Research Centre

Getting to integrated, team-based home and community care

Fragmentation across Ontario's health system has contributed to poor client and provider experiences, health outcomes, and higher costs. This is particularly true for older adults with complex health and social needs. We are exploring how organizations in Ontario are taking a collaborative, integrated approach to home and community care for older adults. We first identified lessons learned from a previous neighbourhood-based initiative, and now aim to see how these lessons can be applied in the context of Ontario Health Teams.

As Ontario Health Teams move towards improved integration and coordination to support aging at home, there are opportunities for learning across current and past integrated care initiatives in the province. In the first part of our research, we analyzed experiences of a care team in a resource-poor urban neighbourhood and found that home and community care organizations were able to collaborate when they had a shared vision for their collaboration, as well as processes for sharing information and resources. Integration was further supported by engagement of community members, clients, and point-of-care staff; strategies to overcome policy barriers and competitive relationships among organizations; and a clear role within the broader health system, along with openness to bottom-up innovation.

Project Overview

Ontario's vision to deliver coordinated care across providers and organizations was prompted by criticisms of a siloed system that contributed to poor patient experiences and outcomes. Ontario Health Teams (OHTs) have been created to deliver care that brings together coordinated teams of health and social care providers and organizations to improve patient outcomes. OHTs can learn from previous initiatives and from each other, to avoid duplication and achieve transformative change in the system.

Before the pandemic, an integrated care team was developed and implemented in a resource-poor urban neighborhood. This team aimed to move towards a more collaborative, integrated approach to home and community care for older adults with complex needs. The team leading this program worked to emphasize client and caregiver choice and shared decision-making, while creating strong linkages within and across care sectors. This team's work offers learnings that may benefit OHTs as they move forward.

What did we do?

The neighbourhood care team ceased operations in

2020, due in part to the effects of provincial policy shifts as well as the challenges posed by the pandemic. However, lessons can still be learned from its work. We analyzed detailed minutes from 25 meetings of the neighbourhood care team. These meetings included members from 10 provider organizations. We examined how the team's collaboration was affected by contextual factors, including the community and clients served, the participating organizations themselves, and the broader health system. The goal was to uncover learnings that could be shared with OHTs to inform sustainable cross-sectoral integration. We then tested our emerging analysis through interviews with five participants who were involved in the neighbourhood care team.

What did we find?

Our preliminary analysis found clinical- (micro), organizational- (meso), and system- (macro) level facilitators and barriers of integration within the neighbourhood care team. In the text that follows, facilitators and barriers are bolded; strategies that the neighbourhood care team used to apply facilitators or cope with barriers are italicized. These complex inter-relationships are also represented in a diagram on the following page.

At an organizational) level, facilitators of integration included:

- Norms (or values and beliefs) including a **shared vision and purpose** and **open discussion and conflict resolution**.
- Functions (or processes) including a **broad membership, learning and evaluation, sharing resources,** and **inter-organizational communication**.

These facilitators were also influenced by other parts of the health system, including micro-level factors like **community engagement, client-centred planning processes,** and **frontline staff engagement**. Several strategies linked these clinical-level factors to organizational integration:

- **Community engagement** and **client-centred planning** were used to strengthen the team's **shared vision and purpose**, as centering on client and community perspectives helped organizations—and individual staff—to *bridge worldviews*.
- **Client-centred planning** also supported **learning and evaluation**, as *aligning outcomes* with client goals helped to ensure the team was measuring what mattered.
- **Point-of-care staff engagement** contributed to **inter-organizational communication**, through *involving frontline managers* to act as a conduit between clinical and strategic processes.

System-level facilitators included **a clear role within the health system, receptive system leadership,** and **infrastructure and policy enabling communication and resource distribution across organizations**. While these factors were not always present throughout the work of the neighbourhood care team, various strategies were used or suggested to cope with the resulting barriers:

- **A clear role within the health system** and **receptive system leadership** underpin a **shared vision and purpose** at an organizational level, by creating space in which organizations can bring their shared vision to life. This requires system-level decisionmakers to collaborate with organizational leaders to *enable bottom-up innovation*.
- When **infrastructure and policy** created barriers to **resource sharing** and **inter-organizational communication**, organizations created *Terms of Reference* to ensure that those benefitting from collaboration are also accountable to contributing. *Privacy experts* were engaged to develop appropriate workarounds.

Across every level, a consistent set of principles were important. These were:

- **Time** to build relationships and develop strategies and structures;
- **Trust** and **Transparency** among the varying people, communities, and organizations involved; and
- **Tailoring** of strategies to local and current needs.

What could the impact be?

As OHTs work to develop local integrated care programs to support aging at home in Ontario, there is an opportunity to share and learn from previous integrated care initiatives and models. Learnings from the neighbourhood care team may be particularly important to OHTs as they navigate the complex context of the home and community care.

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