

# Rapid Synthesis

Lessons Learned from Integrated Care  
Initiatives in Ontario to Inform  
Ontario Health Teams

22 December 2020



HEALTH FORUM

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**Rapid Synthesis:**  
**Lessons Learned from Integrated-care Initiatives in Ontario to Inform Ontario Health**  
**Teams**  
60-day response

22 December 2020

#### Rapid-Improvement Support and Exchange

RISE's mission is to contribute to the Ontario Ministry of Health's 'one window' of implementation supports for Ontario Health Teams by providing timely and responsive access to Ontario-based 'rapid-learning and improvement' assets.

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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 60-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](http://www.mcmasterforum.org/find-evidence/rapid-response)).

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#### Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the rapid synthesis. The funder played no role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the rapid synthesis.

#### 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

### Questions

- How has integrated care been conceptualized in Ontario, and what have been the core components of Ontario-wide integrated-care initiatives (i.e., integrated funding models, Health Links, rural health hubs, Local Health Integration Networks, Community Care Access Centres, the *Entités*, French Language Service Coordinators within the LHINs, and the Indigenous Healing and Wellness Strategy)?
- What quadruple-aim outcomes have been achieved through integrated-care initiatives in Ontario?
- What barriers and facilitators have been encountered during implementation of integrated-care initiatives in Ontario?
- How have integrated-care initiatives in Ontario been adapted to meet the needs of specific populations?

### Why the issue is important

- The introduction of Ontario Health Teams (OHT) represents a substantial change from current practices, as teams aim to offer coordinated and integrated care for a defined population.
- OHT leaders can learn from the experiences of previous integrated-care initiatives in Ontario.

### What we found

- We identified seven primary studies and 19 grey literature reports including internal and external evaluations and undertook 14 key informant interviews.
- Findings related to question 1 point to a range of conceptualizations and core components:
  - integrated care has been defined in many ways, but some stakeholders in Ontario referenced a particular framework based on structural, functional, interpersonal, normative, and process integration;
  - some previous initiatives took a ‘low-rules’ approach with few core components; and
  - features of integrated-care initiatives may vary depending on whether the initiative targets a sub-population or entire population, and whether the initiative targets an episode of care or the complete care continuum.
- Findings related to question 2 identify variation in outcomes across previous integrated-care initiatives:
  - quadruple-aim outcomes are not comparable across previous integrated-care initiatives, due to variation in scope, aims and contexts of these initiatives;
  - health outcomes were rarely measured, but outcomes for utilization varied across initiatives as did per-capita costs, while patient and provider experiences were not consistently measured; and
  - evaluation of many initiatives was hindered by a lack of up-front planning for evaluation, unclear objectives, and challenges accessing and generating data.
- Findings related to question 3 include a number of factors affecting the implementation process:
  - implementation of integrated care in a ‘low-rules’ environment requires clear objectives, predictable funding, balancing comfort with risk, and employing strategies to mitigate uncertainty; and
  - implementation was affected by financial issues, data and communications, legal considerations, organizational culture, inter-organizational relationships, clinician engagement, planning processes, and communication with policymakers.
- Findings related to question 4 address adapting integrated care to meet specific populations’ needs:
  - stakeholders suggested that adaptations for specific populations’ needs should be considered from the start of the planning process;
  - evaluations of initiatives to support French-language health services found that a lack of clarity around roles and gaps in service availability pose barriers for care coordination for this population; and
  - reports and studies have concluded that Indigenous health services require sufficient funding to meet population needs, and that community ownership, autonomy, self-determination, and cultural competency are crucial when integrating Indigenous and western approaches in health services.

## **QUESTIONS**

- 1) How has integrated care been conceptualized in Ontario, and what have been the core components of Ontario-wide integrated-care initiatives?
- 2) What quadruple-aim outcomes have been achieved through integrated-care initiatives in Ontario?
- 3) What barriers and facilitators have been encountered during implementation of integrated-care initiatives in Ontario?
- 4) How have integrated-care initiatives in Ontario been adapted to meet the needs of specific populations?

## **WHY THE ISSUE IS IMPORTANT**

In 2019, Ontario announced a health-system transformation aimed at reducing silos and connecting care across services and sectors. The hallmark of the transformation is the development of Ontario Health Teams (OHTs). OHTs comprise voluntary, intersectoral networks of health organizations that jointly work towards achieving quadruple-aim outcomes (improved health outcomes, improved patient, family and caregiver experiences, keeping per-capita costs manageable, and improved provider experiences). While OHTs will target specific sub-populations, or “priority populations,” in early implementation, they will eventually be accountable for managing population health across an entire geographic region. Implementing seamless integrated care to achieve this goal will require substantial changes to current practices across the health system.

However, this is not Ontario’s first provincial effort to integrate care through care coordination. While the scope and scale of OHT reforms exceeds that of previous integrated-care initiatives in Ontario, OHT leaders can learn from the experiences of previous integrated-care initiatives in the province. These past integrated-care initiatives can offer lessons about the outcomes achieved, what barriers and facilitators were encountered during implementation, and what adaptations were made to meet the needs of specific populations. This rapid review provides a tailored summary of these lessons and points to implications for OHTs, with a focus on past province-wide initiatives as well as initiatives focused specifically on addressing the needs of francophone and Indigenous populations.

Of course, the context for integration has changed radically since the first 24 OHTs were announced in December 2019. Just months later, on 11 March 2020, the World Health Organization declared the COVID-19 pandemic. Health services in Ontario rapidly refocused on managing the emergent threat posed by COVID-19. While the bulk of this rapid synthesis was completed prior to the declaration of a pandemic (with some interviews taking place in the weeks following), the findings continue to be relevant. Drawing lessons from previous integration efforts can help to surmount the additional challenges to integration that are posed by COVID-19 and associated mitigation strategies. Moreover, recurrent concepts in this synthesis – including

### **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](http://www.mcmasterforum.org/find-evidence/rapid-response)).

This rapid synthesis was prepared over a 60-business-day timeframe and involved four steps:

- 1) submission of a question from a policymaker or stakeholder (in this case, an Ontario Health Team);
- 2) identifying, selecting, appraising and synthesizing relevant research evidence about the question;
- 3) drafting the rapid synthesis in such a way as to present concisely and in accessible language the research evidence; and
- 4) finalizing the rapid synthesis based on the input of one merit reviewer.

setting clear objectives, managing uncertainty, tailoring to population needs, and balancing standardization with flexibility – have a heightened resonance in the current context of the pandemic.

## **WHAT WE FOUND**

This rapid review considered past integrated-care initiatives that were provincial in scope and that met the *Connecting Care Act's* definition of integrated care (i.e., involve integration across at least three sectors, for example primary care, home and community care, or mental health and addictions services).(1) Regional and local initiatives, along with condition-specific initiatives, were excluded. We also searched for initiatives with the specific aim of providing integrated care for and with francophone and Indigenous people in Ontario. This synthesis addresses eight integrated-care initiatives: rural health hubs (2016-present); integrated funding models (also called bundled funding or bundled care, 2015-present); Health Links (2012-present); Local Health Integration Networks (2006-2019); Community Care Access Centres (2007-2017); and three population-specific initiatives including French Language Service Coordinators within the LHINs, the French Language Health Planning Entities (2010- present), and the implementation of the Indigenous Healing and Wellness Strategy (1994-present). These eight initiatives all offer lessons about the conceptualization, outcomes, implementation considerations, and population-specific adaptations of integrated care in an Ontario context.

We searched for literature specific to integrated care in the Ontario context and identified seven published primary studies and 19 grey literature reports including internal and external evaluations. To gain insight from those who have been involved in integrated-care reforms in Ontario, we also conducted 14 key informant interviews. These key informants included individuals working as policymakers in Ontario, individuals who have supported previous integrated-care initiatives, managers of organizations and initiatives, frontline service providers and researchers.

**Question 1:** How has integrated care been conceptualized in Ontario, and what have been the core components of Ontario-wide integrated-care initiatives?

Key informants suggested that essential elements of integrated care include centring patient and family experiences, and ensuring continuity in care, communication, relationships and information. Several key informants highlighted Singer and colleagues' framework (2) as a helpful tool to understand integrated care. This framework highlights five types of integration within and across healthcare organizations:

- structural integration, including integrated financial, legal, or governance structures;
- functional integration, describing the development of policies and protocols to support integration;

### **Box 2: Identification, selection and synthesis of research evidence**

We identified research evidence (systematic reviews and primary studies) by searching Health Systems Evidence ([www.healthsystemsevidence.org](http://www.healthsystemsevidence.org)) and PubMed in February 2020. In Health Systems Evidence, we used the following search strategy: (integrated care OR integrat\*) AND health AND Ontario. In PubMed, we ran three searches. The first was: (integrated care) AND health AND Ontario). The second search was: (integrated care) AND health AND (indigenous OR Inuit OR First Nations OR Metis). The third search was: (integrated care) AND health AND (francophone OR French-language services). In addition, we searched grey literature for evaluation reports of integrated-care initiatives that were provincial in scope. We also conducted targeted Google searches to identify documents related to the included initiatives and drew on the personal files of study authors.

The results from the searches were assessed by two reviewers for inclusion. A document was included if it addressed integrated-care initiatives implemented at a provincial scale in Ontario and was not focused on a single condition.

For each report or primary research report we included in the synthesis, we documented the focus of the study or report, methods used, a description of the sample, the jurisdiction(s) studied, key features of the intervention or initiative, and key findings. We then used this extracted information to develop a synthesis of the key findings from the included studies and reports.

In addition to document review, we conducted key informant interviews with 14 key informants. Interviewees included individuals working as policymakers in Ontario, individuals who have supported previous integrated-care initiatives, managers of organizations and initiatives, frontline service providers and researchers.

- interpersonal integration, including interdisciplinary and inter-organizational teamwork;
- normative integration, referring to social features, what people believe, and how they behave together; and
- process integration, describing the course of care-delivery actions or activities (such as referral management and the use of shared care planning).(2)

This framework is similar to other frameworks, including the rainbow model of integrated care. (3)

OHT building blocks (which are derived from the ministry's original guidance document for OHTs), collectively encompass the five domains. Some building blocks correspond with a specific domain in Singer and colleague's framework. For instance, building block 4 (patient care and experiences) largely aligns with process integration. However, other building blocks cross multiple domains, highlighting that to be successful in any one of the building blocks requires consideration not only of other building blocks, but also multiple types of integration. For example, the OHT building block 3 (patient partnership and community engagement) includes structural elements (e.g., including patients in governance structures), functional elements (e.g., patient-relations processes), interpersonal elements (e.g., collaboration through co-design) and normative elements (e.g., a declaration of patient values).

Integrated-care initiatives in Ontario have focused on various components of integration. Rural health hubs, bundled care, and Health Links were all based on conceptualizing integration as voluntary, cross-sectoral collaboration to support person-centred care (for individuals with complex needs, within a single episode of care, and across a rural region, respectively). Rural health hubs and Health Links hubs were "low-rules," flexible initiatives with few core components. Bundled care, meanwhile, included defined patient populations, care pathways, and episode-based payment. Local Health Integration Networks (LHINs) involved more formal approaches to integration, with designated authority over planning, funding and integration (including mergers and amalgamations) within a geographic region. Community Care Access Centres, meanwhile, oversaw multi-sectoral community-based care, including community-based care coordination functions, while also managing integration across a number of contractual agreements. The French Language Health Planning Entities collaborated with LHINs to ensure legislative and regulatory requirements for French-language services were accounted for in planning, while the French Language Service Coordination functions of the LHINs coordinated French-language care for francophone patients. The programs implemented under the Indigenous Healing and Wellness Strategy integrated care across ministries and health sector, as well as across western and Indigenous ways of knowing, ensuring cultural safety in services. In Table 1 below, the components of previous integrated-care initiatives are mapped to corresponding OHT building blocks.

OHTs share some features with previous integrated-care initiatives. In particular, OHTs have also been described as a "low-rules" initiative, with substantial flexibility for local tailoring and adaptation. However, OHT building blocks encompass a much more comprehensive vision of integration than previous initiatives: no initiative described above fully addresses all eight OHT building blocks. OHTs also target a much broader context, including attributed populations based on healthcare-use patterns, and the complete continuum of care. This is important because key informants highlighted the importance of understanding the context of different integration initiatives, recognizing that initiatives aimed at population-level integration often demand more adaptability and are more complex to implement and evaluate than those targeting specific sub-populations or episodes of care. Integration focused on a segment of the population, such as a specific patient diagnostic group, requires coordination, collaborative partnerships and co-design, but requires less adaptivity across a health system than integration initiatives that are seeking to integrate health and social care for whole communities.(4) This rapid synthesis includes integrated-care initiatives across this spectrum, from initiatives targeting diagnosis-specific episodes of care (e.g., bundled care) to those aiming to integrate care across the continuum at a regional level (e.g., rural health hubs). However, OHTs are the first integrated-care initiative in Ontario to include the full scope of integration, the full spectrum of a regional population, and the full continuum of care.

**Table 1: Types of integration in Ontario integrated-care initiatives**



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<b>Initiative</b>	<b>Components</b>	<b>OHT building blocks (BB)</b>
Rural health hubs	<ul style="list-style-type: none"> <li>Voluntary networks of organizations to integrate care in a rural region</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #2: In-scope services</li> <li>BB #6: Leadership, accountability, and governance</li> </ul>
Integrated funding models	<ul style="list-style-type: none"> <li>Tightly defined patient population based on a specific diagnosis or procedure</li> <li>Multi-sectoral care pathways across a voluntary network of organizations</li> <li>Single payment for complete episode of care across the continuum</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #2: In-scope services</li> <li>BB #4: Patient care and experiences</li> <li>BB #6: Leadership, accountability, and governance</li> <li>BB #7: Funding and incentive structure</li> </ul>
Health Links	<ul style="list-style-type: none"> <li>Targets patients with complex needs and high healthcare utilization</li> <li>Coordinated care plans</li> <li>Voluntary networks of providers</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #4: Patient care and experiences</li> <li>BB #6: Leadership, accountability, and governance</li> </ul>
Local Health Integration Networks	<ul style="list-style-type: none"> <li>Plan and integrate care within a geographical area (where integration includes organizational mergers and amalgamation as well as coordination)</li> <li>Allocate funding to health services within a geographical area</li> <li>Include community engagement during planning activities</li> <li>Evaluate and monitor local health-system performance</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #3: Patient partnership and community engagement</li> <li>BB #6: Leadership, accountability, and governance</li> <li>BB #7: Funding and incentive structure</li> <li>BB #8: Performance measurement, quality improvement, and continuous learning</li> </ul>
Community Care Access Centres	<ul style="list-style-type: none"> <li>Coordinate access to home and community care in a geographical region</li> <li>Manage contracts with private not-for-profit and for-profit service providers</li> <li>Directly provide nursing services in three specific programs (rapid response for children and seniors with complex needs; mental health and addictions supports in schools; and palliative care)</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #2: In-scope services</li> <li>BB #4: Patient care and experiences</li> <li>BB #6: Leadership, accountability, and governance</li> </ul>
French Language Service Coordinators	<ul style="list-style-type: none"> <li>Coordinate French-language services within LHINs</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #4: Patient care and experiences</li> </ul>
French Language Health Planning Entities	<ul style="list-style-type: none"> <li>Collaborate with LHINs to plan delivery of healthcare services in accordance with legislative and regulatory requirements for French-language services</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #2: In-scope services</li> <li>BB #4: Patient care and experiences</li> <li>BB #6: Leadership, accountability, and governance</li> </ul>
Indigenous Healing and Wellness Strategy	<ul style="list-style-type: none"> <li>Multi-ministry collaboration</li> <li>Protected funding for Indigenous primary-care and community-care models</li> </ul>	<ul style="list-style-type: none"> <li>BB #1: Defined patient population</li> <li>BB #2: In-scope services</li> <li>BB #3: Patient partnership and community engagement</li> <li>BB #4: Patient care and experiences</li> </ul>

	<ul style="list-style-type: none"> <li>• Focus on cultural safety, holism, and community leadership and engagement</li> </ul>	<ul style="list-style-type: none"> <li>• BB #6: Leadership, accountability, and governance</li> <li>• BB #7: Funding and incentive structure</li> </ul>
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**Question 2:** What quadruple-aim outcomes have been achieved through integrated-care initiatives in Ontario?

The quadruple aim refers to four broad objectives for the health system: improved health outcomes; improved patient, family and caregiver experiences; keeping per-capita costs manageable; and improved provider experiences.<sup>(5)</sup> Working towards the quadruple aim is an explicit objective of OHTs.

Previous integrated-care initiatives have not consistently been evaluated according to quadruple-aim measures, but evaluations of health outcomes, costs and experiences do exist. However, key informants noted that while similar indicators were often measured across initiatives, the differences in program objectives prevent comparability. For instance, bundled care projects were highly targeted with respect to patient populations and applied to single episodes of care. Key informants suggested that this narrow focus facilitated the identification of relevant objectives and the achievement of quicker gains. In contrast, Health Links intentionally targeted patients with highly complex health needs, making it harder to identify appropriate measures and to achieve short-term gains. This complexity of determining, achieving and measuring targets is further increased in LHINs, which covered the entire population and a broad scope of care. Key informants noted that OHTs, while initially focusing on specific priority populations, will eventually have the complicated task of improving quadruple-aim outcomes across an entire population and care continuum, and suggested that teams keep this objective in mind during the early planning process.

Quadruple-aim outcomes of integrated-care initiatives are summarized in Table 2 and further described below. Outcomes of previous population-specific integrated-care initiatives in Ontario, namely French-language service coordinators, the French Language Health Planning Entities, and Indigenous Healing and Wellness Strategy, are included in Table 2 and are discussed further under the fourth question below (how have integrated-care initiatives in Ontario been adapted to meet the needs of specific populations?).

**Table 2: Quadruple-aim outcomes of previous integrated-care initiatives in Ontario**

Initiative	Quadruple-aim outcome			
	Health outcomes (and health service utilization)	Patient, family and caregiver experiences	Per-capita costs	Provider experience
<b>Rural health hubs</b>	<ul style="list-style-type: none"> <li>• Not available</li> </ul>	<ul style="list-style-type: none"> <li>• Not available</li> </ul>	<ul style="list-style-type: none"> <li>• Not available</li> </ul>	<ul style="list-style-type: none"> <li>• Some sites built relationships, trust, and knowledge of available services, and others faced challenges due to inter-organizational and inter-sectoral tension</li> </ul>
<b>Bundled care</b>	<ul style="list-style-type: none"> <li>• Greater reduction in length of stay, readmissions, and return to emergency department (6)</li> </ul>	<ul style="list-style-type: none"> <li>• Positive patient experiences, with some unmet caregiver needs particularly related to transition from acute care to community (7; 8)</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced per-episode costs (6)</li> </ul>	<ul style="list-style-type: none"> <li>• Interviewees reported that participating providers built relationships and knowledge of available resources</li> </ul>

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<b>Health Links</b>	<ul style="list-style-type: none"> <li>Relative to matched comparators, Health Links enrollees had poorer outcomes for hospitalizations, days in acute care, and emergency visits, with no difference for readmissions or primary-care follow-up (9)</li> </ul>	<ul style="list-style-type: none"> <li>Caregivers largely perceived Health Links as helpful, with variation in the degree of continuity of care they experienced (10)</li> </ul>	<ul style="list-style-type: none"> <li>Costs increased relative to comparators (9)</li> </ul>	<ul style="list-style-type: none"> <li>Interviewees reported that participating providers built relationships and knowledge of available resources</li> </ul>
<b>LHINs</b>	<ul style="list-style-type: none"> <li>Across the province, LHINs improved performance on some service indicators while performance on others declined, and performance gaps between LHINs widened over time (11)</li> </ul>	<ul style="list-style-type: none"> <li>Regional variation may adversely affect patient experience (11)</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>
<b>CCACs</b>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Surveyed patients indicated positive experiences (12)</li> <li>Regional variation may adversely affect patient experience (13)</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Regional variation in contracts may adversely affect provider experience (13)</li> </ul>
<b>French-language service coordinators</b>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Lack of role clarity and working outside of scope may affect provider experiences (14)</li> </ul>
<b>French Language Health Planning Entities</b>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Complex approval process and lack of role clarity may affect provider experiences (15)</li> </ul>
<b>Indigenous Healing and Wellness Strategy</b>	<ul style="list-style-type: none"> <li>Aboriginal Health Access Centres contribute to reduced emergency-room visits and time to follow-up after discharge, and improved chronic-disease management and health promotion (16)</li> </ul>	<ul style="list-style-type: none"> <li>Aboriginal Health Access Centres increase access to culturally competent health promotion services (16)</li> </ul>	<ul style="list-style-type: none"> <li>Not available</li> </ul>	<ul style="list-style-type: none"> <li>Funding shortages and jurisdictional barriers to federal and provincial collaboration have an impact on the achievement of IHWS objectives (16; 17)</li> </ul>

## **Health outcomes**

Little data was available that directly addressed health outcomes of previous integrated-care initiatives in Ontario. More commonly, evaluations studied health-service utilization as an indicator of quality of care. Utilization outcomes were mixed across initiatives.

An evaluation of bundled care showed positive results with respect to health-service utilization. Across six bundled-care pilot sites, participating facilities achieved greater reductions in length of stay (a reduction of 1.3 days in participating sites, compared to reduction of 0.57 days in non-participating sites).(6) Bundled-care facilities also achieved reductions of 6% for both 30-day return to emergency (or death), and 30-day readmission (or death), compared to no change on these indicators in non-participating sites.(9) The evaluation authors note that these positive results were driven by changes observed within the two largest bundled-care pilots, one of which focused on chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF), and the other on cardiac surgery.(6)

Health-service utilization indicators were not consistently improved in Health Links. A difference-in-difference study comparing Health Links enrollees with completed care plans to matched comparators found that: acute hospitalizations decreased by 16% for matched enrollees, but by 34% for matched comparators; days in acute care increased by 12% for matched enrollees and decreased by 15% for matched comparators; and ED visits decreased by 14% for matched enrollees and 30% for matched comparators.(9) There was no significant difference between enrollees and comparators for 30-day readmissions or seven-day primary-care follow-up.(9) In this evaluation, Health Links therefore did not appear to lead to improved utilization. This evaluation also found that no individual Health Links performed strongly on all health-service utilization measures. Instead, all Health Links demonstrated variability in improvements or setbacks across the set of measured indicators.(9)

An auditor-general report compared 15 provincewide health-service indicators for 2007 (the year of LHIN implementation) with 2015. LHINs' performance declined on eight utilization and process indicators (including those relating to readmissions, repeat visits and some wait times), improved on six (including those relating to length of stay in emergency rooms and some wait times), and did not change on one (cardiac bypass wait times).(11) The highest-performing LHINs were able to achieve targets set for 10 out of 15 indicators, while the lowest-performing LHINs met only four; gaps in performance were observed to widen over time.(11)

Evaluations of health outcomes or health-service utilization in rural health hubs and CCACs were not available.

## **Patient, family and caregiver experiences**

Patient, family and caregiver experiences have not been consistently assessed across integrated-care initiatives in Ontario. However, patient-experience surveys have been conducted in bundled care and Community Care Access Centres, while family and caregiver experiences were assessed for bundled care and Health Links.

Evaluations have pointed to positive patient experiences of some previous integrated-care initiatives, while regional variation has been identified as a concern. A mailed survey was sent to a random sample of bundled-care patients. More than 900 patients responded to the survey; 87% of patients reported a positive in-hospital experience, and 88% reported positive post-discharge experiences. Also, 87% felt their own and their family's preferences were taken into account during the transition out of hospital.(7) At a provincial level, the Ontario Association of Community Care Access Centres reported that 93% of CCAC patients indicated positive experiences with CCAC care.(12) However, regional inconsistencies have been identified as a barrier to consistent positive patient experiences across Ontario's CCACs.(13) This regional variation is an artifact of the historical development of CCACs: 43 CCACs were developed in the 1990s, but these were collapsed into 14 larger bodies in 2007. While three direct patient-care programs were subsequently rolled out through CCACs across the province (rapid-response nursing, mental health and addiction nurses, and a palliative care nurse practitioner program), other patient-facing services are provided through private-sector contracts which often predate service amalgamation and which vary across the province. Regional variation has also been identified as

a problem affecting patient experience across the LHINs.(11) However, the impact of regional variation on patient experiences in CCACs and LHINs has not been formally evaluated.

Family and caregiver experience information was assessed in evaluations of bundled care and Health Links. Caregiver surveys were sent out with bundled-care patient surveys, and over 150 caregiver surveys were returned. Hospital and community experiences were largely positive for caregivers, with 77% reporting a positive in-hospital experience during the program, and 83% reporting positive post-discharge experiences.(8) However, transitions between hospital and community were more challenging. Only 59% reported being included in transition planning, and 41% were not asked if they were able or willing to help with the patient's care.(8) A mixed-methods study involving 27 surveys and 16 in-depth interviews explored caregivers' perceptions of Health Links.(10) This study found that caregivers perceived care coordinators as helpful. Most caregivers received copies of the patient's care plan, but some caregivers felt that they were not consistently included in care planning, and that care plans did not reflect their needs as caregivers. Caregiver perceptions of the continuity of care achieved through Health Links varied; where care was continuous, caregivers felt supported by the Health Links program. Out-of-pocket costs were noted as a challenge for caregivers.(10)

Patient, family and caregiver experience information was not available for rural health hubs or LHINs.

### **Keeping per-capita costs manageable**

Cost was assessed in bundled care and Health Links. Bundled care was successful in reducing costs over specific episodes of care: per-patient savings over 30 days were \$1,297 greater for participating facilities than non-participating facilities; over 90 days, the cost savings were \$1,719 greater.(6) In Health Links, total health-care costs increased in both enrollees and comparators, but with a steeper increase among enrollees (from \$43,300 to \$57,900 per person-year, compared to an increase from \$44,400 to \$53,300 among comparators).(9) This suggests that Health Links did not attain cost-control objectives.

Both LHINs and CCACs have been criticized for not measuring the cost-effectiveness of interventions.(11; 13) An auditor-general report noted that CCACs' costs could be reduced through measures to shift the proportion of funding away from administrative costs. The report also noted that contracted service providers (both for-profit and not-for-profit) derive profit from CCAC funding, and that this represents another area where cost-control measures could be targeted.(13) However, the overall impact of a CCAC service model on cost control has not been evaluated. There is a similar lack of data and analysis to demonstrate the cost impacts of LHINs, in particular, the effects of cost-control measures including integration of back offices and group purchasing were not systematically assessed.(11)

Cost information for rural health hubs was not available.

### **Provider experiences**

Provider experiences were not directly measured or evaluated in any of the initiatives included in this synthesis. However, key informants noted that bundled care and Health Links had benefits for providers including stronger relationships among providers, and greater awareness of services and resources. Key informants suggested that this relationship, together with awareness-building, could help providers to address patient needs more holistically.

It was also noted that integrated-care initiatives could provoke or exacerbate tensions among providers. In the rural-health-hubs pilot, some sites built relationships, trust and knowledge of available services, and others faced challenges due to inter-organizational and inter-sectoral tension. The development of LHINs faced opposition from physicians and health-profession unions, who were concerned about lack of input and potential threats to jobs, respectively.(18) However, the impact of LHINs at maturity on provider experience remains to be explored. In CCACs, while regional variation may contribute to inequity in patient experiences as explored above, this variability also affects providers: when the former 43 CCACs were amalgamated into the

more recent set of 14, old contracts were retained. As a result, providers offering identical services can receive different rates of pay. These different rates were retained in a 2012 standard service agreement.(13)

### **Issues in evaluation**

Evaluations and key informants noted facilitators and barriers to evaluation of previous integrated-care initiatives in Ontario.

Key informants with knowledge of the bundled-care implementation process noted a number of facilitators of evaluation: the evaluation process was planned before the initiative was launched; readiness assessment to participate in bundled-care pilot projects included the capacity to collect and manage relevant data; the six pilot projects jointly negotiated a shared set of holistic outcome measures, and ensured comparable data was available; and an active community of practice shared learning along the way.

However, for the other initiatives reviewed in this synthesis, evaluation processes were not built into implementation plans. Logic models tracing inputs, activities, outputs, outcomes and impacts were not publicly available for the reviewed initiatives. Key informants working at the provincial level noted they were not aware of logic models used in the development and implementation of bundled care or Health Links, with the exception of a “maturity model” for Health Links developed several years into the implementation process. However, key informants did note that logic models were sometimes developed at the local level, for example, by a specific Health Link or bundled-care project. This reflects the “low-rules” nature of these initiatives, which allowed for substantial variation and invocation at the local level. Key informants suggested that evaluation would be facilitated by having clear objectives set at the provincial level at the outset of a new initiative. Key informants further spoke to the importance of developing shared indicators and evaluation plans across local iterations of provincial initiatives and noted the importance of working with the Ministry of Health to facilitate this.

The availability of data also posed a challenge for evaluation efforts. Evaluation of Health Links has importantly been facilitated by the development of a registry of enrollees, which was not in place in the early years of the initiative. However, challenges with the registry persist: an evaluation of Health Links notes that 10,871 completed care plans were evident in the Client Health and Related Information System (CHRIS), but 36,772 completed plans were reported to Health Quality Ontario, suggesting a great deal of relevant patient data was unable to be included in evaluation studies. The study authors call for well-planned reporting systems and attention to the manner in which these systems are rolled out.(6) Key informants further stressed the need for registries and noted the importance of collecting data relating to all quadruple-aim objectives. In particular, key informants called for measuring patient engagement, quality of organizational partnerships, and clinician engagement, as these are key ingredients in sustaining integration. One key informant with experience in the rural health hubs project spoke to the importance of contextually relevant data. This informant noted that some common indicators made less sense in the context of a small rural community with few services, and as such evaluation needed to reflect local realities. Evaluation of outcomes and experiences of specific populations, such as francophone populations, are also limited by the lack of available data on population-specific interactions with the health system.(15)

Evaluation is a core component of OHTs, comprising the eighth building block (performance measurement, quality improvement, and continuous learning). Data is also highlighted in building block 5 (digital health). OHTs therefore have an opportunity to proactively develop plans to generate data and evaluate outcomes to inform ongoing improvement.

**Question 3:** What barriers and facilitators have been encountered during implementation of integrated-care initiatives in Ontario?

We identified an overarching context of implementation in a low-rules environment, along with eight thematic groupings of implementation facilitators and barriers. Leadership and to a lesser extent trust were topics that came up across many of these thematic groups.

### **Implementation in a low-rules environment**

When discussing implementation barriers and facilitators, academic and grey literature sources and key informants all highlighted the unique challenges of implementation within a low-rules environment. This is particularly relevant for OHTs, which are being developed within a flexible policy framework.

Successful implementation in a low-rules environment was found by key informants and in the literature to require both tolerance for risk and a willingness to embrace complexity,(19; 20) and strategies to mitigate uncertainty including a clear set of core components and predictable funding.(20) Key informants described the latter as facilitating the former. Stable funding was described as an essential enabler of bold action, since organizations already operate on tight budgets and may be hesitant to take on risk. Accountability agreements were also noted as a barrier to innovative and risky action in low-rules environments, since failure to meet original mandates would further threaten funding. With respect to clear expectations, key informants stressed the importance of establishing clear objectives at the outset in order to manage uncertainty and facilitate planning. A key informant with experience in primary care further noted that these objectives must be understood, not only by health-system leaders, but also by the clinicians ultimately implementing these policies. Meanwhile, a key informant with experience in the Ministry of Health suggested that organizations should work closely with the Ministry to develop shared guideposts and expectations. It was also noted by key informants that many people involved in OHTs have previous experience from past low-rules integrated-care initiatives. Key informants highlighted the need for transparent expectations from the ministry, up-front delivery of funding, and support for information technology as critical to address the challenges that had limited previous integrated-care initiatives.

Beyond this balance between embracing and managing uncertainty, a number of other barriers and facilitators were identified. These were fairly consistent across initiatives, and between academic and grey literature and key informant interviews. These are reviewed below and mapped onto OHT building blocks.

### **Flexible and patient-centred planning**

The importance of a flexible planning process that places patient needs at the centre was highlighted in studies, evaluations and key informant interviews. Stakeholders interviewed in an evaluation of bundled care noted that models needed to be thoughtfully developed to match patient needs, incorporating ground-up feedback from across the care continuum.(21) Participants in the bundled-care evaluation also suggested building models that can account for complexity, including social complexity.(22) A study of Health Links' implementation process suggests that identifying a feasible target population was a crucial first step in the planning process.(20) Efforts to identify patients based on catchment areas needed to be abandoned in order to adopt a more flexible approach, manageable within the constraints imposed by data availability.(20) Key informants further underscored the importance of a flexible, patient- and family-centred, ground-up planning process. Planning processes also needed to account for variation in local resources and geography; for instance, one key informant noted that geographic barriers must be considered in rural contexts in order to be able to meet patient needs. These influences on implementation align most closely with OHT building blocks 1 (defined patient population) and 4 (patient care and experiences). OHT building block 3 (patient partnership and community engagement) may also facilitate patient-centredness in planning processes.

### **Technological factors**

Technological barriers identified in implementation studies included the lack of shared electronic records, the need for clinicians to buy in and invest time in learning to use new systems,(21) and the need for IT support to manage transitions to new platforms.(23) These messages were reinforced by all key informants, who noted the barriers posed by a lack of shared communication systems. These barriers included difficulties tracking patients across the care continuum due to a lack of shared electronic records. One key informant also noted that information-sharing requires trust as well as technology: organizations need to feel confident that their partners will manage information appropriately. Another pointed to a need for information systems that reduced, rather than added to, workload. A final key informant strongly stressed the necessity of adequate funding to develop information technology systems, describing this as an essential – and often neglected – component in supporting integration. OHT building block 5 (digital health) addresses the need for integrated data systems to support integrated care.

### **Legal factors**

Legal issues relating to data sharing, as well as to organized labour, also presented barriers during the implementation of integrated care. Although data sharing was acknowledged across the literature as an important component in integrated care, integrated-care efforts in Ontario have been hampered by difficulties in navigating privacy legislation. A study of bundled-care implementation noted that when partnering organizations held differing interpretations of privacy legislation, efforts to work towards sharing information were further hindered.(21) Concerns about the barriers posed by privacy legislation were echoed in evaluations of Health Links (23) and by key informants involved in both initiatives. Meanwhile, with respect to organized labour, an evaluation of facilitators and barriers in the early stages of Health Links implementation noted that health-profession unions queried what inter-organizational working would mean for existing contracts.(23) As described above, “grandfathering in” of contracts during CCAC amalgamation has also created ongoing challenges with respect to equitable compensation and standardization of services.(13) Legal factors specific to data sharing are important to building block 5 (digital health), while issues relating to collective agreements are most relevant to building block 6 (leadership, accountability and governance).

### **Policy factors**

Some implementation barriers related to relationships between organizations and the ministry. A commentary on early Health Links implementation found that time-intensive, multi-stage approval processes and a lack of clear communication lead to lost momentum and engagement.(19) Silos within the ministry and the perceived slowness of ministry responses were further barriers identified by stakeholders in a separate Health Links implementation study.(23) Interviewees in the latter study also reported feeling pressure to produce deliverables while still in the planning stages, and that this perceived pressure reduced their ability to engage in fulsome planning processes.(23) Key informants echoed the above concerns and also noted challenges including short notice for policy changes, leaving little time to plan and adapt. Policy-related factors described above are most relevant to OHT building block 6 (leadership, accountability, and governance) which includes accountability agreements between OHTs and the Ministry of Health.

### **Inter-organizational factors**

At the inter-organizational level, studies of the implementation of both bundled care and Health Links found that size and resource discrepancies among partnering organizations could present a challenge.(20; 21) Large organizations benefited from being well-resourced, but were often inflexible and resulted in slower processes. Smaller organizations were more nimble and able to make iterative revisions but lacked crucial resources. Difficulties could arise in navigating these different ways of working; in bundled care, these difficulties were even found to lead to the breakdown of one organizational partnership.(21) Sectoral differences were also identified as a source of conflict, in particular through resistance from the hospital sector to primary-care leadership during the early implementation of Health Links.(23) Of note, no particular sector was found to be more effective in leading Health Links; rather, involved stakeholders suggested that the lead organization’s reputation within the community and track record of innovation were critical.(19) Inter-organizational tensions



could also be provoked by overlapping governance. During LHIN implementation, the existence of parallel governance bodies – LHINs overseeing regional health system concerns, and boards overseeing individual organizations, including hospitals – created opportunities for tension and even impasse.(18)

On the other hand, studies of the implementation of bundled care and Health Links consistently found that pre-existing collaborations and experience with integration facilitated the implementation of novel integrated-care initiatives.(19-22) When integrated-care initiatives involved new relationships, concerted efforts towards building relationships and trust were critical.(20; 21) These efforts could include exposure to partnering organizations' practices, in particular across sectoral (hospital/community) divides.(21) During bundled-care implementation, providers came to appreciate and value the work done in other sectors.(21) Many key informants further stressed the centrality of strong relationships to integrated-care initiatives, including at the level of individual clinicians. Relationship-building was described by key informants as a necessary first step before any other steps in the planning process could proceed. It was also noted that some teams may need facilitation of relationship-building.

Inter-organizational factors relate most closely to OHT building block 6 (leadership, accountability and governance), while inter-sectoral issues may also arise under building block 2 (in-scope services).

### **Clinical factors**

Clinician engagement was critical across initiatives, and clinician hesitation could pose a barrier. In particular, physicians raised concerns around billing and loss of autonomy during Health Links implementation.(23) A key informant noted that physicians, in particular those in small or solo practices, may also lack capacity for engaging in integrated-care initiatives. Different strategies were used to foster clinician engagement. Bundled-care implementation was facilitated by engaging clinicians in model development, using clinical champions, and leveraging established relationships with care coordinators.(21) Key informants also stressed the importance of engaging clinicians, especially primary-care providers. One key informant described successful clinician engagement occurring in the context of SCOPE (Seamless Care Optimizing the Patient Experience), a Toronto-based initiative: this project supported physician engagement through social persuasion and social marketing strategies and drew on a family physician lead who provided direct outreach to physicians in solo practice. Another described developing care pathways that empower team members, by focusing on principles of care rather than strict standardization, and by balancing accountability with autonomy. Four key informants noted that integration ultimately happens at the front lines, and as such can be facilitated by ensuring clinicians understand the policy objectives and their role within it. Provider engagement is an element of OHT building block 6 (leadership, accountability, and governance).

### **Financial factors**

Funding issues affected implementation in a number of ways. In some initiatives, funding delays presented a barrier for integration. Some organizations were able to overcome delays through bridge funding offered from other sources, while others lost momentum in their planning and implementation processes as a result.(20) Consistency in funding was also an issue: a key informant stated that funding was sometimes variable across waves of implementation, describing an instance where pilot projects had access to funding for project management while subsequent sites of the same project did not. Another pointed to the importance of considering sustainability and scale when developing funding models. Literature and key informants also identified barriers that occurred when human and technological resources were not adequately funded. Stakeholders interviewed for an implementation evaluation of Health Links identified a need for resources to support the time demands of care coordination.(23) Two key informants echoed this concern, noting the difficulties inherent in implementation efforts that require providers to “work off of the side of their desk.” Two key informants also noted that unstable funding lead to short-term contract-based hiring, and subsequently high turnover that affected continuity across implementation. Finally, reports noted the importance of aligning funding with policy,(22) such that the incentives embedded in funding arrangements are compatible with the objectives of integration. Funding falls into OHT building block 7 (funding and incentive

structure); relationships between OHTs and the Ministry of Health also fall into building block 6 (leadership, accountability, and governance).

### **Organizational culture**

Finally, organizational culture was identified as an important ingredient in successful implementation efforts. A shared vision for integration and a culture of collaboration were found to enable early implementation of Health Links in two evaluations,(20; 23) while stakeholders involved in bundled care called for shifting from a culture of cost-saving to one of sustainability.(22) Other elements of organizational culture that key informants described as facilitators of integration included a sense of urgency, common purpose, embracing risk and disruption, and a willingness to share rather than “own” successes achieved through integration. Key informants described these characteristics as especially crucial at the leadership level, with a need for strong leaders who were willing to change, adapt, and “lead from behind.” Key informants also suggested that meaningful partnering with patients and community would facilitate future integration efforts. One suggested that organizations committed to genuine, empowering, patient-centred relationships would be more likely to manage transformational (as opposed to incremental) change, while another pointed to the crucial importance of empowering communities to identify needs and develop solutions. Organizational culture crosses OHT building blocks, with a shared vision of integration animating and linking each of the blocks.

**Question 4:** How have integrated-care initiatives in Ontario been adapted to meet the needs of specific populations?

Several key informants highlighted the need to tailor integrated-care initiatives to population- or community-specific needs. These informants highlighted condition-specific adaptations (such as for children, or for individuals with complex mental health needs) as well as adaptations specific to francophone, Indigenous, and LGBTQ communities. Critical to these adaptations was creating space to build adaptations into integrated-care initiatives from the beginning, rather than addressing them as “add-ons”. OHTs will need to engage with a wide diversity of patients and communities. They are specifically accountable for services for and with francophone and Indigenous communities, and as such can draw on learnings from past Ontario initiatives within these communities.

### **Francophone populations**

The *French Language Services Act, 1990* (FLSA) established a right for Ontarians to communicate in French with, and receive services in French from, the Ministry of Health and its agencies in 26 designated areas.(24) The LHINs were required to fulfil the requirements of the *French Language Service Act* in the planning, design, delivery and evaluation of services, while also promoting health equity and respect for diversity across Ontario’s French-speaking community. As part of the approval process, OHTs are required to describe how they have engaged and will engage francophone communities in their work, and how they will improve care for francophone communities.

Six French Language Health Planning Entities are mandated to support the planning and integration of health services for francophone populations throughout Ontario. Each of the French Language Health Planning Entities is assigned to a unique geographic area served by two or three of the 14 LHINs. Through a set of formal and informal agreements, the LHINs and the French Language Health Planning Entities collaborate to plan the delivery of healthcare services in accordance with legislative and regulatory requirements for French-language services in Ontario. Key informants cautioned that an organization’s designation as a French-language public-service agency must be maintained over time to ensure continuity in French-language services, including during changes to institutional arrangements or new policies or legislation.

Flexibility has been noted as a strength of the French Language Health Planning Entities, while clarity and distinction of roles was highlighted as an area for improvement. An evaluation of the French Language Health Planning Entities described them as important connectors across service providers, community organizations,

and community leaders. This same evaluation of the French Language Health Planning Entities identified considerable variability in how the model is operationalized, shaped by socio-economic profiles, working relationships with their associated LHINs, and the organizational capacity of each French Language Health Planning Entity. Overall, the model was seen as sufficiently flexible to accommodate these varying contextual factors.(15) However, the same evaluation report highlighted confusion around mandates and overlapping roles and responsibilities, particularly between the French Language Services Coordinator positions within the LHINs and the associated French Language Health Planning Entities, leading to delays in implementation. In response, the ministry undertook a comprehensive review and consultation around existing legislative and accountability requirements related to French Language Health Services.(25) While this provided greater clarity around the roles and interdependent responsibilities between the ministry, LHINs and French Language Health Planning Entities, some key informants suggested that community-based organizations, while not mandated or funded to do so, often also take on care coordination roles with their clients. Key informants recommended having clearly stated requirements for French-language health services for OHTs, to help chart a clearer path for organizations to support OHTs in complying with those requirements.

Patient outcomes and experiences within French-language integrated-care initiatives have not been reported. This is in part because of a critical lack of quantitative data on francophone clients and their interactions with the healthcare system.(15) Key informants emphasized the importance of requiring the collection of francophone-specific population-health and utilization data to support effective planning and evaluation. Meanwhile, the previously mentioned evaluation of the French Language Health Planning Entities also recommended broader engagement with the francophone population.(15) The importance of engaging francophone communities and service organizations early on in integration initiatives was emphasized by several key informants, as was the need for customization to the diversity of francophone, and other, communities.

While provider experiences were not evaluated, the same evaluation suggested that lengthy and complex approval processes to become a designated French-language health-service provider limited the availability of resources available to the population.(15) This was further confirmed by key informants, while recognizing some provincial efforts to pilot a simplified designation process. A report produced by EntitéSanté also highlighted the need to catalogue available resources and French-language providers to support collaborative care;(14) key informants described a regularly updated inventory of francophone-specific human resources around the province developed by one of the French Language Health Planning Entities and now funded by the ministry and publicly available. French-language patient navigators were seen as critical resources for integrating care with francophone populations. In a report from one of the French Language Health Planning Entities, navigators described often working outside of their prescribed job description, and their limited ability to influence care teams and decision-making.(14)

No formal evaluations of health outcomes or per-capita costs of integrated care initiatives for and with francophone communities were identified.

### **Indigenous populations**

There are several initiatives across the province aimed at strengthening culturally appropriate healthcare for Indigenous people, guided by Ontario's Aboriginal Health Policy and the Indigenous Healing and Wellness Strategy (IHWS). Established in 1994, the IHWS is a provincial initiative led by the Ministry of Children, Community and Social Services, and jointly funded by the Ministry of Health and Long-Term Care and Indigenous Affairs. This strategy includes funding for 10 Aboriginal health access centres, three Aboriginal community health centres, one Aboriginal nurse practitioner-led clinic, and one Aboriginal family health team across the province. These provide a comprehensive array of health and social services including primary care, traditional healing, mental wellness, cultural programs, health promotion, community development initiatives and social support services.(17)

Early data from a report from the Ontario Association of Aboriginal Health Access Centres indicate that access centres contribute to reducing emergency-room visits and time to follow-up after discharge, and increasing comprehensive cancer screening, chronic-disease management and culturally safe health education and promotion.(16) These successes are crucial: according to an evaluation report, clients seen by Aboriginal health access centres and Aboriginal community health centres, on average, require 30-50% more primary care and have more comorbidities compared to the provincial average.(14) The most frequently accessed services at Aboriginal health access centres include diabetes care, smoking cessation, mental health services, hypertension services, and well care.(14) However, many Aboriginal health access centres face considerable funding shortages, critically limiting their capacity to meet population needs.(26) Aboriginal health access centre reports also highlight jurisdictional barriers to federal and provincial collaboration not encountered by integrated care with non-Indigenous populations in Ontario.(16; 17) In a response to the province's *Patient's First Action Plan* (2015), the Aboriginal health access centres and community health centres outlined the need for increased engagement and autonomy of Indigenous communities in health and inter-sectoral decision-making, and the need for increased accountability to the Ontario Aboriginal Health Policy.(16) Similarly, the *People's Health Care Act* (2019) recognizes the central role of Indigenous people in the planning, design, delivery and evaluation of health services in their communities.(27)

Beyond initiatives funded under the Indigenous Healing and Wellness Strategy, each LHIN also worked closely with Aboriginal communities to better understand local needs, priorities and opportunities. Each LHIN collaborated with a local lead, and developed engagement and strategic plans; the LHIN leads also formed a Provincial Aboriginal LHIN Network to advise the LHINs CEO table. Common focus areas across LHINs were cultural competency training, mental health and addiction services, palliative care, and diabetes. An annual report from the Provincial Aboriginal LHIN network indicated that 10 out of 14 LHINs developed and met targets around staff and board cultural competency training, while recognizing that some targets needed to be increased.(28)

Evaluations of Indigenous-focused integrated-care initiatives along the quadruple aim were not identified. However, an analysis of the integration of Anishinaabe healing practices in primary care in rural northern Ontario found that patients reported receiving more culturally competent services, while providers emphasized that the development of traditional healing guidelines was an essential element for the successful integration of traditional and western health services.(29) A recent review of Indigenous-led health-service partnerships in Canada identified greater integration of western and traditional approaches as critical to supporting health and well-being in Indigenous communities and the province more broadly. This includes building relationships with Indigenous health practitioners and elders, among others, and strengthening community ownership, autonomy and self-determination towards Indigenous-led health services.(30) These principles are essential for OHTs, which are expected to reduce health inequities experienced by Indigenous people, redesign care to meet the diverse needs of Indigenous populations, and deliver culturally safe care for Indigenous people in Ontario, while recognizing the inherent rights of Indigenous people to control their own health services.(31)

The findings outlined above are limited by the fact that they are drawn primarily from document reviews available in Ontario. Unfortunately, we were unable to secure interviews with involved stakeholders during the 60-day timeline for producing this synthesis. While documents offer important insights for OHTs, in order to fully understand and represent the lessons learned from integrated-care initiatives with Indigenous people in Ontario, key informants involved in these initiatives would have to be fully engaged in this synthesis. Key informant perspectives will be integrated into future versions of this synthesis.

## **CONCLUSIONS**

Previous experiences with integrated care in Ontario offer a number of key lessons for Ontario Health Teams.

- OHTs face a challenging task: seeking to integrate care across the continuum of care for a population based on health-care-utilization data will require different strategies than prior initiatives focused on sub-populations or distinct episodes of care.
- Outcome evaluation can be facilitated by developing a plan for evaluation, and supporting data infrastructure, prior to rollout. Tracking the quadruple-aim impact of OHTs will therefore require up-front decisions on objectives, measures and data sources.
- Implementation of OHTs may be supported by facilitators identified in the rollout of previous integrated-care initiatives: stable funding, support to navigate legal barriers, investment in and development of data-sharing systems, trust-building among involved organizations, flexible and patient-centred planning processes, engagement of clinicians, and the development of a shared vision for integration. Like previous low-rules initiatives, OHTs will need to strike a balance between embracing risk and mitigating uncertainty, with strategies for the latter including clear objectives and funding arrangements.
- OHTs can support francophone communities by engaging with existing resources early in their development, tailoring services and structures to diverse populations and geographies, and clarifying the roles of existing supports.
- OHTs can support Indigenous communities by offering culturally competent care, ensuring respectful and early engagement of existing Indigenous-focused services and communities, integrating Indigenous and western approaches, and ensuring Indigenous self-determination in services.

This rapid synthesis also identified several areas that may be of interest for further exploration, many of which were suggested by key informants. There is a rich body of literature describing international and other Canadian integrated-care initiatives that could further inform Ontario's health reform. Many regional and condition-specific integrated-care initiatives across Ontario were identified through document reviews, and several were highlighted as important sources of learning by key informants.

Given that this synthesis was prepared during a pandemic and provincial state of emergency, several key informants did not have the opportunity to contribute. This synthesis will be updated as opportunities to engage with key informants is appropriate.

A subsequent RISE synthesis will examine the impact of the COVID-19 pandemic on OHTs and their efforts toward integrating care in Ontario, and how integration within OHTs has affected their pandemic responses.

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## APPENDICES

The following tables provide detailed information about the review of reviews, primary studies, and grey literature (including reports, evaluations, and other documents) identified in the rapid synthesis.

All of the information provided in the appendix tables was taken into account by the authors in describing the findings in the rapid synthesis. Appendices are organized by integrated-care initiative: first province-wide initiatives in reverse chronological order, and then population-specific initiatives in reverse chronological order.

### Appendix 1: Bundled care

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Evaluating integrated funding models through a difference-in-difference approach (5)	<p><i>Publication date:</i> 2019</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Difference-in-difference analysis</p>	A total of 6,005 index events from patients were identified from project registries from integrated funding models (IFM). These were propensity-matched to index events from historic events from the same facility, and concurrent events from non-participating facilities (which were then matched with historic events within that facility). Change in IFM sites were then compared to non-IFM sites.	Six bundled-funding initiatives were included. Three bundles addressed chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF), and one each addressed stroke, cardiac surgery, and urinary tract infection (UTI) and cellulitis. Each addressed episodes of care that began in acute care and included post-discharge home and community care. The number of participating acute-care facilities in each bundle ranged from one to nine.	Compared to non-participating facilities, facilities participating in bundled care achieved greater reductions in length of stay (reduction of 1.3 days compared to reduction of 0.57 days). Bundled-care facilities also achieved greater reductions in 30-day emergency-department visit or death rate (6% for participating, no change for non-participating) and readmission or death rate (6% for participating, no change for non-participating), although only two individual projects achieved significantly greater reductions on these measures than comparators. Per-patient savings were \$1,297 greater for participating facilities. All results were driven largely by changes observed within the two largest integrated-funding models, one of which focused on COPD/CHF and the other on cardiac surgery.
Patient experiences of integrated funding models (6)	<p><i>Publication date:</i> 2018</p> <p><i>Jurisdictions studied:</i> Ontario</p> <p><i>Methods used:</i> Survey</p>	Patient-experience surveys were mailed out to a random sample of integrated funding model patients. Total sample size	The intervention was any one of six integrated-funding-model pilot projects. Features of the	A total of 86.7% of patients reported a positive in-hospital experience, and 87.9% reported positive post-discharge experiences. Also, 86.7% felt their own and their family's preferences were taken into account during the transition out of hospital, and 79.5% felt they received enough information

		and response rate are not described in this document. No more than 951 respondents replied to any individual question.	intervention are not described in this document.	to know what to do if worried about their health post-discharge.
Caregiver experiences of integrated funding models (7)	<p><i>Publication date:</i> 2018</p> <p><i>Jurisdictions studied:</i> Ontario</p> <p><i>Methods used:</i> Survey</p>	Caregiver-experience surveys were included along with a patient-experience survey mailed out to a random sample of integrated-funding-model patients. Total sample size and response rate are not described in this document. No question received more than 158 responses.	The intervention was any one of six integrated-funding-model pilot projects. Features of the intervention are not described in this document.	Results are presented without interpretation. A total of 77% of caregivers reported a positive in-hospital experience during the program, and 83.2% reported positive post-discharge experiences. Also, 58.5% reported being included in transition planning, and 40.9% were not asked if they were able or willing to help with the patient's care. More than half spent greater than 10 hours per week caregiving, and more than 20% spent more than 20 hours per week caregiving.
Evaluating integrated funding models (21)	<p><i>Publication date:</i> 2019</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Combines a number of studies including the difference-in-difference analysis, stakeholder interviews, and patient and caregiver surveys. Note that many of the studies included in this report are also cited separately in this synthesis.</p>	<p>The implementation evaluation included 66 stakeholders over two rounds of interviews. Stakeholders included policymakers, managers, clinical champions and care coordinators.</p> <p>The patient-experience survey was completed by over 900 randomly selected IFM patients; 159 caregiver-experience surveys (mailed out along with patient-experience surveys) were also completed. Twenty patients of COPD/CHF programs completed in-depth interviews.</p> <p>Baseline monitoring was based on a set of common indicators.</p>	<p>Six bundled-funding initiatives were included. Three bundles addressed COPD and CHF, and one each addressed stroke, cardiac surgery, and UTI and cellulitis. Each addressed episodes of care that began in acute care and included post-discharge home and community care.</p> <p>Each pilot developed a time-limited care pathway for a specific client population, funded as a single bundle. Elements of each pilot differed.</p>	<p>An implementation evaluation (cited elsewhere in this synthesis; Embuldeniya, 2018) found that drawing on existing strengths including prior partnerships and clinician engagement facilitated implementation. Where these factors were not in place, building trust, clinician engagement, communication strategies, and careful model development were essential. Stakeholders suggested aligning funding and policy, developing standardized frameworks for data collection, ensuring evaluation captured meaningful data, considering primary-care intake, developing patient-centred care models that account for complexity and social needs and have an adequate bundle length, shifting focus from cost-saving to sustainability, and addressing local context during scale and spread.</p> <p>Patient and caregiver surveys suggested that patients had more positive hospital experiences than caregivers. Care transitions were rated less positively than in international comparators, with concerning evidence that caregivers in particular did not feel prepared or consulted. Both in-hospital and post-acute experiences varied across pilots, which may reflect the extent to which pathways for different conditions were clear and defined.</p> <p>In-depth interviews with CHF and COPD patients found that patients valued self-management skills, tailored resources, 24-hour phone support, strong rapport, and connectivity during</p>

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		<p>The comparative effectiveness analysis used a propensity-matched sample of IFM patients and similar non-participating patients.</p>		<p>transitions. Patients did not have a strong understanding of the program and did not always feel empowered to ask questions about their care. Some experienced unmet needs and others felt overwhelmed by services.</p> <p>Baseline monitoring demonstrated reduced lengths of stay by more than 20% and readmissions by more than 19% in four projects out of six projects, and three reduced emergency visits by more than 20%. In the final year of the pilot, two projects had increased emergency-department visits relative to baseline, and two had increased readmissions relative to baseline.</p> <p>A comparative effectiveness analysis found that participating facilities achieved greater reductions in length of stay, readmissions, emergency-department visits, and costs over time relative to non-participating facilities (see data for Walker, Hall, and Wodchis, 2019 above).</p> <p>Key overall recommendations by report authors were to “go fast” in implementing bundles for surgical care across the province, and to “go slow” in exploring scale and spread of models for bundled medical care, given more uneven successes and greater complexity.</p>
<p>Case study exploring how integration was developed in six bundled-funding projects in Ontario (20)</p>	<p><i>Publication date:</i> 2018</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Multiple case study involving content analysis of key informant interviews, and realist evaluation of cases</p>	<p>Sampled all six pilot projects engaged in the first wave of bundled funding efforts in 2015. Within each organization, interviews were conducted with stakeholders, including organizational leaders, managers, physicians, and care coordinators. A total of 48 interviews were conducted.</p>	<p>“Bundled care” involves providing a pre-specified amount of funding to a group of providers to deliver the complete continuum of care for a specific diagnostic group or intervention. Each of the six bundled-care pilots included organizations from multiple health sectors including acute and community care. Organizations formed voluntary networks and identified a specific population or procedure to address through a bundled initiative.</p>	<p>Six context-mechanism-outcome configurations were identified. First, program structure influenced outcomes, with differences in size, practices, and resources among partnering organizations posing a barrier; in one case, resource discrepancies led to a smaller organization dropping out of the initiative. Second, pre-existing relationships among organizations facilitated implementation of bundled care. Third, trust was built through time and exposure to partnering organizations’ practices, in particular across sectoral (hospital/community) divides. Fourth, models needed to be thoughtfully developed, incorporating ground-up feedback from across the care continuum. Fifth, clinicians could be engaged through involvement in model development, use of clinical champions, and leveraging of established relationships with care coordinators. Sixth, information sharing was challenging in the absence of shared platforms and mutual understandings of privacy legislation; developing shared information systems required clinician buy-in to learn how to use these systems.</p>

<p>Literature review addressing early bundled care initiatives in Ontario and making recommendations for future policies (31)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario and international</p> <p><i>Methods used:</i> Literature review</p>	<p>Literature review</p>	<p>Some existing bundled-care efforts which include value-based payment for a single episode of care were described.</p>	<p>Internationally, a stronger evidence base exists for bundled care for single-disease groups, but the authors argue for a focus on more complex populations to address the prevalence of multimorbidity in contemporary healthcare. They note that internationally, jurisdictions were more likely to bundle complex care if they had prior experience with care integration.</p> <p>In the Ontario context, at the time of publication some CCACs had experimented with single-disorder bundled care. A bundled-care approach to school-based speech-language pathology treatment is described, with evidence of reduced waitlists and provider satisfaction. Other attempts including CCAC-led bundled wound care have been less effective because patient complexity prevents determining accountability for outcomes.</p> <p>The authors argue that Ontario and international examples suggest the following success factors: a centralized care team; an organizational culture committed to change; a focus on care continuity; a shared electronic health record; and trusting and collaborative relationships between partners. They suggest starting with bundling care rather than bundling payment, and building models around patient needs, using the example of Toronto Central CCAC's efforts to create a "one client, one team" experience for defined complex populations.</p>
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Appendix 2: Health Links

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
<p>Hospital utilization and costs among Health Links enrollees with completed care plans, and matched comparators (8)</p>	<p><i>Publication date:</i> 2019</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Pre-post analyses of health utilization indicators were conducted using generalized estimating equation regressions.</p> <p>Propensity-matched difference-in-difference analysis</p>	<p>Patients enrolled in Health Links between 2014 and 2017, with a completed care plan recorded in the Client Health and Related Information System (CHRIS) registry (n=10,871).</p>	<p>Health Links is a low-rules policy supporting local care coordination for individuals with likely high healthcare utilization, as suggested by the presence of four or more medical conditions. Coordinated care plans are a central feature of Health Links.</p>	<p>In pre-post analyses, it was found that hospitalizations decreased by 17% in the year after care-plan completion from 1.23 to 1.02 events per person-year. Days in acute care increased by 10% from 14.5 days to 15.9 days per person-year on average. Emergency-department visits decreased 14% from 2.2 to 1.9 events per person-year. Thirty-day readmissions and seven-day primary-care follow-up did not change significantly. For all of the above indicators, increases in utilization were observed among enrollees who died in the year after care-plan completion. Costs increased by 35% per person-year (from \$44,900 to \$60,800) in an analysis of two years following care-plan completion. Only one Health Link sub-region achieved improvement in some indicators without having worsening performance on others.</p> <p>In the propensity-matched difference-in-difference analysis: acute hospitalizations decreased by 16% for matched enrollees, but by 34% for matched comparators; days in acute care increased by 12% for matched enrollees and decreased by 15% for matched comparators; and ED visits decreased by 14% for matched enrollees and 30% for matched comparators. There was no significant difference between enrollees and comparators for 30-day readmissions or seven-day primary-care follow-up. Costs increased in both groups, but with a steeper increase among enrollees (from \$43,300 to \$57,900 per person-year, compared to an increase from \$44,400 to \$53,300 among comparators).</p> <p>The study authors note that only 63% of Health Links patients in fact had four or more chronic conditions, despite this criterion serving as guidance for identifying the target population. They further note that rates of mortality and of psychosocial concerns were high, and questions remain about access to palliative and mental healthcare. Finally, while 10,871 completed care plans were evident in CHRIS, 36,772 completed plans were reported to HQO, suggesting a need for careful design and implementation of reporting systems.</p>

*Lessons Learned from Integrated-care Initiatives in Ontario to Inform Ontario Health Teams*

<p>To understand experiences of caregivers for Health Links patients (9)</p>	<p><i>Publication date:</i> 2020 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> Survey and in-depth qualitative interviews</p>	<p>Twenty-seven caregivers completed the survey and 16 took part in interviews. Caregivers lived in six different regions in Ontario.</p>	<p>Participants were all caregivers for an adult client of Health Links.</p>	<p>Participants viewed care coordinators as helpful. Most caregivers had copies of the patient’s care plan, but some caregivers felt that they were not consistently included in care planning but that care plans reflected their needs as caregivers. Caregiver perceptions of the continuity of care achieved through Health Links varied; where care was continuous, caregivers felt supported by the Health Links program. Caregivers who did not feel care was continuous and coordinated also did not feel supported by the program. Out-of-pocket costs were noted as a challenge for caregivers.</p>
<p>Discuss key leadership and governance issues influencing the implementation and success of the Health Links (18)</p>	<p><i>Publication date:</i> 2015 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> Key informant interviews</p>	<p>Participants included leaders and providers from Health Links and Local Health Integration Networks (LHINs) as part of the study, “Understanding the Context for Integrating Care,” funded by the Health System Performance Research Network and the Ontario Ministry of Health and Long-Term Care</p>	<p>Not applicable</p>	<p>Reputation, existing relationships and partnerships, and style of the leading organization were found to matter more than type of organization (e.g., hospital versus primary-care led). Other important leadership qualities include: positive image in community and among providers; track record of innovating and following through on commitments; and tolerance for change, risk and ambiguity. Important expertise in existing assets and experience of navigating previous integration initiatives were also seen as helpful characteristics of successful organizations leading integration efforts.</p> <p>Extended and time-intensive multi-stage approval processes led to loss of momentum and engagement. There was a lack of explicit attention to instilling and spreading shared view and understanding among managers and staff around strategies, roles and relationships. Emphasized the need for facilitates conversations to identify, unpack and explore conflicting or unspoken assumptions.</p> <p>“Low-rules” approach may be more appropriate during planning and implementation, with greater standardization to sustain model and identify core change elements. Lack of standardization may contribute to duplication of work, variations in quality and access, and confusion among patients and providers who cross intervention boundaries.</p> <p>There is a potential for better knowledge sharing between Health Links to identify best practices and creative solutions to shared technical and operational challenges.</p> <p>Role clarity and clear lines of communication are needed across the ministry, LHINs and Health Links.</p>

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<p>Lessons from the implementation of Ontario's Health Links (19)</p>	<p><i>Publication date:</i> 2017</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Key informant interviews with stakeholders from regional governance bodies and organizations partnering in Health Links. Qualitative interview data were coded using the key concepts of complex adaptive systems of sense-making, self-organization, interconnections, co-evolution, and emergence.</p>	<p>A total of 37 interviews were conducted with 55 participants. In phase 1, 26 managers and administrators from all 14 LHINs were interviewed. In phase 2, 29 participants representing 38 of the 56 then-active Health Links across 14 LHINs (some participants worked with more than one Health Link) were interviewed. Participants were recruited from a variety of organizations including primary-care practices (48%), hospitals (35%), and community-based organizations (17%). The majority of participants worked in the Health Links initiative in addition to their regular full-time duties. Maturity of Health Links ranged from early implementation to two years since implementation.</p>	<p>No specific intervention described.</p>	<p>Complexity compatible policy design stimulated local delivery dynamics, experimentation and learning, but ability to implement this varied across different Health Links. Groups that had previous experience with integrated interventions were more comfortable with Health Links approach (e.g. FHTs). Contexts that viewed complexity as healthy and inherent were better able to navigate a “low-rules” context.</p> <p>Leadership is critical in coordinating existing top-down dynamics with the emergent, self-organizing nature of Health Links. There is a need for a few, simple well-defined goals, strong communication and feedback, and measuring of performance while allowing for autonomy and adaptation through implementation and across different sites. Authors reported that Health Links did not have sufficient balance between experimentation, adaptation and standardization both in ministry directives and implementation. Interventions with well-defined core components may help lessen anxiety around remaining flexible.</p> <p>A partnering process created new connections between organizations and professionals; working through partnership process also led to collective sense-making.</p> <p>Health Links needed more structured opportunities for feedback and shared sense-making to support knowledge sharing and “trickle up” learning to inform policy and structures.</p> <p>Identifying patients by condition based on catchment population was abandoned because of challenges identifying and reaching them; once a patient was identified and care was the focus, implementation moved forward more easily.</p> <p>Funding delays stifled innovation and slowed momentum; some LHINs provided bridge funding and many organizations struggled to redirect resources to support integration.</p> <p>Large organizations with more resources often delayed processes and lacked flexibility; small flexible organizations designed iteratively and were more nimble, but often lacked important resources.</p>
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<p>To identify how early adopter Health Links defined and created value, and to describe barriers and facilitators to realizing long-term plans for Health Links (22)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Interviews</p>	<p>Twenty-one stakeholders (including executive directors, steering committee members and other leaders) were interviewed, representing 10 Health Links. Health Links were selected for inclusion based on advancement of implementation and promising practices, as well as variation in setting, location, and type of lead organization.</p>	<p>At the time of this study, Health Links was in its second year of implementation.</p>	<p>Health Links moved from retrospective to real-time identification of target populations and expanded their definitions beyond initial expectations to encompass additional patients who may benefit from coordinated care. Interviewees described value in terms of patient experience, quality and safety of care, seamless care, and cost or service use. Few considered population health.</p> <p>Early adopter Health Links tended to be built on pre-existing collaborations. Where hospitals were the lead organization, a more top-down leadership style was observed; primary care-led Health Links tended to have a more horizontal approach. Health Links in rural locations or those with a smaller lead organization were observed to have a broader scope of integration (i.e., to integrate care throughout the organization, not only for high users). Some Health Links restricted their efforts to care coordination, while others developed interdisciplinary programs.</p> <p>A number of strategies to create value were identified. In the domain of individual care, these included patient engagement and tools for patient-provider communication, seeking “quick wins” through appropriate use of existing, complementary resources (e.g., tele-home care programs for COPD), attaching care coordinators to primary care, allowing flexibility in the organization leading care for each patient, creating dedicated primary-care clinics, and having inter-organizational and inter-disciplinary care coordination round tables. Additional strategies to facilitate care coordination included engaging all potential partners and drawing on external facilitators and a leadership secretariat. At the population-health level, strategies for value included earlier identification, expanding inclusion criteria to address social determinants, and use of standardized tools and notification systems to identify potential patients. In the cost domain, strategies included “risk of readmission” tools and a rapid-referral clinic to reduce emergency department use.</p> <p>Early development of value included inter-organizational relationships (including engagement of primary care and social services) and capacity for coordinated care planning. Interviewees also mentioned patient satisfaction, small health gains, and reduced emergency-department use.</p>
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				<p>Identified enablers of Health Links included flexibility for local adaptations, strong pre-existing partnerships, a culture of collaboration, and data-sharing agreements. Challenges included managing billing and physician compensation, financial uncertainty in the absence of a long-term funding model, legal issues with respect to data sharing and liability, union responses to inter-organizational working, lack of IT support, duplication across Health Links, struggles over leadership (including hospital resistance to primary-care leadership), sustainability and scale-up, slow responses and silos within the ministry, and pressure to produce deliverables in the early stages of transformation. Interviewees expressed a need for resources, including IT systems, human resources to address the time demands of care coordination, and resources to meet social needs including housing.</p>
<p>Hospital utilization and costs among Health Links enrollees and matched comparators (32)</p>	<p><i>Publication date:</i> 2018</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Pre/post analysis of select indicators using generalized estimating equation regressions. Analyses were conducted on the entire population and on sub-populations of interest.</p> <p>A propensity-matched, difference-in-difference design was then used to compare enrollees to similar, non-enrolled patients.</p>	<p>Data were drawn from the Health Link registry and linked administrative databases. All individuals in the registry with a “Health Links start” date from 2012-2016 were included, regardless of coordinated care-plan completion. A total of 10,368 individuals were included in the study.</p> <p>A total of 8,945 enrollees were matched to comparators for the propensity-matched difference-in-difference analysis. Matched enrollees tended to have less service use and lower costs than unmatched enrollees prior to enrolment.</p>	<p>Health Links is a low-rules policy supporting local care coordination for individuals with complex health and social needs. Coordinated care plans are a central feature of Health Links.</p>	<p>Enrollees had reduced new admissions per person-year, with 1.42 admissions per person-year before enrolment and 1.28 after. Number of days in acute care decreased from an average of 17.9 days to 14.1, although relative reductions decreased for each year of follow-up. Among low-income enrollees, days in acute care increased following enrolment. The decrease in emergency-department visits was not statistically significant. Readmissions did not change. Significant increases in primary-care visits within seven days of discharge were only observed in the 2013/14 cohort and were marginal. Costs per person increased by 55%, with the relative difference in costs decreasing each cohort. However, costs decreased when only enrollees surviving one year after enrolment were included.</p> <p>In the propensity-matched analysis, it was found that comparators had greater decreases in hospital admissions and emergency-department use compared to enrollees. Days in acute care increased among matched enrollees and decreased among comparators. There were no significant differences in readmissions among either group. Enrollees had marginally higher rates of seeing primary care within seven days of discharge, but the difference-in-difference relative to comparators was not significant. Costs increased in both groups, with a steeper increase among enrollees. These findings should be interpreted cautiously as matched enrollees differed from the population as a whole.</p>

				Increase in costs and acute-care use observed following index among enrollees are likely attributable at least in part to mortality, as utilization and costs increase at end of life. The authors suggest considering the appropriateness of the Health Links model for people at the end of life.
To report on the baseline performance of Health Links among palliative and end-of-life populations (33)	<p><i>Publication date:</i> 2016</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Health Links were grouped into deciles by performance on seven indicators of palliative and end-of-life care. Health Links were also compared to provincial averages. Caterpillar plots were used to compare Health Links grouped by deprivation, rurality, and lead organization type.</p>	Administrative data was used to identify two cohorts within the 2012 fiscal year: patients discharged home from hospital and identified as receiving palliative care (8,590 discharges among 7,357 patients), and end-of-life patients (decedents; 91,130 patients). These patients were assigned to a Health Link based on primary- or usual-care provider postal code, or individual's postal code when there was no provider.	Reports on baseline (pre-intervention) performance. A total of 67 Health Links were in operation at the time of the report.	<p>Home support for palliative patients varied widely, from 25.0-52.1% among the lowest decile of Health Links, to 81.3-90.0% among the top decile. Similarly, estimates for 30-day readmissions for palliative patients ranged from 46.0-54.2% in the poorest-performing decile, to 17.3-25.6% in the top-performing decile. For both of these indicators, rural Health Links performed more poorly than urban Health Links. Palliative hospital readmissions ranged from 37.7-41.9% in the poorest-performing decile to 18.5-21.3% in the top decile, with little variation by rurality. Material deprivation was generally not associated with palliative-care indicators.</p> <p>Emergency visits in the two weeks preceding death ranged from 44.0-47.6% for the poorest-performing decile, to 32.5-37.0% for the top-performing decile. Rurality was not associated with this indicator, but material deprivation was associated with poorer performance. End-of-life costs were 40% higher in the lowest decile of Health Links compared to the top decile, with higher costs in urban Health Links, and lower costs in Community Health Centre-led Health Links. Proportion of deaths in hospital ranged from 58.6-62.6% in the poorest-performing decile, to 35.2-39.9% in the top-performing decile; poor performance was associated with deprivation. Days in hospital at the end of life ranged from 5.3-12.0 across Health Links, with urbanity and deprivation associated with more days in hospital. Pockets of high performance, where a Health Link performed strongly across all end-of-life indicators, were apparent.</p> <p>Overall, variation on palliative and end-of-life indicators occurred at the LHIN level, rather than the level of individual Health Links. Deprivation tended to be associated with worse performance; urban Health Links tended to perform better on palliative indicators and worse on end-of-life indicators.</p>
To describe trends in health-service utilization and costs among Health	<p><i>Publication date:</i> 2016</p> <p><i>Jurisdiction studied:</i> Ontario</p>	Individuals in the Health Links target population were those under the age of 105 with an	Health Links is a low-rules policy supporting local care coordination	Across all members of the target population, costs per month alive decreased by 1%, low-acuity ED visits decreased by 10%, and seven-day primary-care follow-up

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<p>Link's target population in Health Link catchment areas from 2012 (when Health Links was first launched) to 2014 (34)</p>	<p><i>Methods used:</i> Longitudinal trends and relative change were calculated for specific indicators between 2012 and 2014</p>	<p>active OHIP card and four or more medical conditions. A total of 514,848 individuals were included for 2012, and 546,450 were included for 2014. These individuals were assigned to one of 82 Health Links based on primary-care or usual-care providers' postal code, or own postal code when there was no provider.</p>	<p>for individuals with complex health and social needs.</p>	<p>increased by 2% between 2012 and 2014. ED visits increased by 4%. Hospitalizations, hospital 30-day readmissions, and primary-care enrolment did not change significantly.</p> <p>For members of the target population not assigned to one of the 82 Health Links, no indicators changed significantly except ED visits, which increased by 4%.</p> <p>Among individual Health Links, there was wide variation in the extent of changes on any given indicator. No individual Health Link was consistently a high or low performer across all indicators.</p>
<p>To report on baseline indicators for Health Links (35)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Administrative data was used to measure indicators within geographic bounds of individual Health Links. Health Links' performance were compared to the provincial average and to informal physician networks, and were also compared by rurality, early adopter status, and a marginalization index to assess differences.</p>	<p>Administrative data was included for the 2012 fiscal year, for all residents of Ontario with an OHIP card. Ontarians were assigned to a Health Link based on primary-care or usual-care providers' postal code, or own postal code when there was no provider. Indicators were calculated for two populations: 1) all Ontarians; and 2) top 5% high users. The lack of a Health Links registry prevented specifically sampling enrolled patients.</p>	<p>Reports on baseline (pre-intervention) performance. Fifty-four Health Links were in operation at the time of the report.</p>	<p>Analysis of Health Link performance at baseline showed a great deal of variability. No Health Link consistently performed well or poorly across all indicators. Performance was also variable for Health Links within a single LHIN.</p> <p>Urban Health Links tended to perform well on costs and low-acuity ED use, and poorly on primary-care rostering, with the reverse pattern observed for rural and suburban Health Links. Among top 5% users, monthly costs and primary-care rostering were higher than average in urban Health Links, while costs for this population were lower than average in rural Health Links. While urban Health Links tended to perform equally well on their total and top 5% populations, rural Health Links tended to perform comparatively better on their top 5% population than their total population. Overall, urban Health Links (and physician networks) tended to perform better than provincial average, and rural Health Links (and physician networks) tended to perform worse.</p> <p>Higher marginalization predicted worse performance for both the total and top 5% populations, although this effect was less strong for top 5% users.</p>

### Appendix 3: Local Health Integration Networks

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
<p>Auditor General Evaluation of LHINs (10)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Audit at four selected LHINs (Central, Hamilton Niagara Haldimand Brant, North East, and Toronto Central), including reviews and interviews at HQO, Cancer Care Ontario and the Ministry</p>	<p>Primarily at four selected LHINs - Central, Hamilton Niagara Haldimand Brant, North East, and Toronto Central</p> <p>Document review, KII (including CEO and Board Members of all 14 LHINs)</p>	<p>Assess whether Local Health Integration Networks (LHINs), in conjunction with the Ministry of Health and Long-Term Care (ministry), have effective systems and procedures in place to facilitate the provision of the right care at the right time in the right place for Ontarians.</p>	<p>The lack of a clearly articulated vision of what would constitute a “fully integrated health system” or measuring how effective LHINs are at performing as planners, funders and integrators of care limited the possibility of effectively evaluating the LHINs.</p> <p>The ministry set out 15 areas of performance for measuring effectiveness of LHINs around access to health services, coordinated healthcare and high-quality health services. For 11, there were both a provincial target (ideal target) and LHIN-specific targets (negotiated based on past performance and local challenges). Overall performance declined from 2007 (or 2010 depending on when data was available) to 2015 for:</p> <ul style="list-style-type: none"> <li>• readmissions within 30 days for selected case mix groups (CMGs);</li> <li>• percentage of alternative levels of care (ALC) days;</li> <li>• repeat unplanned emergency visits for patients with mental health conditions;</li> <li>• repeat unplanned emergency visits for patients with substance abuse conditions;</li> <li>• cataract surgery provided within 182 days;</li> <li>• hip replacement provided within 182 days;</li> <li>• knee replacement provided within 182 days; and</li> <li>• diagnostic CT scan provided within 28 days.</li> <li>•</li> </ul> <p>Performance remained consistent from 2007 to 2015 for cardiac by-pass procedures provided within 90 days. Performance improved from 2007 (or 2009 when earliest comparable data available) to 2015 for:</p> <ul style="list-style-type: none"> <li>• Length of stay (LOS) in emergency room for admitted patients;</li> <li>• LOS in emergency room for complex patients not admitted to hospital;</li> <li>• LOS in emergency room for non-complex patients not admitted to hospital;</li> <li>• MRI scan provided within 28 days;</li> <li>• cancer surgery provided within 84 days; and</li> <li>• wait time for CCAC in-home services.</li> </ul>

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Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				<p>The best performing LHIN met local targets in 10 areas, and worst performing LHINs (4) met only four. Performance gaps between LHINs widened over time. There is a need to better understand reasons for the widening gap and implement changes to narrow that gap.</p> <p>No timelines were established for when all 14 LHINs were expected to meet provincial targets. Performance measures primarily assessed effectiveness of hospital care with few measures of LHIN performance as planners, funders and integrators of health care.</p> <p>LHINs were not able to assess whether their planning and integration activities were effective in providing a more efficient and integrated health system or determining how much cost-savings have been reinvested into direct patient care as a result. There were few accountability mechanisms in place to correct low performance.</p> <p>LHINs were unable to demonstrate economic efficiencies through group purchasing, and “back-office” integration resulted in cost savings or service efficiencies. Cost-effectiveness was not systematically assessed and varied greatly between LHINs.</p> <p>Patient Experiences: Inconsistency in care and levels of integration result in inequities in care and excessive costs across the province.</p> <p>Provider Experiences: Greater planning capacity is needed to match services to population needs, along with a system to leverage and utilize real-time data for planning, health-provider performance and patient complaints.</p>
<p>Policy analysis of integration and regionalization within the LHIN reforms (17)</p>	<p><i>Publication date:</i> 2018</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Policy analysis based on documentary and historical data</p>	<p>Not applicable</p>	<p>Implementation of LHINs</p>	<p>Many interest groups such as the Ontario Hospital Association and Community Health Centres supported the LHIN reform, approving the goals of integration and increasing responsiveness of the system. However, other stakeholders including the Ontario Medical Association (OMA), Ontario Health Coalition (OHC), the Canadian Union of Public Employees and the Ontario Public Service Employees Union (CUPE/OPSEU) actively opposed the LHINs (Gardner 2006). The OMA was concerned about negligible input from front-line physicians in the integration of health services, and similarly, the OHC felt there was no</p>

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				<p>public input in the development of LHINs, further worrying that LHINs would be dominated by the provincial government rather than the community (Gardner 2006). Unions were concerned about the loss of jobs through integration or centralization of services, and competitive bidding to fund home-care providers with LHINs as the purchaser of health services (CUPE 2005).</p> <p>The ministry lacked oversight and the LHINs did not consistently monitor nor evaluate whether their integrated health-service plans were effective in achieving an integrated local health system. Inadequately measured targets and performance of LHINs to plan, fund, and integrate healthcare hamper progress towards system integration and evidence-based reinvestment into further system improvements. Regionalization is a “means for others to find a solution.”</p> <p>Physicians are not under LHIN authority as they retain their independence through fee-for-service contracts with the provincial government. Physicians, the main deliverers of primary care, are then outside of LHIN control and do not have accountability for patient outcomes back to LHINs. Additionally, Ontario’s choice to retain local healthcare-organization boards may have, in fact, created barriers to health-system integration. The parallel existence of two governance structures (local healthcare-organization boards responsible for organizational oversight and LHIN boards responsible for overall regional oversight) can create opportunities to reach an impasse, preventing quick decision-making by the LHINs to improve patient care in the region.</p>

**Appendix 4: Community Care Access Centres**

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
<p>How CCAC's Care - An Update on Quality Improvement for Patients (11)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Internal evaluation, methods not specified</p>	<p>This evaluation included the 14 Community Care Access Centres (CCACs) in Ontario. CCACs are responsible for helping people access home- and community-based health care and related social services outside a hospital setting.</p>	<p>Not applicable</p>	<p>The number of more complex patients with higher needs has increased by 83 per cent since 2009/2010.</p> <p>There was a 41% increase in personal-support hours from 2010 to 2014. Of nearly 29,000 patients surveyed, 92% reported positive care experiences from CCAC. Since 2009, 10.4% more people are going home from hospital with support and 49% fewer people are going to long-term care homes from hospital. In 2014-15, 94% of patients received first visit within 5 days; 85% of complex patients received first visit within five days.</p>
<p>Office of the Auditor General of Ontario audited financial operations and service delivery at CCACs, as well as the Ontario Association of Community Care Access Centres in response to a request from the Legislature's Standing Committee on Public Accounts in 2014 (12)</p>	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> Document review, key informant interviews, survey with follow-up interview; analyzed compensation information, expense trends, review of care protocols in Ontario and compared to international best practices</p>	<p>Key personnel and documents of the Ministry of Health and Long-Term Care (ministry), selected Community Care Access Centres (CCACs), the Ontario Association of Community Care Access Centres (association), and nine contracted service providers receiving 69% of total CCAC spending on procured direct services in the year ending March 31, 2014. Visited three CCACs that serve regions of various geographical sizes and that have budgets of various sizes. Met with key personnel from the LHINs that oversee these three CCACs. Obtained information from 11 remaining CCACs through a survey, and followed up with all of them regarding their responses.</p>	<p>Not applicable</p>	<p>Rationale: To date, there had been no thorough evaluation of the current CCAC service-delivery model to ensure that this model is optimally providing consistent and quality care. A key factor contributing to the inconsistencies in the current model that any evaluation should address is the unsystematic manner in which home- and community-based health initiatives have evolved in Ontario.</p> <p>This report highlighted inconsistencies in care delivery across the 14 CCACs, where patients with similar conditions were not consistently treated using agreed-upon best practices.</p> <p>This report also suggested greater streamlining of funding could contribute to cost savings and opportunities for more consistent adoption of best practices related to spending funds and overseeing employed and contracted staff. No analysis had been done to link spending on patient outcomes.</p> <p>There were also inconsistencies in CCAC CEO compensation framework as service-provider CEOs followed different frameworks. The lack of cost/benefit analysis of new service models (e.g. CCAC nurses providing services under three new programs (rapid response, mental health and addiction, and palliative care) made evaluation difficult and the effectiveness of these programs has not been evaluated.</p>

## Appendix 5: Integrating care for francophone populations

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Evaluation of 6 Entité as part of Local Health Integration Network- French Language Health Planning (14)	<p><i>Publication date:</i> 2015</p> <p><i>Jurisdiction studied:</i> Ontario Local Health Integration Network - French Language Health Planning Entity Model</p> <p><i>Methods used:</i> Document review, 99 key informant interviews, 2 focus groups</p>	Six French Language Health Planning Entities	Each Entité is assigned to a geographic area served by two or three of the 14 LHINs. Through a set of formal and informal interactions, both the LHINs and the entities collaborate in order to appropriately plan for the delivery of healthcare services in accordance with the legislative and regulatory requirements related to French language services in Ontario.	<p>The lack of clearly delineated roles and responsibilities between the LHINs (in particular, the French Language Services Coordinator positions) and the Entités initially triggered some confusion and delays. This led to confusion around a common understanding of the nature and scope of interactions that both parties are expected to have with service providers, community organizations, and other stakeholders.</p> <p>The Entités model operates differently in the various regions of the province due to the differences in the socio-economic profile of each francophone community, the nature of the collaboration between the LHIN and the entity, the number of LHINs assigned to each entity, and their respective organizational capacity. The model has proven to be sufficiently flexible to accommodate these variations.</p> <p>There is very limited quantitative data on francophone clients and their interactions with the healthcare system. This remains a critical gap in the planning process. Engagement in the Entities has involved service providers, community organizations, and community leaders, however, broader engagement of the francophone population has been limited.</p> <p>Complex and lengthy approval processes for designated service providers is sometimes seen as a barrier to supporting French language services.</p>
Report on Lessons Learned from French-Language Health System Navigators (13)	<p><i>Publication date:</i> 2019</p> <p><i>Jurisdiction studied:</i> Hamilton Niagara Halidimand Brant and Waterloo Wellington</p> <p><i>Methods used:</i> Surveys and key informant interviews</p>	Seniors, community members, service providers in Welland, Hamilton and Cambridge, with a special focus on those experiencing social isolation.	Not applicable	<p>The French-language navigator role was reported as going beyond the prescribed job description and as both a benefit and a challenge. There is limited ability of navigators to influence cooperation within care teams and of decision-making authority. Navigators need greater capacity in understanding how to address social determinants of health</p> <p>There is continued need to raise awareness of available resources (policies and procedures to facilitate collaboration, cataloguing organizations and providers offering services in French.) Gaps in available resources (lack of forms/information in French, English resources not adapted to needs of francophones, navigators cover vast territory, often unavailable) are areas requiring continued improvement. Additional opportunities for mentoring within and across Entités are recommended</p>



**Appendix 6: Integrating care for Indigenous populations**

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
<p>Aboriginal Health Access Centres and Aboriginal Community Health Centres - Report to Communities (16)</p>	<p><i>Publication date:</i> 2016</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> In-depth interviews and focus groups (17 service providers, 23 clients)</p>	<p>Findings from 10 AHACs, three Aboriginal CHCs, one Aboriginal NPLC, and one Aboriginal FHT</p>	<p>Not applicable</p>	<p>Clients seen by AHACs and Aboriginal CHCs require, on average, 30%-50% more primary care compared to the average Ontarian, and 40% of the AHAC population require higher healthcare overall, compared to 16% of the Ontario population. Of the AHAC population, 57.1% have five or more co-morbidities, compared to a provincial average of 43.6%. 15.4% of the AHAC population served have 10 or more comorbidities, compared to a provincial average of 7.7%. The top reasons for clients accessing primary-care services are: Type 2 diabetes, smoking cessation, mental health, hypertension and wellness care.</p> <p>AHACs report actively breaking down jurisdictional barriers by working with First Nations, Inuit and Métis (FNIM) communities and provincial health systems to integrate federal and provincial health resources.</p> <p>About half of the AHACs and Aboriginal CHCs, along with the Aboriginal Nurse Practitioner-Led Clinic (NPLC) and Aboriginal Family Health Team (FHT), serve non-insured clients. The Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs) invest approximately \$45-million in 10 AHACs, three Aboriginal CHCs, one Aboriginal NPLC, and one Aboriginal FHT. A total of 10 Traditional Healer positions are funded to base budgets.</p> <p>AHACs and ACHCs provide health services in the following Indigenous languages: Oji-Cree, Cree, Inuktitut, Iroquois, Mohawk and Ojibway. Primary-care services are provided through the Ontario Telemedicine Network (OTN).</p>
<p>Provincial Aboriginal LHIN Report (27)</p>	<p><i>Publication date:</i> 2016</p> <p><i>Jurisdiction studied:</i> Ontario</p> <p><i>Methods used:</i> analysis of LHIN-based data</p>	<p>Snapshot of the progress that LHINs have made around four areas of focus: Advancing Aboriginal Cultural Competency Training; Alignment of Mental Health and Addictions; Aboriginal Hospice Palliative Care Planning; and</p>	<p>Each LHIN has a dedicated staff lead to facilitate care and to engage directly with local Aboriginal communities. These LHIN Leads have formed a community of practice called the Provincial Aboriginal LHIN Network (PALN), which is linked to the LHINs CEO table. LHINs have common areas of focus: Advancing Aboriginal Cultural Competency Training;</p>	<p>Most LHINs have developed local Aboriginal advisory structures to provide recommendations and guidance around appropriate and respectful engagement and inclusion of Aboriginal/First Nations in healthcare decision-making. These advisory circles, networks and committees provide an accountability mechanism between the healthcare system and the Aboriginal communities. Enhanced cultural competency has facilitated better relationships. LHINs have also developed relationships beyond the LHIN-funded health-service providers.</p> <p>Based on the 2013-14 PALN Report, 10 of 14 LHINs reported that they developed and met targets around staff and board training in</p>

*Lessons Learned from Integrated-care Initiatives in Ontario to Inform Ontario Health Teams*

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
		Supporting Aboriginal Engagement in Diabetes	Alignment of Mental Health and Addictions; Aboriginal Hospice Palliative Care Planning; and Supporting Aboriginal Engagement in Diabetes.	2013-14 on Indigenous Cultural Competency training; however, the target levels varied between 25% and 100%. Four LHINs had not yet met their targets, and one LHIN had yet to develop a target.
Integration of Anishinaabe healing practices in primary care in rural northern Ontario (28)	<p><i>Publication date:</i> 2010</p> <p><i>Jurisdiction studied:</i> Northern Ontario</p> <p><i>Methods used:</i> In-depth interviews and focus groups (17 service providers, 23 clients)</p>	Documents lessons learned and critical processes to integrate traditional Anishinaabe healing practices and mainstream clinical services in rural northern Ontario.	Not applicable	<p>Development of traditional healing protocols, inter-professional education for providers and community members, and a focus on client access to traditional Anishinaabe health services provided the basis for the integration of western and traditional healing practices. Funding delays stifled innovation and slowed momentum; some LHINs provided bridge funding, though many organizations struggled to redirect resources.</p> <p>Patients reported benefits of culturally competent services including accessing care without fear of judgment, receive services that are appropriate for them and their beliefs, religions and personal backgrounds.</p> <p>Ongoing learning opportunities geared towards community members as well as Aboriginal and non-Aboriginal healthcare providers was highlighted as critical to sustainability. The development of traditional healing guidelines was an essential element for the successful integration of traditional and western health services.</p>





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