

Rapid Synthesis

Examining the Intersections between Ontario Health Teams and Public Health

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HEALTH FORUM

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Rapid Synthesis:
Examining the Intersections between Ontario Health Teams and Public Health
30-day response

McMaster Health Forum

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Timeline

Rapid syntheses can be requested in a three-, 10-, 30-, 60- or 90-business-day timeframe. This synthesis was prepared over a 30-business-day timeframe. An overview of what can be provided and what cannot be provided in each of the different timelines is provided on McMaster Health Forum's Rapid Response program webpage (www.mcmasterforum.org/find-evidence/rapid-response).

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Conflict of interest

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Merit review

The rapid synthesis was reviewed by a small number of policymakers, stakeholders and researchers in order to ensure its scientific rigour and system relevance.

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KEY MESSAGES

Question

- What does the evidence say about what can support the involvement of public health in population-health management initiatives?
- What can we learn from initiatives similar to Ontario Health Teams about how they intersect with public health?

Why the issue is important

- Ontario's health system is undergoing a transformation to enable population-health management at a local level through the creation of Ontario Health Teams (OHTs)
- To be approved as an OHT, this must include – at a minimum – home and community care, primary care, and hospital-based care
- However, many OHTs see the transformation as an opportunity to explicitly leverage the critical role that public health plays in determining population health

What we found

- We identified five reviews and five primary studies focused on the intersection of public health and population-health management initiatives
- Available literature largely described implementation considerations, with little focus on the effectiveness of establishing intersections on policy development or ways to address the misalignment between attributed population focus of OHT-like initiatives and the geographic focus on many public-health initiatives
- We identified considerations for financial and delivery arrangements, structural and process elements, and relational elements that support the intersection of public health and population-health management
- Financial and delivery arrangement considerations include:
 - cross-government funding to support multi-sectoral place-based initiatives
 - transformation grants and expanded coverage of preventive services
 - tax-exemptions conditional on completion of community needs assessment, implementation plans, and on-going monitoring and reporting requirements
 - contracting with non-governmental and community organizations to address access barriers
 - incentivizing collaborative work, particularly for providers compensated only for direct clinical care
- Structural and process considerations include:
 - creating well-defined roles that focus on achieving an optimal scope of practice while also being accountable for strengthening integration
 - shared information-technology systems and processes to support data-driven decision-making
- Relational considerations include:
 - commitment to shared vision and catalyzing collaboration through opportunity and innovation
 - building trust and interdependence in inter-institutional and inter-sectoral relationships
- We identified three initiatives similar to Ontario Health Teams – one each in Canada (Quebec), Australia, and the United Kingdom, – from which we identified the following insights:
 - scaling up collaborations over time and supported by a consistent mandate and stable funding
 - using mutually reinforcing mechanisms to support patient partnership and community engagement
 - facilitating shared understanding and data literacy for collaborative analysis of population data
 - building trusting, transparent, and responsive relationships between those funding and assessing performance and those implementing population-health management and population-based strategies
 - building confidence in collaborative commissioning as a mechanism to drive integration
- Ontario Health Teams can use these findings to build on population-health focused collaborations initiated in response to the pandemic as well as with initiatives already in place that often focus on populations with complex health- and social-care needs
- OHTs can leverage public-health expertise and engagement in the development of their 'population-health management and equity' plans (also known as the 'OHT plan') and other upcoming deliverables

QUESTIONS

- What does the evidence say about what can support the involvement of public health in population-health management initiatives?
- What can we learn from initiatives similar to Ontario Health Teams about how they intersect with public health?

WHY THE ISSUE IS IMPORTANT

Ontario's health system is undergoing a transformation to enable [population-health management](#) at a local level through the creation of Ontario Health Teams (OHTs). First announced in February 2019, OHTs are cross-sectoral networks of organizations (including healthcare, and in some cases public health and broader human services) that at maturity will be held clinically and fiscally accountable for the health and wellbeing of their attributed population. OHTs are expected to provide a complete continuum of care to their populations through their networks. To be approved as an OHT, partners must include, at a minimum, coordinated primary, home and community, and hospital-based care for defined populations.

Many OHTs see the transformation as an opportunity to explicitly leverage the critical role that public health plays in determining individual and, and when aggregated, the health of populations. As a result, some Ontario Health Teams have partnered with public-health agencies and organizations, including, though not limited to, their COVID-19 pandemic response. Some examples include:

- surveillance of population-health risks and needs by combining clinical and demographic data;
- coordinating community testing and immunization outreach, particularly among populations most at-risk of COVID-19 infection; and
- coordinating multi-sectoral decision-making tables to share resources for a more effective response to pandemic (and other) needs.

While the healthcare system often targets individual service users, public health aims to protect and improve population health. Though public health often operates independently from health-service delivery organizations in Ontario, it is being increasingly involved in helping to improve access to care for the acute needs of populations with complex health and social issues, including through community-health centres and community access hubs.(1) This contributes to what is often referred to as the 'first curve' of population-health management, focused on addressing the acute needs of individual patients able to access care.(3)

Public health also has the potential to play an important role in strengthening a population-health focus while health services, and most notably primary care, can also support and strengthen some public-health functions.(2) Intersections with public health may be particularly important in proactively advancing preventive and chronic illness care for defined populations, often referred to as the 'second curve' of population-health management (and sometimes called clinical population-health management). This includes segmenting populations using data to understand risks and care needs, and then developing and implementing care models to proactively fill those care

Box 1: Background to the rapid synthesis

This rapid synthesis mobilizes both global and local research evidence about a question submitted to the McMaster Health Forum's Rapid Response program. Whenever possible, the rapid synthesis summarizes research evidence drawn from systematic reviews of the research literature and occasionally from single research studies. A systematic review is a summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select and appraise research studies, and to synthesize data from the included studies. The rapid synthesis does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

Rapid syntheses can be requested in a three-, 10-, 30-, 60- or 90-business-day timeframe. An overview of what can be provided and what cannot be provided in each of these timelines is provided on the McMaster Health Forum's Rapid Response program webpage (www.mcmasterforum.org/find-evidence/rapid-response).

This rapid synthesis was prepared over a 30-business-day timeframe and involved five steps:

- 1) submission of a question from a policymaker or stakeholder;
- 2) identifying, selecting, appraising and synthesizing relevant research evidence about the question;
- 3) conducting key informant interviews;
- 4) drafting the rapid synthesis in such a way as to present concisely and in accessible language the research evidence; and
- 5) finalizing the rapid synthesis based on the input of at least one merit reviewer.

needs across the full continuum of care. This often requires health-service providers to develop partnerships with very specific services like community mental health supports and the full array of broader human services.(3)

Public health may also play an important role in Ontario's health-system transformation as OHTs expand their focus and place greater emphasis on factors not directly related to healthcare, but that have an important influence on population health and well-being through policies and services that directly address upstream socio-economic determinants of health (often referred to as the 'third curve' of population-health management).(3) These include social and economic factors, such as income, education, food security, transportation, and employment, and factors related to the physical environment, such as access to clean water and air quality, that influence people's exposures to health risks and shape their opportunities to recover from illness and injuries.(3) Many of these factors influence the upstream determinants that contribute to, for example, chronic diseases and risk factors in aging populations. Addressing this 'third curve' requires population-based strategies that involve multi-sector and multi-stakeholder partnerships where coordinated intersectoral action with public health and broader human services will be critical.(2; 3) Together with organizations coordinating and delivering broader human services, public health plays an important role in providing targeted services, such as connecting people with housing or income supports, as well as shaping broader determinants of health through policy and program development related to children's and early years services, disability services, employment supports, housing services, and other community programs. Given their strong relationships with and understanding of community governance structures, both public health and broader human services are well-positioned to inform population-based interventions, and particularly those aimed at addressing upstream determinants of health. Intersections between OHTs and broader human services are addressed in more detail in a complementary suite of products including a rapid synthesis and brief available on the RISE website.

Greater integration with public health has the potential to bring additional population-health perspectives to health systems, leading to improved patient and caregiver experiences, equitably improving the health of populations, and reducing the per capita cost of healthcare.(4) Greater integration with public health can make important contributions to OHTs across each of the curves of population-health management:

- through public health's experience coordinating and/or providing individual patient care to populations underserved by primary care (e.g., for those with sexually transmitted infections, tuberculosis or other conditions often linked to economic insecurity) in line with population-health management's 'first curve' (focused on addressing the acute needs of individual patients for the treatment of illness and disease, leaving no one behind);(2-4)
- through the application of public-health data, tools and methods to support segmenting the population into shared needs and shared barriers to accessing care, building a better understanding of the adequacy of health services and equity concerns, and integrating and prioritizing services according to epidemiological, organizational and economic needs of populations in line with the 'second curve' of population-health management, which is focused on the active management and prevention of illness for defined populations;(2; 3)
- through public health's capacity to create and promote healthy public policy by coordinating a comprehensive and coherent approach to policy development and implementation, targeting the structural drivers of health, including working with partners across sectors, organizations and populations in line with population-health management's 'third curve', focused on population-based strategies to address broader social determinants of health. (2; 3)

To be most effective, OHTs will also need to intersect with local and regional public health agencies on aspects related to the eight OHT building blocks. Many services and functions offered by public health will require close collaboration with OHTs to be most effective, recognizing that public health agencies play a distinct role and carry distinct responsibilities from OHTs. For example, while both health-service organizations and local public-health agencies contribute to health promotion and disease and injury prevention, each of their respective efforts are strengthened when they are able to build upon, promote, and strengthen the work of the other.(2) Several reviews highlighted areas such as screening and immunization, health promotion and behaviour modification, and surveillance and protection as areas of shared responsibility, and at the interface of population-based and individual-level interventions.(2; 4-5)

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In Ontario, public-health agencies and related organizations are funded and governed by provincial and municipal governments, often with mandates that cross municipal, regional and provincial levels. This adds a layer of complexity to OHTs working with public-health agencies, as it requires coordination, collaboration and integration across multiple levels of governance and traditionally separate budgets. While many OHTs have representation from public-health agencies and broader human services on their boards and committees, differences in the attributed population-focus of OHTs and the geographic focus of regional public-health agencies and local public health units create important differences in outreach and responsibility for population health. Some of the resulting challenges include:(2; 4)

- a lack of clarity on differences in accountabilities by attributed populations and geographic focus;
- a perceived loss of public-health authority, expertise and capacity, particularly when public-health roles are fragmented and distributed across a health system;
- a fear of loss of linkages to community and multi-sectoral partnerships; and
- competing priorities and historical power and resource differences between preventive and treatment services.

As many OHTs are still in the process of planning, there is an opportunity to take a detailed look at how public health can best work with OHTs to optimize population-health management in all three curves and achieve the quadruple aim.

WHAT WE FOUND

We identified five reviews (four older, low quality and one of recent-medium quality), and five qualitative studies that focused on the intersections of public health with population-health management initiatives. Most reviews and studies focused on the integration of public health and local health and social-care systems. Where identified, we also included findings related to multi-sectoral collaboration to address social determinants of health. We did not identify evidence specifically addressing how to support collaborative governance in areas where coverage areas differ (e.g., where attributed populations of population-health management initiatives and the boundaries of the public-health agency and municipality overlap, but with some mismatch), how integration may support a greater focus on population-health in policies and programming both within health as well as within other sectors, and the challenges related to shared accountability for population health.

Based on the literature search, we identified considerations for financial and delivery arrangements, structural and process elements, and relational elements that support the intersection of public health and population-health management (Question 1).

Other jurisdictions that have adopted population-health management approaches have grappled with similar questions around how to establish intersections between local networks of care and public health. Through our literature search, we identified three initiatives similar to OHTs implemented in the province of Quebec in Canada, in Australia, and in the United Kingdom. (Question 2). Drawing from the reports on and evaluations of these initiatives as well as from a complementary synthesis on intersections between OHTs and broader human services, we identified nine insights, spanning many of the OHT building blocks.

Appendix 1 provides an overview of the identified population-health management in terms of the targeted population, sectors and settings, and a brief description of the initiative. Appendices 2, 3 and 4 provide summaries of country-specific initiatives, and findings from the identified and relevant reviews and primary studies.

Question 1: What does the evidence say about what can support the involvement of public health in population-health management initiatives?

In the literature, we identified considerations for financial and delivery arrangements, structural and process elements, and relational elements that could support the integration of public health to better support population-health management. Each of these are described in turn while Table 1 presents contributions of public-health functions to population health identified in the literature and considerations for the Ontario context, organized by population-health management step.

Financial and delivery arrangements

We identified seven elements focused on financial and delivery arrangements. Each of these is described below:

Financial arrangements

Within the literature, we identified five funding strategies to promote the intersections of public health with population-health management initiatives. These include:

- providing cross-government funding to support multi-sectoral initiatives addressing place-based determinants of health, such as environmental health and structural elements of food insecurity;(5)
- offering community transformation grants focused on the prevention of chronic diseases, with clinical preventive services as a necessary component and health care providers as partners in public-health focused funding initiatives;(5)
- contracting with non-governmental and community organizations to overcome access barriers (e.g., due to geographic size or scope of jurisdictions);(4; 5)
- tying tax-exemption status of large health-service provider organizations to the completion of community needs assessments, implementation plans and ongoing monitoring and reporting requirements, which could include a

requirement for community input (not just the patients) served by the institution and/or for the deliverables to be informed by public-health expertise;(5) and

- incentivizing collaborative work, particularly for healthcare providers compensated only for direct clinical care.(2; 7)

Delivery arrangements

Across the literature, we identified two elements related to delivery arrangements to strengthen the role of public health within population-health management initiatives. These include:

- offering primary-care extension programs to support the incorporation of evidence-based approaches to preventive medicine, health promotion and chronic disease management, and mental and behavioural health services;(5; 6) and
- expanding commissioned care to include preventive services (such immunization, screening, and self-management support programs), including when provided in non-traditional locations, such as schools, public housing and workplace sites, as well as expanding qualification criteria for providers able to offer preventive services.(5)

Process and structural elements

In addition to financial and delivery arrangements, we identified three process and structural elements that could support the integration of public health to better support population-health management, each described in more detail below.

Well-defined roles and accountabilities

There is strong alignment between public health and local health systems in a shared commitment to supporting individual and population-level health and well-being. However, each bring a unique set of skills and perspectives to the work, while also carrying different accountabilities. Several reviews and primary studies highlighted the importance of clearly defining the roles and boundaries between public health and health services, including opportunities for cross-sector collaborations.(2; 4) Where public health often provides clinical care to address priority gaps in primary care (such as in response to a health crisis or for under-served populations), this often strains already limited human and other resources as acute needs may divert resources away from investments that often only show results in the long term.(7) While these services demonstrate the benefit of offering clinical services concurrently with population-based public-health programs, greater coordination is needed to best support shared infrastructure and services. Several studies suggest that co-location or opportunities for structured interaction are beneficial to collaboration, such as combining diagnosis, prevention, treatment and rehabilitation with educational counselling, outreach and case management, together with social services that address broader determinants of health.(7; 8)

Strategic coordination around shared objectives also facilitated opportunities for collaboration, where both health-service organizations and public-health agencies contribute to shared objectives while working within their optimal scope of practice.(9) For example, the prevention of chronic diseases requires both individual and population-based interventions (e.g., tobacco cessation programs applied at the individual level, and tobacco taxation and smoke-free public areas applied at the population level), requiring both clinical expertise and population-level analysis and interventions.(2) Public-health staff may be particularly skilled at building and maintaining multi-sectorial partnerships to promote healthy public policy, including approaches rooted in community development, and may be able to effectively act as a key link within and between sectors.(9)

Shared data, systems and processes to support data-driven decision-making

Several studies highlighted the value of collectively reviewing clinical and population-level data to develop shared priorities and guide integration efforts. This was particularly beneficial for identifying and planning population-based interventions using data-driven processes. Better access to timely information about community and population needs has been shown to enhance:(2; 7; 10)

- shared data infrastructures to integrate clinical and population-based data;
- clinical decision-making while also supporting better alignment of services with population needs;

- community and population-health assessments that integrate clinical data with data on relevant environmental, social and behavioural and other health risks; and
- decisions about practice management such as site locations, service provision at each site, staffing patterns, and need for patient education programs, including identifying how to best address disparities.

Explicit incentives and responsibilities to support integration

Several reviews and studies identified the need to create structures and processes to guide greater collaboration between health services and public health. These include shared structures, mandated connections, and explicit roles and responsibilities to strengthen integration, supported by open communication about competing priorities, resource allocation and sustainability, and accountability.(4; 10) Coordinating and convening across different professional cultures and structures requires time, resources and dedicated attention to organizational and practice-based change management.(9) Strategies to support greater integration include:

- assigning responsibility for greater coordination and integration across teams and to specific roles and/or positions (8; 11);
- investing in relationship building, including developing an understanding of one another's roles and expertise (9; 10);
- identifying and regularly monitoring measures of successful integration and collaboration;(12) and
- developing practical tools to guide the collaboration of health-service providers and public-health staff.(7)

Relational elements

In addition to the structural and procedural elements, we also identified three relational elements that could support the integration of public health to better support population-health management initiatives. Each of these is described in more detail below.

Commitment to shared vision and greater collaboration

A scoping review highlighted the importance of commitment to and support for greater collaboration across jurisdictional and organizational leadership. This includes identifying and removing barriers to integration where possible, actively pursuing a shared vision for improving the health of locally defined populations, and valuing the complementarity of expertise, skills and resources to achieve shared objectives.(10) A different scoping review highlighted the added value of having clinical and population-level expertise work together to identify and implement interventions across multiple areas of influence, such as health-promotion counselling, self-management supports and educational materials at an individual and community level, while also leveraging non-clinical tools and resources to influence regulations and policies that promote conditions more conducive to safety and well-being of populations.(7) Collaboration was also supported through facilitated learning networks focused on accelerating the dissemination of innovations in public-health intersections with population-health management often led by, but not limited to, recipients of transformation grants focused on strengthening preventive services.(5; 6)

Catalyzing collaboration through opportunity and innovation

A primary study focused on the experience on the integration of public health and primary care across five states in the United States highlighted that collaborative efforts increased in response to emerging, often strategic, opportunities. This included in response to a health crises or funding for innovative approaches to care. With appropriate structures and processes in place, these often brought new energy and motivation to collaborative efforts.(8) Authors of a scoping review developed a self-assessment tool to assess organizational readiness and potential scope of opportunities for greater collaboration between clinically-oriented services and public health.(7)

Investing in building trust and interdependence in inter-institutional and inter-sectoral relationships

A report on an initiative to support state-wide partnerships for systems change and public-health innovation in the United States identified the importance of transforming relationships from ones that foster competition and insularity to being driven by a shared vision and commitment to improvement and addressing health inequities. This report highlighted the value of involving non-conventional stakeholders, particularly those who may not have had decision-making power in previous structures, as a catalyst to create more horizontal relationships between

organizations. In more mature collaborations, relationship-building was focused on influencing sectors and institutions beyond the conventional boundaries of the health sector.(10; 13)

Table 1: Contributions of public-health functions to population health identified in the literature and considerations for the Ontario context (primarily for the ‘first and second-curves’ of population-health management) organized by population-health management component

Component in population-health management approach	Contributions of public-health functions by population-health management component	Considerations for successful integration with Ontario Health Teams
Population identification	<ul style="list-style-type: none"> Established methods for comprehensive health needs assessments and system report cards (11) 	<ul style="list-style-type: none"> Greater data integration could contribute to improved data quality and data interpretation (2)
Segmentation for needs, risks and barriers	<ul style="list-style-type: none"> Surveillance and analysis of population health and well-being through aggregate data of registered patients or area-based populations can allow for a better understanding of client characteristics, the identification of community needs, and the development of interventions and assessment tools (2) 	<ul style="list-style-type: none"> Greater data integration could contribute to improved data quality, data interpretation, needs assessment and commissioning of appropriate services (2)
Co-designing person-centred care models and service mix	<ul style="list-style-type: none"> Strong multidisciplinary partnerships across sectors and organizations (e.g., public, private, municipal, community-based) provide structure for multi-sectoral collaboration (4) Strong public-health-oriented community engagement contributes to greater stakeholder involvement in policy and decision-making (4) 	<ul style="list-style-type: none"> Ground partnerships in shared objectives and recognize comparative advantage of each partner (11) Identify opportunities to leverage and build upon public-health expertise in community and cross-sectorial engagement (4)
Implementation and reach	<ul style="list-style-type: none"> Often deliver individual patient care for select populations with complex medical and social-care needs (e.g., infectious diseases associated with economic deprivation like tuberculosis)(2) Manage secondary prevention of infectious diseases (2) 	<ul style="list-style-type: none"> Need clear role delineation and accountabilities around core functions and scope of work of public health versus clinical care (e.g., public health versus primary-care providers, working at individual versus community level) (19) Establish clear budgets for public health versus Primary-care objectives, with expenditures reported publicly (19)
Monitoring and evaluation	<ul style="list-style-type: none"> Public-health methods can contribute to the assessment of the adequacy and equity of primary care (e.g., first contact, continuity, comprehensiveness, coordination, community orientation, cultural sensitivity and family centredness) (2) Public-health competencies and tools can contribute to better aligning health services with population needs, and help to prioritize activities according to epidemiological, organizational, and economic trends (2) 	<ul style="list-style-type: none"> Developing and tracking specific indicators to assess interaction between public health and health services would be helpful to guide integration (2)

Question 2: What can we learn from initiatives similar to Ontario Health Teams about how they intersect with public health?

We identified three initiatives similar to Ontario Health Teams implemented in Australia, in the province of Quebec in Canada, and in the United Kingdom. In Australia, Primary Health Networks (PHNs) aimed to improve the efficiency and effectiveness of medical services, particularly for those at risk of poor health outcomes, while also improving overall care coordination. PHNs were also responsible for regional needs assessments and commissioning of care for people at greater risk of poor health outcomes.(6; 15) The creation of Health and Social Services Centres (HSSCs) in Quebec sought to integrate health- and social-care to improve population's health and well-being, distribute services more equitably, and manage clients with more socially complex care needs.(1; 14; 20) In the United Kingdom (U.K.), 11 community-oriented primary-care (COPC) centres were mandated to evaluate the health and well-being of their populations and determine service needs, to coordinate the use of healthcare services and to develop integrated local care networks connecting health and social service partners.(16-18) COPCs also informed the later development Primary Care Trusts in the U.K. Individual initiatives are described in more detail in Appendix 1. A complementary rapid synthesis on intersections between OHTs and broader human services identified seven additional initiatives from Germany, the Netherlands, New Zealand, the U.K., and the United States (U.S.) that play an important role in providing targeted social care, as well as shaping broader determinants of health. Given public health's important role in working with health service organizations and broader human services, we have also included relevant insights from this synthesis below.(21)

Drawing from the reports on and evaluations of these initiatives, we identified the following nine insights, spanning many of the OHT building blocks (BB):

- scaling up intersections and collaborations over time, beginning with coordinating around shared clinical services, disease and injury prevention, and health promotion, and transitioning towards initiatives more focused on broader social determinants as relationships mature [Canada and U.K.] (BB#2 and 3);(1; 13; 14; 18; 20)
- developing a shared understanding of social complexity accompanied by shared assessment tools and strong partnerships with social care organizations to meaningfully address broader determinants of health [U.S.] (BB#2); (21)
- utilizing multiple and reinforcing mechanisms to support effective community and patient and caregiver engagement [Canada] (BB#3);(1; 13; 15; 20)
- facilitating the collaborative analysis of population and clinical data by building shared understanding around data literacy and a proactive approach to data management and sharing [U.K.] (BB#5);(6; 16-18; 21)
- maintaining momentum and agility by building trusting, transparent and responsive relationships between those funding and assessing performance, and those implementing population-health management initiatives [Australia] (BB#6);(6)
- building greater recognition of collaborative commissioning of services as a mechanism to drive integration through co-design and cooperative partnerships, and better identify opportunities for regional coordination of services [Australia] (BB#6 and 7);(6)
- maintaining consistent mandates and stable funding allows for the building of capabilities, capacities and partnerships to advance population-health management while also attending to associated change management needs [Australia, U.K., U.S] (BB#6 and 7);(6; 18; 21)
- providing healthcare providers with additional funding to address care linked to social complexity can increase their ability to address social determinants of health [U.S.] (BB#7);(21) and
- consolidating learning throughout implementation can inform the development of technical and administrative supports, recognizing that success and challenges will vary across implementation sites [Australia] (BB#8).(6)

Potential implications for Ontario Health Teams

The available literature largely described implementation considerations, with little focus on the effectiveness of developing intersections between OHT-like initiatives and public health. Similarly, little empirical evidence was found addressing governance arrangements and challenges stemming from the misalignment between the attributed

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population focus of OHT-like initiatives and the geographic focus on many public-health initiatives. As OHTs mature, findings from this review suggest that it will be important to:

- build on population-health focused collaborations that have already been initiated, including those developed in response to the pandemic (e.g., mobile vaccination units and housing initiatives), with attention to under-served segments of the population;
- take stock of and align OHT implementation plans with population-level initiatives that are already in place in the community, particularly those that serve populations with complex health- and social-care needs and/or those that engage very specific services like community mental health supports and the full array of broader human services; and
- involve and engage local public-health agencies in the development of their ‘population-health management and equity’ plans (also known as ‘OHT plans’), given their experience and expertise, in part by finding ways to reassure agencies that they will maintain their focus on population-level needs with a continued focus on reducing health inequities within and across populations.

Future opportunities to develop insights that may be relevant to OHT development and maturity include exploring models and experiences that address governance arrangements and specific strategies to support collaboration and integration across organizations working with both an attributed population focus and a geographic focus (such as regional approaches or cross-OHT working groups).

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APPENDICES

Appendix 1: Overview of identified initiatives similar to Ontario Health Teams that intersect with public health in terms of the targeted population, sectors and settings, and brief description of the initiative.

<p>Health and Social Services Centre (HSSC) (1; 14; 20)</p>	<p><i>Country/region:</i> Canada, Quebec <i>Population:</i> 95 HSSCs across the province responsible for the care of a population within a specific territory</p>	<ul style="list-style-type: none"> • Primary care • Public health • Home and community care • Mental health and addictions • Family and social supports • Social work and case management • Municipal services 	<p><i>Objective:</i></p> <ul style="list-style-type: none"> • Integration of health- and social-care to improve population’s health and well-being, distribute services more equitably, facilitate the use of services and manage clients with more socially complex care needs • Guided by creating population-based responsibility for the delivery of services and the hierarchical provision of services <p><i>Scope:</i></p> <ul style="list-style-type: none"> • Each HSSC has the mandate to evaluate the health and well-being of their populations and determine the healthcare service needs, to coordinate the use of healthcare services, to manage the healthcare services offered and to develop integrated local care networks connecting health and social service partners <p><i>Outcomes:</i></p> <ul style="list-style-type: none"> • Though we did not identify an overall assessment of Health and Social Services Centres by the government of Quebec, strengths and weaknesses of the approach have been noted in studies, including: <ul style="list-style-type: none"> ○ the emphasis on prevention and public health as well as the development of care according to population health and social needs ○ the establishment of care pathways that ensure patient follow-up ○ significant administrative burden for professionals who took on the case-management role ○ the critical role of trusting relationships between health centres and communities, as well as the time required to build and strengthen these relationships
<p>Community-oriented primary care (16-18)</p>	<p><i>Country/region:</i> United Kingdom <i>Population:</i> 11 COPC piloted in four rural and urban areas</p>	<ul style="list-style-type: none"> • Primary care • Public health 	<p><i>Objective:</i></p> <ul style="list-style-type: none"> • Drawing on epidemiology, public health and financial management to maximize health for a given population. <p><i>Scope:</i></p> <ul style="list-style-type: none"> • Each COPC has the mandate to evaluate the health and well-being of their populations and determine the healthcare service needs, to coordinate the use of healthcare services and to develop integrated local care networks connecting health and social-service partners <p><i>Outcomes:</i></p>

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			<ul style="list-style-type: none"> • Developed capacity in collecting and analyzing health data, integrating evaluative processes and advancing interprofessional collaboration • Increased understanding of population-based health needs among health authorities
Primary Health Networks (PHNs) (6; 15)	<p><i>Country/region:</i> Australia <i>Population:</i> 31 PHNs were created across the country in 2015</p>	<ul style="list-style-type: none"> • Primary care • Public health • Pharmacy • Community development 	<p><i>Objective:</i></p> <ul style="list-style-type: none"> • To improve the efficiency and effectiveness of medical services, particularly for those at risk of poor health outcomes, while also improving overall care coordination <p><i>Scope:</i></p> <ul style="list-style-type: none"> • Each PHN is an independent organization, governed by clinical councils and community advisory boards, with regions closely aligned with those of state and territory Local Hospital Networks • PHNs support general practice as well as systematic and opportunistic screening, health checks, smoking cessation, exercise, weight reduction and diet, and interventions focused on specific chronic conditions such as diabetes and cardiovascular disease • PHNs also focus regional needs assessment and commissioning for people at greater risk of poor health outcomes <p><i>Outcomes:</i></p> <ul style="list-style-type: none"> • PHNs have demonstrated a better understanding of the health needs of their communities (through analysis and planning), identified and built effective partnerships to address shared priorities, and have developed innovative ways of commissioning services • Effective consumer engagement, including patient feedback for shaping future service design, is an ongoing area of development; while Community Advisory Committees provide an opportunity for this, other mechanisms need to be put into place by PHNs to enable them to engage better with the people in their regions

Appendices 2 & 3

The following tables provide detailed information about the systematic reviews and primary studies identified in the rapid synthesis. The ensuing information was extracted from the following sources:

- systematic reviews - the focus of the review, key findings, last year the literature was searched, and the proportion of studies conducted in Canada; and
- primary studies (in this case, economic evaluations and costing studies) - the focus of the study, methods used, study sample, jurisdiction studied, key features of the intervention and the study findings (based on the outcomes reported in the study).

For the appendix table providing details about the systematic reviews, the fourth column presents a rating of the overall quality of each review. The quality of each review has been assessed using AMSTAR (A MeaSurement Tool to Assess Reviews), which rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to delivery, financial or governance arrangements within health systems. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, a review that scores 8/8 is generally of comparable quality to a review scoring 11/11; both ratings are considered “high scores.” A high score signals that readers of the review can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the review should be discarded, merely that less confidence can be placed in its findings and that the review needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1):S8).

All of the information provided in the appendix tables was taken into account by the authors in describing the findings in the rapid synthesis.

Appendix 2: Summary of findings from reviews about the intersections between public health and Ontario Health Teams

Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
Linkages and strategies to integrate primary and public-health systems (11)	This scoping review identified 10 models. Models varied in their level of implementation. The United Kingdom’s Public Health in Primary Care Trusts was the only model found that focused on national-level implementation imposed from top levels of government down to providers. Five models were introduced at the community level. There were three models at the patient–provider level that were more narrowly focused on the relationship between a public-health department and primary-care providers. Five models were developed in Canada.	2003	2/9 (AMSTAR rating from McMaster Health Forum)	9/27
Collaboration between primary care and public health (10)	<p>This scoping review found that the use of a standardized shared system for collecting data and disseminating information enhanced access to quality medical information and supported effective interdisciplinary care. Shared protocols were useful for facilitating multidisciplinary, evidence-based practice and quality assurance, and for collecting data and disseminating information.</p> <p>This review also identified that collaboration occurred more commonly where initiatives had common goals such as reducing health disparities, and meeting the healthcare needs of disadvantaged populations, improving quality of care, improving evidence-informed practice or improving emergency preparedness. Government involvement, including the ‘fit’ of collaboration with a government’s agenda and endorsement of the value of collaboration by government officials were important facilitators. Resource limitations were the most commonly identified organizational barrier to collaboration and included deficits in human and financial resources, space, team building and change-management capacity.</p> <p>This review identified several facilitators including organizational structures such as personnel designated to enhance cooperation, mentorship programs for new employees, involvement of someone able to bridge sectors, physician and non-physician champions, and job descriptions requiring collaboration. An important management process was to prepare the organization for changes associated with collaboration and ensure organizational structures and processes that enabled healthcare providers to function optimally, and assisting them to develop knowledge and skills needed to support the work of collaborative teams.</p> <p>This review also noted that many studies highlighted the importance of direct and open communication and decision-making to promote understanding, trust and respect between sectors and the community. Facilitators included attention to process, open, upfront communication about competition and control issues, and appreciation of collaborating partners’ various complementary resources, skills and expertise. Co-location of organizations and team members was also an important facilitator of collaboration. Geographic proximity of team members facilitated communication, information exchange, a sense of common purpose, and high levels of trust between providers. Creating networks also allowed for the building of a critical mass among geographically dispersed team members.</p>	2008	3/9 (AMSTAR rating from McMaster Health Forum)	12/114
Identifying shared functions between public and primary-health systems and organizational models that could	This scoping review identified screening and immunization as actions that may be carried out in primary care, but that can benefit from the support of public-health departments. In addition, health promotion and behavior modification were also seen by most authors as a shared responsibility at the	2013	2/9 (AMSTAR rating from	6/55

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<p>facilitate their interaction (scoping review)(2)</p>	<p>interface of collective and individual intervention. Another aspect that was the subject of analysis in many documents concerned the surveillance and protection functions of public health from a case identification and prevention or early-treatment perspective. Primary care was seen as the “ear on the ground,” the service to which people would present, while public health had the role of investigation and provided advice back to clinical settings.</p> <p>This review also suggested that access to timely information about regional and community health concerns and needs is required to promote complementary action across sectors. The benefits of greater interaction could be an improvement in data quality, data interpretation, needs assessment and commissioning of appropriate services.</p> <p>This review also highlighted that the field of public health has methodologies that can be used to evaluate equity of health services administered by community providers, and can provide expert advice that may help to integrate and prioritize services. Many authors noted that public-health competencies and tools are crucial for planning of primary care that is more aligned with the actual needs of the population, and that it could help to prioritize activities according to epidemiological, organizational, and economic trends. This applied also to the evaluation of primary-care services with regards to changing population health and analysis of needs of groups of patients.</p> <p>Finally, this review presented an overview of several models of intersections between local health systems and public-health organizations and functions, citing approaches to support the integration of public-health perspectives in medical practice, such as family health teams (Canada), multidisciplinary health clinics (France), patient-centred medical homes (U.S.) and GPs with a specialized interest (United Kingdom); integrating primary care and public health in the provision of care for individuals, such as community health centres (Canada and United States) and community-oriented primary care (United Kingdom); and public health and primary care interaction as part of a broad health system, such as health and social service systems (Canada).</p>		<p>McMaster Health Forum)</p>	
<p>Defining and classifying public-health systems and how they intersect with health systems frameworks (4)</p>	<p>This critical interpretive synthesis describes how public health can contribute to system integration and the role of public health in promoting a population-health approach. This review defines integration as the relationship between public health and healthcare, and the extent to which services are provided to promote and achieve health. Potential benefits of integration include bringing a population-health perspective to the healthcare system, increased access to care, and the reduction of direct and indirect healthcare costs. This review also cites various challenges, including the potential loss of public-health authority and expertise, capacity and management of competing priorities, potential diversion of public-health resources to primary care, loss of positions in public-health agencies, and loss of linkages to community partners and communities. This synthesis suggests that defining public health and the boundaries of public-health systems could be an important step towards measuring performance and preventing public-health systems from becoming too overburdened from the increasing scope of public-health clinical activities. This was supported by evidence suggesting that there was a trend towards a substantial portion of public-health funding directed at individual clinical services (e.g., maternal and child health, mental health, prenatal visits, family planning).</p> <p>Many of the articles reviewed as part of this synthesis touched on elements of the OHT building blocks, most notably:</p> <ul style="list-style-type: none"> • the importance of community engagement and partnerships to the work of public health and how these skills may be highly transferable to supporting population-health management across health systems; 	<p>2016</p>	<p>3/9 (AMSTAR rating from McMaster Health Forum)</p>	<p>16/67</p>

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	<ul style="list-style-type: none"> • the importance of clear, consistent and timely communication is essential for delivering messages across partnerships, to the public, preventing mixed messages, and encouraging public engagement; • the importance of digital tools to support collaboration; and • partnerships and contracts with non-governmental and community organizations as strategies to overcome barriers to service provision (e.g., due to geographic size or scope of jurisdictions). <p>This synthesis highlights that integration of healthcare and public health will be difficult at best given that the aims, governance, finance and service delivery are not often aligned. There would have to be significant incentives for integration together with a shared vision of health to drive collaboration. This synthesis also cautions that public health will not be able to inform healthy public policies unless they have a seat at the decision-making table for policies outside of the public-health realm.</p>			
<p>Collaboration between clinical care and public health (7)</p>	<p>This scoping review identified examples of cross-sectoral integration in health systems internationally, and organized these by Lasker's synergy grouping, which describe the resources and skills required to achieve collaboration. This review identified many clinical areas of collaboration between local health systems and public health, while highlighting the critical opportunity of this collaboration to strengthen the application of a population perspective to clinical practice. This review suggests that important advances in health information technology may facilitate these collaborations, particularly in leveraging clinical and population-level data to inform population-health interventions. This review also highlights the need for mutually reinforcing strategies to support greater integration, accounting for different types and scope of collaboration required across local health and public-health systems. This review also highlighted several examples of how public health can support local health systems in addressing health inequities.</p> <p>This review also presents a self-evaluation tool that can serve as a resource for identifying opportunities for cross-sectoral collaborations.</p>	<p>2017</p>	<p>4/9 (AMSTAR rating from McMaster Health Forum)</p>	<p>7/45</p>

Appendix 3: Summary of findings from primary studies about the intersections between public health and Ontario Health Teams

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Organizational factors influencing successful primary care and public health collaboration (9)	Interpretive descriptive qualitative study involving in-depth interviews	74 key informants from three Canadian provinces; sample included policymakers, managers, and direct service providers in public health and primary care	Independent examples of collaboration between local health systems and public health in Canada	<p>This study identified several findings that supported strong collaborations, including:</p> <ul style="list-style-type: none"> • physical proximity to build relationships and trust, while also sharing administrative and infrastructure costs • community partnerships, particularly to support improved services for under-served communities • dedicated roles and funding to drive collaboration, in part through formal agreements and organizational structures that enable collaboration • formalized communication processes and shared strategic plans • coordinated clinical and administrative services, including appropriately matching skills to tasks and role delineation • seamless exchange of client/health information
Integration of primary care and public health (8)	Qualitative analysis of key informant semi-structured interviews	40 key informants from primary care and public-health practice-based research networks in Colorado, Minnesota, Washington, and Wisconsin	Collaborations between local health systems and public health through practice-based research networks in Colorado, Minnesota, Washington and Wisconsin	<p>This study identified several elements of included cases that contributed to strong collaborations, including:</p> <ul style="list-style-type: none"> • public health’s roles as convener across diverse sector and communities; this often led to public health driving much of the organization and communication around collaborative initiatives; • developing a mutual understanding of skills, expertise and roles across different sectors and organizations, often by working together on joint projects; and • formal structures were important to support collaborations, such as shared structures and mandated connections <p>This study also identified the following elements that were reported to energize existing partnerships or catalyze new ones:</p> <ul style="list-style-type: none"> • actively pursuing a shared vision; • collaboratively interpreting clinical and population-level data to determine shared objectives; • jointly reviewing capacity and resources to support sustainability of collaboration; and • leverage opportunities (e.g., funding, health reform) or crises to build or further develop partnerships.
Promoting systems change through state-level multi-sector partnerships with public health (13)	Document review and qualitative analysis of key informant semi-structured interviews and focus groups	21 state grantees together with state and federal-level program coordinators	State-wide partnerships established for systems change and innovation in public-health systems, funded by the Robert Wood Johnson Foundation	<p>This study identified several factors that supported strong partnerships, primarily led by public-health organizations. but that require and are built upon strong integration with local health systems. These include the need for partnership to be built around common language, identifying common goals, and developing the partnership’s structure and decision-making procedures. While these structures were seen as critical, these initiatives also required fostering of trustworthy interpersonal relationships, the</p>

				<p>transformation on conventional thinking around organizational boundaries and competition, and the support for paid staff time and other material resources. External funding was seen as critical to allow public-health agencies and communities to address issues of broad system reform outside the normal categorical funding streams.</p> <p>This study also highlighted the value of involving nontraditional stakeholders and communities in decisions about public health, especially those who have not had power under previous systems. This study highlighted the importance of creating structures to share power with new partners to achieve a common, mutually defined purpose. Other elements that facilitated the successful formation of partnerships and the effective implementation of partnership plans included:</p> <ul style="list-style-type: none"> • involvement of key sectors across relevant communities and governmental agencies, as well as influential “champions” or sponsors to lend visibility, credibility, and commitment (i.e., both horizontal and vertical connections); • skillful leadership to manage large-scale organizational change and to foster strategic interpersonal and interorganizational relationships; • sufficiently clear, stable, and yet flexible organizational structures for the collaborative effort, as well as adequate coalition infrastructure (material resources and paid staff); • choosing projects that are both reasonably achievable and yet significant – sometimes through accomplishing smaller goals and then building on those to take on more ambitious, comprehensive efforts; and • identifying the most relevant participants and environmental features for a given state’s activities, which vary from one state to another, although the broad principles of the initiative remain consistent.
Commissioning public and primary health services (8)	Qualitative analysis of key informant semi-structured interviews and online surveys	69 decision-makers involved in commissioning care in the United Kingdom, including from Primary Care Trusts	n/a	<p>This study highlights that reducing health inequities has proven difficult to prioritize within healthcare systems, in policy development for sectors with an impact on health, or through wider social and economic policies that promote social justice. This study suggests this is likely due to a range of factors, often acting in combination, including: the complexity of public-health challenges and their interconnectedness with political and commercial interests; the inseparability of health inequalities from wider social and economic inequalities; a relatively underdeveloped evidence base for public- health interventions and the challenges of evaluating them; and that demands of the healthcare sector overshadow longer-term investment in population health.</p> <p>This study also suggests that a policy emphasis on a preventive agenda is a critical support for enabling investments in prevention and population health, while demands from the acute sector were described as the main barrier for investing in preventive services. Findings from this study suggest</p>

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				<p>that tools for prioritizing investment and disinvestment should be developed, including public-health modelling with economic projections, in order to demonstrate return on investments. Tensions discussed in relation to prioritizing prevention include:</p> <ul style="list-style-type: none"> • how to disinvest in existing services; • how to prioritize investment in health without growth funding or when funding is being reduced; • a lack of skills and resources for the application of priority-setting techniques; • limitations of existing techniques in light of complex public-health challenges; and • the role of performance management and incentives that prioritize short-term priorities and/or process targets in the acute sector (versus preventive or public-health focused).
<p>Policy and funding levers to support integration of primary care and public health (5)</p>	<p>Study commissioned by the Health Research Services Agency (HRSA) and the Centre for Disease Control (CDC) in the United States; the commission held six open meetings and two closed meetings, and meetings were supported by literature reviews, qualitative analysis of key informant semi-structured interviews and focus groups</p>	n/a	<p>Looked at integration of public health and primary care across the United States, as well as focused case studies on maternal and child health, cardiovascular disease prevention and colorectal cancer screening</p>	<p>This report described several possible funding levers, including community transformation grants, established through allocations from the Prevention and Public Health Fund, which is a compelling example of a public-health-led initiative that could be used to integrate primary care and public health. The program consists of two parts: Community Transformation Grants and a National Network. The goal of the program is to reduce chronic disease rates, prevent secondary conditions, reduce health disparities, and assist in developing a stronger evidence base for effective prevention programs. These goals are to be met by supporting the implementation, evaluation, and dissemination of community preventive health activities that are grounded in evidence. The Community Transformation Grants program gives priority to the prevention and reduction of Type 2 diabetes and the control of high blood pressure and cholesterol. Clinical preventive services are embedded in the basic structure of the Community Transformation Grants program, making healthcare providers a core partner in the types of broad-based coalitions whose involvement is essential to the program. The accompanying National Network is aimed at community-based organizations that are positioned to accelerate the speed with which communities adopt promising approaches to health transformation and can carry this out by disseminating Community Transformation Grants strategies to their partners and affiliates, and second, by supporting and funding sub-recipients.</p> <p>Another lever described in this report is a legal standard for determining whether non-profit hospitals will be treated as tax exempt for federal income tax purposes. The community health needs assessments are designed to ensure financial assistance to indigent persons, curb excessive charges for medically indigent patients, bar aggressive collection tactics, and ensure compliance with federal emergency care requirements. Community needs assessments must be accompanied by an implementation strategy that grows out of the needs</p>

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				<p>assessment and ongoing reporting on implementation efforts. The law also requires that community health needs assessments must include individuals with public-health expertise, thereby underscoring the obligation of facilities to involve knowledgeable individuals, not merely use public-health data. This report also describes coverage reforms introduced by the Affordable Care Act, whereby primary-care providers and public-health departments can become participating Medicaid providers and furnish preventive services to adult and child populations. Guidance described best practices in making preventive services more accessible to Medicaid beneficiaries through the use of expanded managed care-provider networks, including covering out-of-network coverage in non-traditional locations such as schools, public housing, workplace sites, and other places, and adjusting qualification criteria for participating providers. Health and Human Services is also scheduled to incentivize the use of preventive services by Medicaid beneficiaries with accountability linked to reduced health risks, combined with targeted support for the co-location of public-health and primary-care service delivery.</p> <p>This report also describes Primary Care Extension programs, designed to provide a detailing function geared to incorporating evidence-based techniques, preventive medicine, health promotion, chronic disease management, and mental and behavioural health services into primary-care practices to facilitate adoption of the principles of the patient-centred medical home and population-health management.</p>
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Appendix 4: Summary of findings from other initiatives similar to Ontario Health Teams that intersect with public health

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Australia				
Evaluation of the Primary Health Networks Program in Australia (6)	Evaluation to determine if Primary Health Networks foundations and functions are fit for purpose, and whether they have increased the efficiency and effectiveness of medical services and care coordination. Used key informant interviews, surveys, case studies, focus groups and document reviews	Members of the Australian government, leads of primary health networks, national organizations working with networks, primary health network staff and other health-service providers	In 2014-15, the Australian government established 31 Primary Health Networks as independent, regional, membership-based organizations. Networks were intended to be planners, commissioners and integrators of services in their region	This evaluation found that primary health networks (PHNs), because they were separate from the department of health, were able to take a more agile and community-inclusive approach to their work. Much of the early focus of PHNs was on developing optimal governance arrangements and understanding their role as regional commissioners of health services. The evaluation highlighted the important of a stable mandate and funding, as competing priorities risk taking focus away from core objectives. The evaluation also highlighted the significant amount of time and resources to adequately support network development. Through the development phase, PHNs demonstrated greater knowledge of the health needs of their communities, fit-for-purpose partnerships to address shared priorities, and developed innovative ways of commissioning services. The evaluation highlighted the importance of broadening the scope of partnerships to include non-medical services, and the highly strategic nature of commissioning services, which requires collaborative data analysis at both clinical and population levels. Some organizations lost funding due to a changed approach to commissioning services, which required PHNs to rebuild trust through data-driven and transparent approaches to commissioning decisions. Most PHNs still need to engage more effectively with their wider community to understand and influence expectations of the health system; to date this has primarily been done through Community Advisory Committees. The evaluation recognized the benefits of a trusting and transparent relationship between the Department of Health (as funder and evaluator of PHNs) and the PHNs themselves; specific benefits included more effective implementation and technical supports in response to challenges faced by PHNs.
Canada (Quebec)				
Lessons from integrating public health into local health delivery systems (1)	Longitudinal case studies	Participant observation and semi-structured interviews with 46 managers	In 2004, the Quebec government reorganized its healthcare system by integrating public health more formally into local governance structures through the creation of Health and Social	This study highlighted how, over time, activities undertaken by HSSCs became increasingly based in a population-based perspective. Temporality was fundamental to identify the nature of the change process following the attribution of a population-based perspective. Activities expanded gradually and cumulatively. Initially, managers engaged in activities more traditionally associated with the healthcare system and with which they were more familiar. As time went on, they gradually engaged in other

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			Services Centres (HSSCs), which were required to develop population-based approaches to address health and social needs	<p>activities to improve the health and well-being of their populations, including health promotion interventions and social projects. HCCS managers sought to improve the support for professionals carrying out preventive interventions. For instance, they promoted the development of preventive clinical practices, more screening activities, and lifestyle counselling. Managers increasingly acted to reach potentially vulnerable clienteles before diseases and psychosocial problems emerged.</p> <p>Over time, HCCS managers invested more in the development of the social area by leading and participating in different projects in their local communities. Including social and health areas within a single governing structure enabled the HCCS managers to continue to invest in the community by taking advantage of links that were already established. Managers had an important role to play in facilitating and coordinating community projects that were likely to improve the health and well-being of their populations. Different activities put in place by HCCS managers suggest that public health and healthcare concerns are getting closer within a local governance structure.</p>
United Kingdom				
Community-oriented primary care and commissioning (17)	Viewpoint	n/a	The King's Fund supported the development of 11 community-oriented primary care (COPC) sites with the mandate to evaluate the health and well-being of their populations and determine the healthcare service needs, to coordinate the use of healthcare services and to develop integrated local care networks connecting health and social-service partners	<p>This study found that COPC models stimulated creative interactions between patient experience provided by physicians and public-health information about services, morbidity, performance and inequalities. Despite strong support, collaborative projects needed to be systematically encouraged, to facilitate greater understanding of the value of each other's contributions. COPCs were seen to strengthen the role of clinical commissioning groups in addressing upstream causes of social inequities in health. COPC training workshops helped develop teamwork and collaboration, and also brought cost-effective benefits to patients.</p>
Evaluation from Community-oriented primary care model (18)	Document review	Reports, theoretical papers, commentaries, reviews and primary studies		<p>This study found limited descriptions of outcomes of most COPCs, largely due to a lack of appropriate evaluative methodology and clearly improved outcomes. The main obstacles to implementation included lack of resources and initiative-specific skills, including evaluative approaches and quantitative data analysis techniques, as well as managing the necessary professional collaboration. Community participation, while central to the COPC model, appears to be largely driven by practitioners rather than by communities.</p> <p>This study found that the benefits of the COPC model include a broadened clinical perspective, the introduction of a public-health perspective into local health systems, and an overall promotion of collaborative and preventive initiatives.</p>



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