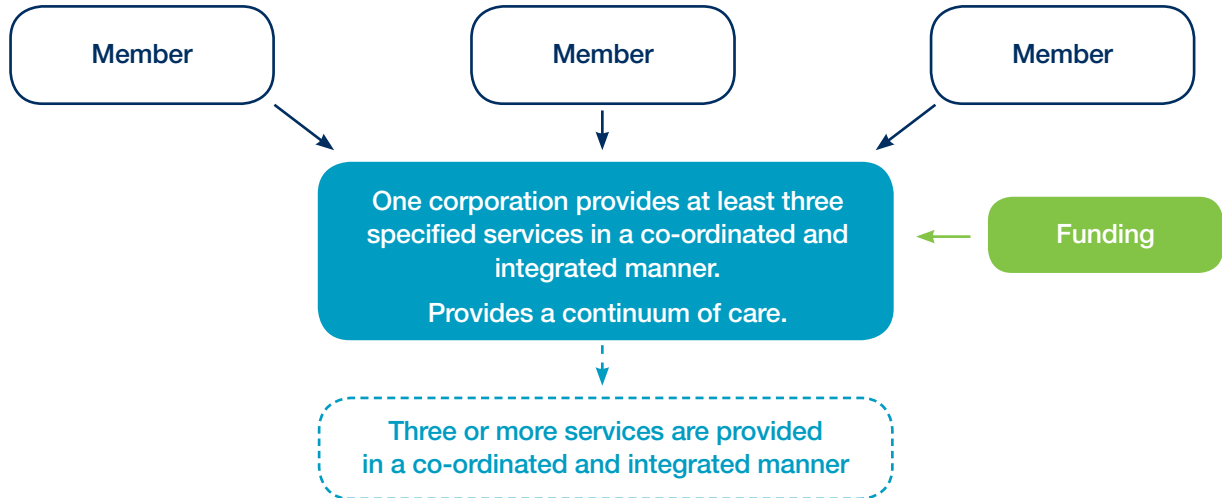
OPTION 2: Single Legal Entity Controls OHT

On the more interdependent end of the OHT governance continuum are arrangements which create or maintain a single legal entity. While these options can be more significant from a transformational perspective, and may be most realistic as end state or “at maturity” models, they can lead to greater service integration and operating efficiencies, and greater centralization of funding, branding, missions and strategic planning.

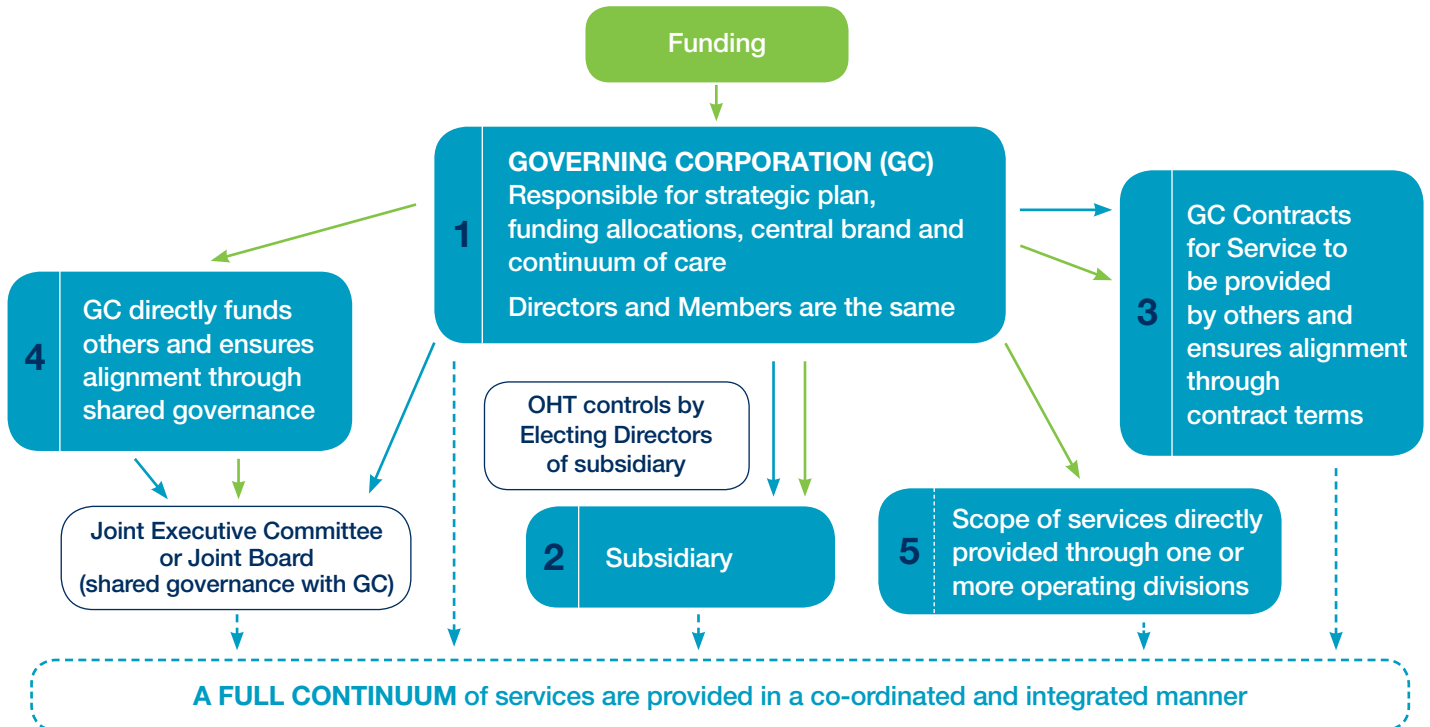
- **Single legal entity OHT** can be achieved by forming an OHT from an existing single corporate entity, or by forming an OHT by way of an amalgamation or asset transfer. Regardless of the methodology, this is perhaps the most straightforward OHT governance model once up and running; however, amalgamations and asset transfers can be complex and time consuming and involve a significant degree of organizational change management.
- **OHT comprised of multiple corporations controlled by a single governing corporation**, on the other hand, can manifest in a number of ways, but all involve one accountable board overseeing other providers. These models allow for the involvement of entities, such as local government, that have important overlapping mandates with the OHT, such as public health and housing, but that would not be fully integrated from a governance perspective given their other mandates. While these models tend to be more complex from a governance perspective, but are more likely to represent the “at maturity” state of an OHT providing a full continuum of care in a defined population with a clear clinical and fiscal accountability framework through the governing corporation.

	Single Legal Entity OHT	Multiple Legal Entities Controlled by Governing Corporation
Attributes	<p>Can be achieved via:</p> <ul style="list-style-type: none"> • Single corporate entity (new or existing) acquiring operations of others • Amalgamation of existing entities <p>Result is single:</p> <ul style="list-style-type: none"> • Legal entity • Strategic plan • Board • Employer • Professional or clinical staff • Funding agreement • Patient/client record • Brand (sub brands for sites or specific programs are possible) 	<ul style="list-style-type: none"> • Entity with a single Board that may directly provide services and/or may fund others to provide services • Assets and liabilities of some current operating entities are combined in a single legal entity (Governing Corporation) through amalgamation or asset transfer • Governing Corporation may have governance and/or funding control over other entities (e.g., divisions or separate corporations) • If an existing entity is used and services/assets of other HSPs transferred to that entity, governance structure may be reflective of that contribution (i.e., restructured board) • Model could involve member agreements and service level agreements if services are provided to or by members
Implications	<ul style="list-style-type: none"> • Accountability is in Board • Stable without ability to unwind • One corporation owns all assets and is responsible for all liabilities • Scope to offer a full continuum of integrated and coordinated services may be limited as not all providers may be able to fully integrate in a single corporation (i.e., primary care and local government) 	<ul style="list-style-type: none"> • If a true continuum of care is to be established, the “at maturity” state, OHTs may need to include more than one entity; there may be organizations that provide services which do not overlap fully with the Ministry’s mandate, or entities which retain a provincial mandate, or entities which for other reasons will need to remain separately controlled. All such entities could be part of the OHT although not fully integrated from a governance perspective. Clinical and fiscal accountability could be achieved through a number of means: <ul style="list-style-type: none"> • OHT may include a “subsidiary” controlled by the Governing Corporation through the right to elect the directors of the “subsidiary” • Other options to achieve stability and common vision with independent entities that are members of the OHT might include: <ul style="list-style-type: none"> – Joint Executive Committee (delegated authority) – Mirror Image Boards or Overlapping Boards – Service contracts and funding agreements

Sample Structure:
Single Legal Entity OHT



Sample Structure:
Governing Corporation:
Accountable for Clinical and Fiscal Framework and Ensuring Full Continuum of Integrated and Co-ordinated Care



1. Merged or newly created entity: directly provides services and/or contracts for services delivered by others, responsible to Ontario Health for delivery of the full continuum of coordinated and integrated services
2. GC Subsidiary: GC has governance and funding control
3. Service provider contractually bound to GC
4. Joint Executive Committee or other shared governance with GC oversees services and ensures alignment for areas of shared services
5. GC is also a direct provider of services: service delivery could be structured through various operating divisions, e.g., hospital division, long-term care division and home and community care

OHT Models: High Level Comparison

	Working Together	Collaborations and Joint Venture Agreements	Network/Alliance	One Governing Corporation
Meets OHT criteria	<ul style="list-style-type: none"> Likely not (but may be an important first step) 	<ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> Yes
Ease to Establish	<ul style="list-style-type: none"> Easy to understand, establish 	<ul style="list-style-type: none"> Simple and clear for specific services Challenge of dual reporting 	<ul style="list-style-type: none"> More complex for Boards Harder to achieve: <ul style="list-style-type: none"> One employer/staff, One set of financial and business records One funding agreement and common brand One patient record 	<ul style="list-style-type: none"> Implementation is more complex particularly if structure involves other entities within the OHT
Single Funding Agreement	<ul style="list-style-type: none"> No 	<ul style="list-style-type: none"> Low 	<ul style="list-style-type: none"> Moderate – High 	<ul style="list-style-type: none"> Yes
Scope for Integration	<ul style="list-style-type: none"> Limited Best model for limited and specific project 	<ul style="list-style-type: none"> Moderate Common strategic planning, funding and branding are more limited in scope but can be done on a program or service specific basis Shared governance contractual relationship with options to end or renegotiate Creates opportunity for other service-governance integration 	<ul style="list-style-type: none"> Moderate to high Single point of accountability and direction setting Facilitates common planning and integration of many services and resources, and development of common processes Can enable further integration and additional providers Potential for common brand 	<ul style="list-style-type: none"> Highest Single point of accountability and direction setting Accountability is clearer for Board, management and staff Integration as one employer and operational entity is possible Other entities may join and maintain separate existence but be part of OHT and subject to governance/contractual/funding/control by governing corporation Single funding agreement and common brand are enabled
Stability	<ul style="list-style-type: none"> Lacks stability; no formal agreement 	<ul style="list-style-type: none"> Lacks stability; ability to unwind 	<ul style="list-style-type: none"> May lack stability; alliance can be unwound (escape clause); but the longer the alliance endures, the more difficult it is to unwind 	<ul style="list-style-type: none"> Most stable; no ability to unwind single corporation To the extent there are other entities within the OHT, stability will depend on funding and governance control relationship

Checklist: Elements Required for OHT Governance

Based On Current Ministry Guidance

- Must include at least three services and **preference given to hospital, home care, community care and primary care**
- Written/formal agreement among the providers** if more than one provider is involved
- Governance agreement must include:
 - Decision making**
 - Conflict resolution**
 - Performance management**
 - Information sharing and resource allocation**
- Patients must be involved** in the governance model (no guidance on how or what role)
- Physicians and clinical leaders to be involved** as part of the OHTs leadership or governance structure
- Model must enable:
 - Central brand**
 - Strategic plan/strategic direction for the OHT**
 - Physician and clinical engagement**
 - Strong financial management and controllership**
 - Ability to work towards a single clinical and fiscal accountability framework**
 - A plan/process to phase in the full continuum of care** and meet population need at maturity (including to add primary care if not part of initial offering of services): ability to add other providers



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