HEALTHCARE
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Politiques de Santé

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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision-making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision-makers.

We publish original scholarly and research papers that support health policy development and decision-making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision-makers or researcher–decision-maker collaborations that address knowledge application and exchange.

While *Healthcare Policy/Politiques de Santé* encourages submissions that are theoretically grounded and methodologically innovative, we emphasize applied research rather than theoretical work and methods development. The journal maintains a distinctly Canadian flavour by focusing on Canadian health services and policy issues. We also publish research and analysis involving international comparisons or set in other jurisdictions that are relevant to the Canadian context.

* * *

Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

Bien que *Politiques de Santé/Healthcare Policy* encourage l'envoi d'articles ayant un solide fondement théorique et innovateurs sur le plan méthodologique, nous privilégions la recherche appliquée plutôt que les travaux théoriques et l'élaboration de méthodes. La revue veut maintenir une saveur distinctement canadienne en mettant l'accent sur les questions liées aux services et aux politiques de santé au Canada. Nous publions aussi des travaux de recherche et des analyses présentant des comparaisons internationales qui sont pertinentes pour le contexte canadien.

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EDITORIAL

The Changing Face of Healthcare Delivery: Making Room for Other Disciplines

Each of Canada's provinces and territories needs to modernize its basket of insured health services to reflect a broader conceptualization of healthcare. The narrow focus on hospital and physician services excludes multidisciplinary care models, such as those reflected by Family Health Teams in Ontario, Groupe de médecine de famille in Québec and primary care networks in Alberta. In these models, a wider range of services and supports is being used to respond to changing demographics and patterns of morbidity, and whose residents' care needs include social workers, mental health providers, personal support workers and dietitians.

Research is also challenging provincial governments and healthcare service deliverers to modify programs and address factors related to health, such as with social care services. The silos of healthcare and social care are breaking down; the roles of homelessness, immigration status, accessibility of language services and food security on health and healthcare are clear. In some countries, barriers to integrating health and social care are being overcome and factored into healthcare delivery (Drewes et al. 2017; Harlock et al. 2020); similar new initiatives are needed in provinces and territories.

In This Issue

This issue of *Healthcare Policy* is focused on the confluence of topics related to a wider range of disciplines being folded into healthcare delivery, and building a case for closer integration of health and social care services. The latter is certainly overdue, as most provincial governments have split healthcare and social care ministries, each with independent governance and accountabilities.

The challenges associated with healthcare's assimilation of interdisciplinary models of care and integration with social care are aligned with international directions to reduce fragmentation between providers, integrate a wider range of healthcare services and address social care issues associated with aging, health and health outcomes.

A reader of this issue of *Healthcare Policy* might wonder if the province of Ontario is the genesis of all scholarship on Canadian delivery reform, as all articles are based on research from that province. While modest reform of healthcare delivery models is occurring elsewhere in Canada, a vibrant health services and policy research community in Ontario is following the province's innovation in developing and implementing team-based care and community-based delivery models.

This issue is led by a Discussion and Debate article that highlights the lack of policy and processes of healthcare or social care for Ontarians affected by homelessness (Jenkinson et al. 2020). The article provides evidence of poorer health outcomes among the homeless and a strong rationale for the following: prioritizing policy affecting this group of people, having stronger links between health and social care sectors and generating data to inform effective policy making. The issue of disparities in health outcomes attributable to homelessness is likely relevant to all provinces struggling to address gaps between healthcare and social care programs.

A rejoinder to the Discussion and Debate article adds that high rates of homelessness seen in provinces is a fairly recent phenomenon (Forchuk 2020). The rejoinder describes that homelessness is associated with higher use of emergency care and its basis is rooted in the following: a lack of policy prioritization; reductions in financial support by federal, provincial and municipal governments; high prevalence of mental health problems; and incentives for shortening length-of-hospital stay. The article concludes by describing promising developments on quickly identifying and supporting hospitalized homeless patients through linkages with housing and income support programs before the patient's discharge from the hospital.

Tadic et al. (2020) examine the role of social workers in interprofessional primary healthcare teams. Not unsurprisingly, the research finds significant variation in the amount and scope of social work services provided within interprofessional primary healthcare teams, with gaps in social workers being able to support patient's healthy living, self-management and chronic disease management. The article notes that there are significant limitations to data currently collected and reported from interprofessional teams, and points out that knowing the amount of social care services provided would be very beneficial to informing relevant policy.

Hutchison et al. (2020) report on Ontario's process for prioritizing and implementing performance measures for primary care. Indicators representing practice- and system-level performances were chosen, though the authors noted that indicators were missing at both levels, including mental health and comprehensiveness of care. The article describes that Ontario's alignment with the Canadian Institute for Health Information, and other provinces, on performance measures for primary care was poor, and concludes that consensus on the indicators is unlikely in the near term.

An article by Kiran et al. (2020) reports on the results of a survey measuring awareness and use of community services among primary care physicians. Contrasting team- and non-team-based primary care practices, the researchers found that team-based primary care practices were significantly more likely to be aware of, and refer to, community services. An inference of this research is that patients of non-team-based practices had potentially been disadvantaged in their access to community services.

In an article examining facilitators and barriers to accessing French-language healthcare, Savard et al. (2020) report that obtaining, and maintaining, access to French-language healthcare in Ontario is challenging for many patients. The research describes the complexity of the issue, noting that potential solutions span service availability and coordination between organizational, regulatory and policy structures of health and social care services.

Olaizola et al. (2020) report on a study examining the impact of minimum wage change on personal support workers' wages in Ontario. The research reported that while wages increased, the effects were difficult to attribute to the minimum wage policy because personal support workers' wages were concurrently rising in other provinces. The study also found that the minimum wage policy had no impact on personal support workers' hours or on the stability of their employment.

Special Focus on Research Related to COVID-19

This issue of *Healthcare Policy* concludes with an invited article from the Canadian Institutes of Health Research's Institute of Health Services and Policy Research (McMahon et al. 2020). The paper reports on the institute's findings of seven areas where COVID-19-related health services research is required, and three overarching themes: health of Indigenous Peoples and vulnerable populations, data and infrastructure, and learning health systems. The article concludes by articulating the need for vibrant health services and policy research as the reverberations of COVID-19 are felt by provinces' public health programs, across their health delivery systems and by all those impacted by the pandemic.

True to its mission, *Healthcare Policy* encourages submissions that engage Canadian healthcare policy makers on timely and relevant healthcare policy issues.

JASON M. SUTHERLAND, PHD
Editor-in-Chief

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ÉDITORIAL

Changements dans la prestation des services de santé : faire place aux autres disciplines

Les provinces et territoires du Canada doivent moderniser leur panier de services de santé assurés, adhérant ainsi à une conceptualisation élargie des services de santé. L'accent mis sur les services hospitaliers et la consultation médicale entrave la mise en place de modèles de soins multidisciplinaires, tels qu'on en retrouve dans les équipes Santé familiale en Ontario, les groupes de médecins de famille au Québec ou les réseaux de soins primaires en Alberta. Ces modèles proposent une vaste gamme de services et de soutien qui répondent aux changements démographiques et aux schémas de morbidité, ainsi qu'aux besoins en matière de travail social, de services de santé mentale, de soutien à la personne et de services diététiques.

La recherche presse aussi les gouvernements provinciaux et les prestataires de services de santé à modifier leurs programmes et à traiter certaines questions touchant à la santé, notamment par le biais du travail social. Le cloisonnement entre les services de santé et les services sociaux s'estompe; les situations d'itinérance, le statut d'immigrant, la langue d'accès aux services et la sécurité alimentaire ont tous une incidence, clairement identifiée, sur la santé. Dans certains pays, on surmonte peu à peu les obstacles à l'intégration des services sociaux aux services de santé dans le contexte de la prestation des soins (Drewes et coll. 2017; Harlock et coll. 2020); de telles initiatives seraient les bienvenues dans les provinces et territoires.

Dans le présent numéro

Ce numéro de *Politiques de Santé* porte sur la confluence de sujets touchant une vaste gamme de disciplines liées aux services de santé et souligne l'importance d'une meilleure intégration des services sociaux et de santé. Cette intégration est plus que nécessaire puisque la plupart des gouvernements provinciaux ont créé des ministères séparés pour la santé et pour les services sociaux, chacun doté de systèmes de gouvernance et d'imputabilité distincts.

Les défis liés à l'intégration des services sociaux et à l'adoption de modèles interdisciplinaires de soins s'alignent sur les directives internationales qui visent à réduire la fragmentation entre les divers prestataires de services, à intégrer une vaste gamme de services de santé et à traiter des problèmes d'ordre social associés au vieillissement, à la santé et aux résultats en santé.

Un lecteur du présent numéro pourrait se demander pourquoi l'Ontario constitue le centre du savoir sur les réformes de la prestation des soins au Canada, étant donné que tous les articles portent sur des recherches qui ont eu lieu dans cette province. Bien que de modestes réformes aient aussi lieu ailleurs au Canada, l'Ontario jouit d'une vibrante communauté de recherche sur les politiques et services de santé, laquelle est stimulée par les innovations en matière de conception et de mise en œuvre d'équipes multidisciplinaires et de modèles de prestation axés sur la communauté.

Ce numéro commence par un article de la section Discussion et débat qui souligne le manque de politiques et de processus dans les services sociaux ou de santé pour les Ontariens en situation d'itinérance (Jenkinson et coll. 2020). Preuves à l'appui, l'article montre que les sans-abri connaissent de moins bons résultats en santé et présente de forts arguments en faveur de la priorisation d'une politique, à l'intention de ce groupe, qui assurerait des liens plus forts entre le secteur de la santé et celui des services sociaux. Il préconise également la production de données pour éclairer l'élaboration efficace d'une telle politique. La question des disparités en santé attribuables à l'itinérance est possiblement pertinente pour tout service qui s'efforce de combler l'écart entre les programmes de soins de santé et les programmes de services sociaux.

Une réplique à cet article indique que les forts taux d'itinérance observés dans les provinces sont un phénomène relativement récent (Forchuk 2020). On y explique que l'itinérance est associée à un plus grand recours aux services des urgences et qu'elle découle des situations suivantes : le manque de politiques de priorisation, la réduction du soutien financier offert par les gouvernements fédéral, provinciaux et municipaux, la forte prévalence de problèmes de santé mentale et les mesures incitatives pour réduire la durée des séjours à l'hôpital. L'article conclut en décrivant les développements prometteurs qui permettent d'identifier rapidement et de soutenir les patients itinérants hospitalisés avant leur sortie, et ce, en favorisant le réseautage avec les programmes de soutien à l'hébergement et au revenu.

Tadic et coll. (2020) examinent le rôle des travailleurs sociaux au sein des équipes interprofessionnelles de soins de première ligne. Il n'est pas surprenant de constater que leur recherche permet de dégager une importante variation dans l'ampleur et la nature des services sociaux fournis au sein des équipes interprofessionnelles de soins de santé primaires, avec certaines lacunes observées dans la capacité des travailleurs sociaux à favoriser le bien-être des patients, dans l'autogestion et dans la gestion des maladies chroniques. L'article souligne d'importantes limites quant aux données actuellement recueillies et divulguées par les équipes interprofessionnelles. Il indique aussi qu'il serait hautement bénéfique, pour l'élaboration de politiques pertinentes, de connaître la quantité de services sociaux fournis.

Hutchison et coll. (2020) font état du processus ontarien de priorisation et de mise en œuvre de mesures de la performance pour les soins de santé primaires. Pour ce faire, on a choisi des indicateurs représentant les performances au niveau des cabinets et au niveau du système. Les auteurs notent cependant l'absence de certains indicateurs dans les deux niveaux, notamment en ce qui concerne la santé mentale et l'intégralité des soins. L'article indique le faible alignement de l'Ontario avec l'Institut canadien d'information sur la santé et avec d'autres provinces pour ce qui est des mesures de la performance dans les soins primaires et conclut qu'il est peu probable d'atteindre un consensus en ce sens à court terme.

Dans leur article, Kiran et coll. (2020) font état des résultats d'une enquête pour mesurer le degré de connaissance et d'utilisation des services communautaires chez les médecins de première ligne. En comparant les médecins qui pratiquent au sein d'équipes et ceux qui pratique en dehors de telles équipes, les chercheurs ont découvert que ceux qui œuvrent au sein d'équipes sont significativement plus susceptibles d'être au fait des services communautaires et d'y aiguiller des patients. Un constat de cette recherche est que les patients qui consultent auprès de médecins qui ne pratiquent pas au sein d'équipes sont susceptibles de se trouver désavantagés pour ce qui est de l'accès aux services communautaires.

Dans un article qui examine les facilitateurs et obstacles à l'accès aux services de santé en français, Savard et coll. (2020) rapportent que l'obtention et le maintien de l'accès à des services de santé en français en Ontario demeure un défi pour de nombreux patients. La recherche décrit la complexité de l'enjeu, en soulignant que les pistes de solutions vont de la disponibilité des services à la coordination entre les organismes, en passant par la structure réglementaire et politique des services de santé et sociaux.

Olaizola et coll. (2020) se penchent sur l'impact du changement du salaire minimum pour les préposés aux services de soutien à la personne en Ontario. La recherche indique que même si les salaires ont augmenté, il est difficile d'en attribuer l'effet à la politique sur le salaire minimum puisque les salaires des préposés sont actuellement en hausse dans les autres provinces. L'étude permet également d'observer que la politique du salaire minimum n'a pas eu d'impact sur les horaires ou sur la stabilité d'emploi pour les préposés.

Attention spéciale sur la recherche liée à la COVID-19

Ce numéro de *Politiques de Santé* se conclut avec un article commandé à l'Institut des services et des politiques de la santé des Instituts de recherche en santé du Canada (McMahon et coll. 2020). L'article fait état des conclusions de l'Institut au sujet de sept domaines et trois thèmes transversaux où il y a besoin de recherche en matière de services et de politiques de santé dans le contexte de la COVID-19. Les trois thèmes transversaux sont la santé des peuples autochtones et des populations vulnérables, les données et les infrastructures ainsi que les systèmes de santé apprenants. L'article conclut en énonçant le besoin d'une recherche dynamique, puisque que les répercussions de la COVID-19 se font sentir jusque dans les programmes provinciaux de santé publique, dans tout le système de prestation de services de santé et par tous ceux qui subissent l'impact de la pandémie.

Fidèle à sa mission, *Politiques de Santé* vous incite à soumettre des articles qui interpellent, en temps opportun et de façon pertinente, les responsables des politiques de santé au Canada.

JASON M. SUTHERLAND, PHD
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DISCUSSION AND DEBATE

Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue

Planification des sorties d'hôpital pour les personnes en situation d'itinérance qui ont reçu des soins de courte durée : un enjeu négligé

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Abstract

People experiencing homelessness have worse health outcomes than the general population and limited access to primary/preventative healthcare. This leads to high hospital readmission rates. Effective discharge planning can improve recovery rates and reduce hospital costs. However, most hospital discharge policies and best practice guidelines are not tailored to patients with no fixed address, contributing to inappropriate discharges and health inequities for people experiencing homelessness. We discuss the lack of discharge policies, identifiable processes or plans specifically tailored to this population as a healthcare and policy gap, and we identify key areas for better understanding and addressing this issue.

Résumé

Les résultats cliniques des personnes en situation d'itinérance sont moins bons que ceux du reste de la population et leur accès aux soins de santé primaires ou préventifs demeure limité. Cela donne lieu à de forts taux de réadmission à l'hôpital. Une planification efficace des sorties pourrait améliorer le taux de rétablissement et réduire les coûts hospitaliers. Cependant, la plupart des politiques de sortie ainsi que les pratiques exemplaires ne sont pas conçues pour les patients sans domicile fixe, ce qui se traduit par des sorties inappropriées et des inégalités en matière de santé pour ces personnes. Nous discutons du manque de politiques de sortie, de processus identifiables ou de plans spécialement conçus pour ce groupe, ce qui constitue une lacune en matière de services de santé et de politiques. Nous identifions des secteurs clés pour mieux comprendre et traiter cet enjeu.

* * *

Introduction

Every hospital has patients who frequent their emergency departments. They are often individuals in precarious situations who are discharged after receiving care, only to return shortly thereafter for the same or related health issues. Many of these patients are readmitted because they are unable to complete follow-up care, experiencing multiple social challenges and limited supports outside the hospital. Hospitals are particularly challenged in this regard by people experiencing homelessness.

Discharge planning aims to effectively transition a patient's care from the hospital to the community, addressing the interdisciplinary care needs for a patient's recovery. Individuals experiencing homelessness are most commonly discharged to emergency shelters or the streets. These destinations lack resources to support critical follow-up care and can exacerbate existing mental and physical health issues. With few alternative discharge destinations available, such as affordable and supportive housing, these types of discharges exemplify a broader systemic failure for people experiencing homelessness.

The goal of this commentary is twofold. First, to bring attention to a glaring healthcare and policy gap – a lack of discharge policies or identifiable processes specifically tailored to this population. Second, to propose possible pathways toward redressing this gap. The importance of hospital discharge planning should not be underestimated. Effective discharge planning is an important part of a systems approach transitioning people out of homelessness (Backer et al. 2007). While addressing homelessness requires broad social and economic changes fuelled by the political will to ensure the right to housing, this commentary focuses on individuals experiencing homelessness for whom hospital discharge policies are ill-adapted. We review the link between homelessness and health. We then explain issues in the hospital discharge of people experiencing homelessness. Finally, we provide suggestions for better understanding and addressing this issue. We draw on the Ontario provincial context to inform our discussion, but the issues identified here are common across many geographic contexts, and suggestions for moving forward can be drawn on to inform action more broadly.

The Link between Homelessness and Health

The current state of homelessness in Canada has been described as a national disaster (Shelter and Housing Justice Network n.d.). Homelessness has progressively worsened since the 1990s as a result of reduced investments from the federal government in affordable housing, economic shifts impacting employment opportunities and decreased spending on health and social services (Gaetz et al. 2016). Increasing costs of living, a shortage of affordable housing and decreased social and financial supports place people with untreated or unsupported mental health and substance use issues at a higher risk of entering homelessness. The development of a National Housing Strategy (https://www.placetocallhome.ca/) and Housing First approaches (Stergiopoulos et al. 2019) are both promising long-term solutions; in the meantime, tens of thousands of individuals remain in situations of homelessness in Canada (Government of Canada 2019).

The negative physical health, mental health and psychosocial impacts of homelessness are well documented. The contexts in which homeless individuals live increase exposure to rough climates, psychological strain and communicable diseases, leading to worse health outcomes (Public Health Ontario 2019) and higher rates of mortality at younger ages than the general population (Morrison 2009). Homeless populations also suffer disproportionately from poor mental health, often comorbid with substance use (Medlow et al. 2014).

Housing status affects access to preventive or primary healthcare, and therefore, people experiencing homelessness use the acute healthcare system at higher rates than the general population (Hwang et al. 2013). Healthcare needs for people experiencing homelessness may be more advanced and complex than for their housed, low-income peers, resulting in longer average in-patient stays (Hwang et al. 2011). Longer in-patient stays may also be associated with difficult discharges (e.g., difficulty finding a discharge destination to meet the patient's complex needs). These admissions have financial impacts for the healthcare system. Longer hospital stays for homeless patients are associated with increased costs for treating these patients (in Toronto, $961 more per admission for homeless than housed patients, or $2,559 more when adjusting for age, gender and resource intensity; Hwang et al. 2011). People experiencing homelessness are less able to access care at early stages of illness, resulting in more severe and complex symptoms by the time they present at hospitals, as well as correspondingly higher rates of hospital admission.

It is against this backdrop that homeless patients experience greater disadvantage at discharge from acute care hospitals compared to their domiciled counterparts. Insufficient access to follow-up care is often associated with worsening health outcomes, so having an effective discharge plan in place is critical. Without an effective plan, or the resources to adhere to it, people experiencing homelessness are more challenged in recovery.

Hospital Discharge for Housed and Homeless Individuals

The point at which a patient is discharged from a hospital is a key transition in their care pathway, providing opportunities to address a patient's health and social needs (Fader and Phillips 2012). Discharge plans may involve improving the physical accessibility of a patient's existing housing or plans for coordinating care around the patient in their community. It may also involve changes to where patients live, such as applying to move into long-term care. Best practice guidelines (e.g., "Managing Transitions" by the Ontario Hospital Association) assume a fixed discharge destination. There is little formal knowledge of best practice for discharging patients with no fixed address from non-psychiatric hospitals, including what types of planning best support successful follow-up care, and how to execute such a plan in light of resource and social service constraints. Currently, there is no provincial strategy for discharging people experiencing homelessness from acute care health settings, and we were challenged to find publicly available hospital policies or guidelines that are tailored to people experiencing homelessness.

Hospital discharge for people experiencing homelessness remains a complex and challenging process, particularly in the face of limited housing or shelter resource availability; yet, there is a lack of research in this area. The literature on discharge planning focuses on those who have a stable home and on the discharge of patients (both homeless and housed) from tertiary mental healthcare (Gonçalves-Bradley et al. 2016; Xiao et al. 2019). Effective discharge models have been developed for people experiencing homelessness when leaving acute and tertiary psychiatric hospitals (e.g., Forchuk et al. 2013); however, their appropriateness for non-psychiatric hospital contexts is unclear. We identified limited research within the Canadian context that examines the hospital discharge of individuals from non-psychiatric hospital wards who are currently homeless or precariously housed. Furthermore, although a 2015 provincial report by the expert panel on homelessness identifies transitions from provincially funded institutions as effective points of intervention, we failed to find provincial policy documents or statements that identify the connection between discharge planning and homelessness (Ontario Provincial Government 2015).

Although people experiencing homelessness are frequently discharged to emergency shelters, this discharge pathway does not provide a fixed or long-term solution and puts a strain on emergency housing facilities. Most emergency shelters are not equipped to provide post-discharge healthcare for individuals (Tansley and Gray 2009), and community care is not meeting the needs of the population (Kiran et al. 2020). Overloading the shelter system with patients discharged from hospitals who require health resources not readily available within shelters is an ineffective way of supporting people experiencing homelessness. Although interim healthcare facilities, such as medical respite centres, provide a short-term post-discharge option, these are few and far between, with limited bed space and restrictive and exclusionary rules on patient/client behaviour, and often require that the patients have a fixed address to go to after leaving respite care.

What Is Needed?

Addressing this issue will require the coordination of services between federal, provincial and municipal levels of the government and across multiple sectors. Hospital discharge planning is a key point of service that can be leveraged to help address the needs of people experiencing homelessness, and that doing so is an important part of a larger approach to addressing health inequities for this population. To explore these issues, our team is working on a qualitative research study that examines the experiences of discharge planners working with people experiencing homelessness in Toronto, Canada. We have identified the following key areas that require further attention:

1. *Evaluative and exploratory research:* There is a limited public-facing understanding of the actual process of discharging patients with no fixed address. To properly identify the scope of the problem and develop appropriate responses, hospitals that serve people experiencing homelessness should conduct needs assessments to clarify the decision-making process in hospitals surrounding discharge for this patient population, as well as the nature of care available and accessible post-discharge. Collaboration and information sharing between hospitals – that is, in a network setting – and other agencies (e.g., shelters) could support this goal.
2. *A policy priority:* Developing targeted, contextually flexible interventions and specific policies and practices around discharge planning that meet the needs of people experiencing homelessness is urgently needed. Yet, there remains limited provincial government investment on hospital discharge for this patient population, particularly from non-psychiatric hospitals. The challenge lies in the intergovernmental and the intersectoral nature of this issue. Housing is funded at the federal level, and emergency shelters are administered and managed by municipalities. Healthcare is overseen by the provincial government. Adequately addressing the issue requires an unprecedented collaboration from all levels of governments to work together across portfolios concerning both housing and health. Inadequate responses to the COVID-19 pandemic for people experiencing homelessness provide a clear example where poor coordination and collaboration have delayed the implementation of appropriate public health measures (e.g., social distancing, testing) in shelters and moving homeless individuals into housing.
3. *Data generation:* Problematically, there is a dearth of post-discharge outcome data for people experiencing homelessness. Without this evidence, it remains challenging to build a compelling case to policy makers for addressing this issue. There are multiple reasons for this lack of data. First, the transient nature of this population makes following and tracking patients with no fixed address challenging. Second, hospital information

systems do not consistently identify patients with no fixed address in a way that can be tracked within administrative data sets (Greysen et al. 2013). Moreover, shelters and drop-in centres often intentionally gather limited identifying information to operate as low-barrier facilities. Innovative ways of collecting data that take these contexts into account are needed. Several agencies (e.g., ICES and the Canadian Institute for Health Information) are already collecting information on patient health outcomes. These agencies could further develop their work to specifically explore health outcomes for individuals experiencing homelessness.

4. *System improvements:* Improvements need to be made within and between the healthcare and social service sectors. Programs are often short-term, one-off interventions that show short-term improvements for people experiencing homelessness but are not necessarily permanently integrated into daily practice. A combination of short-term and long-term improvements is needed to sustainably address the needs of this population. Specific system solutions should be developed in partnership with people with lived experience of homelessness; representatives from both health and housing sectors across municipal, provincial and federal levels of government; and networks focused on homelessness (e.g., The Canadian Alliance to End Homelessness). Such an approach could potentially be supported within the National Housing Strategy.

Conclusion

Hospital discharge is geared toward sending someone to a fixed address, yet most people experiencing homelessness do not fit into this discharge pathway. The Ontario Hospital Association identifies a number of discharge or transfer destinations, including emergency shelters (Byrick 2016). Including shelters as a legitimate discharge destination reflects the current context of housing and care options available for people experiencing homelessness; this discharge pathway also exacerbates health inequities through barriers to follow-up care and can create complications when the clinical recommendations made do not align with available resources at the discharge destination. This is an incredibly complex and multifaceted issue that requires further research and policy consideration. Ideally, affordable, secure and supportive housing would be available for patients upon hospital discharge. Until the right to housing is actualized, creating tailored discharge policies and processes will provide an opportunity to intervene in the current discharge experiences for people experiencing homelessness. Greater coordination, communication and collaboration are required to rectify this policy gap and address health inequities for homeless populations.

Conflict of Interest

The views expressed in this article are those of the authors and do not reflect the position of the University of Toronto, Sunnybrook Hospital, the Ministry of the Attorney General, McGill University Health Centre, or any other agency.

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Commentary: Discharging the Homeless – A Daily Issue in Acute Care

Commentaire : Sortie d'hôpital des personnes sans-abri : un enjeu quotidien dans le secteur des soins de courte durée

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Abstract

There are complex issues surrounding hospital discharge planning for people experiencing homelessness. The issue involves the disconnection across policy areas of housing, income supports and mental health, and later health generally. Different models for different types of communities (large urban, mid-size, small and rural areas) likely need to be developed as well as for different types of conditions and different housing histories. The quality of data needs improvement including accuracy. Housing items need to be part of admission processes so that the need for post-discharge housing can be quickly flagged and more accurate data can be made available. System improvements need to include all levels of government, people with lived experience, and health as well as housing/homeless sectors. The income support sector also needs to be included. Discharge planning often assumes there is a fixed address after discharge. This clearly misses the needs of people who have lost their housing.

Résumé

La planification des sorties d'hôpital pour les personnes en situation d'itinérance apporte son lot d'enjeux complexes. La question touche au manque de connexion en matière de politiques entre divers secteurs, dont l'hébergement, le soutien du revenu et la santé mentale, puis éventuellement la santé en général. Il faudrait vraisemblablement mettre au point différents modèles pour les divers types de communautés (grands centres urbains, villes moyennes, petites régions éloignées) ainsi que pour divers types de situations et d'historiques d'hébergement. La qualité des données doit être améliorée, notamment pour ce qui est de leur précision. La question de l'hébergement doit faire partie du processus d'admission de sorte que les besoins en matière d'hébergement après la sortie soient rapidement signalés et que des données plus précises soient disponibles. Les améliorations du système doivent impliquer tous les niveaux de gouvernement, les personnes qui ont l'expérience pertinente ainsi que les secteurs de l'hébergement et de l'itinérance. Le secteur du soutien du revenu doit aussi être impliqué. On tient souvent pour acquis, dans la planification des sorties, que le patient possède une adresse fixe. Les besoins des personnes qui ont perdu leur domicile sont clairement délaissés.

Introduction

Jenkinson and colleagues (2020) discuss many of the complex issues surrounding hospital discharge planning for people experiencing homelessness. They accurately describe the dearth of literature and proactive policy on this complex topic. Yet, people practising in acute care settings often experience the difficulties involving these complex situations daily.

Often, while speaking to younger healthcare providers, I have found that they are surprised to learn that the issue of discharge to homelessness is a relatively new phenomenon in Canada. When I worked as a clinical nurse specialist in the 1980s and 1990s, if someone was discharged homeless, we had to fill the same critical incident form as that used for a patient assault. In the early 1990s, I recall the alarm at the Hamilton hospital where I worked when this happened twice in a single year. A special leadership meeting was called to examine how such a terrible thing could happen. Yet, only a few years later, a study we conducted revealed that this happened at least 196 times in a single year in London, Ontario, from psychiatric programs alone (Forchuk et al. 2006).

The discussion that these types of discharges exemplify a broader systems failure is important. The disconnection between federal, provincial and municipal policies that is described certainly contributes to the increase in homelessness seen in recent years. However, it is important to understand that the issue also involves the disconnection across policy areas of housing, income supports and mental health, and later health in general. Together, these factors created the perfect storm for the marked increase in homelessness and the overrepresentation of people with mental illness among the homeless population.

Understanding the history of policy changes is important to understanding the current problems of discharge to homelessness. In Ontario, in the 1990s, the issues included the downloading of housing from the federal, to the provincial, to the municipal level, despite all other industrial nations having this responsibility at the federal level. With each passing of the housing responsibility to a different level of the government, the resources and the political will similarly lowered. New investment into public housing was reduced, and increasing waiting lists meant people could wait years for affordable housing. In Ontario, in the same period (1997), the *Ontario Works Act* replaced the General Welfare Assistance program, with a decrease in actual funds available to each individual or family. In 1999, the Health Services Restructuring Committee recommended that provincial psychiatric hospitals be transferred to community hospitals and that the number of psychiatric beds be reduced (policy disconnection summarized from Forchuk et al. 2007). Jenkinson and colleagues

(2020) point to the 2015 Ontario plan to reduce homelessness, the very recent national housing policy (https://www.placetocallhome.ca/) and reinvestment in Canada Mortgage and Housing Corporation after a long federal absence from housing policy and investment (Ontario Provincial Government 2015). These are both signs of policy progress.

Analysis of Key Points and Recommendations

Jenkinson et al. (2020) concisely summarize key points from the large body of literature that links homelessness to poor health outcomes and to higher hospital need. People who are homeless tend to have multiple mental and physical illnesses, and they remain in the hospital longer and are more likely to visit the emergency department and/or be readmitted after discharge (Hwang et al. 2011; Mikkonen and Raphael 2010; Munn-Rivard 2014). Managing one's health while homeless is not easy. Medication storage, food insecurity and exposure to the elements and violence are just a few of the challenges. One oversight that I noted is that there is an implicit assumption that the only people being discharged to homelessness were people who were already homeless upon admission. In our five-year Community–University Research Alliance program on homelessness, housing and mental health (Forchuk et al. 2011), we found that many people actually started their journey of homelessness with a discharge from the hospital. Housing can be lost following a hospitalization in many ways. Relationship breakups, loss of income (including income support programs) and an inability to pay rent or missing an eviction notice (and thus appeal) while in hospital are but a few examples.

Health practices and policies to shorten the length of stay (the push to discharge as soon as possible) contribute to inappropriate discharges to unsafe places. These practices and policies are in place owing to the limited number of hospital beds and the presumed efficiency of turning patients over quickly to accommodate more people. However, as in the commentary by Jenkinson and colleagues (2020), if discharging to homelessness means that the person will shortly return to the emergency department and be potentially readmitted even more ill, this is an illogical approach.

The commentary by Jenkinson and colleagues (2020) has four recommendations: evaluative and exploratory research, a policy priority, data generation and system improvements. I would agree with these recommendations. As noted in the literature review, there is a dearth of information outside the mental health field. Context matters. Different models for different types of communities (large urban, mid-sized, small and rural areas), conditions and housing histories likely need to be developed. We are nowhere near this level of evidence-informed interventions. The COVID-19 pandemic highlights some of the many gaps in healthcare for people experiencing homelessness and the need for homelessness to also be seen as a health-related priority issue. The quality of data, although improving with health records now containing more housing/homelessness fields, needs further improvement, including more accuracy. Often, admission data (such as address) become the discharge data, unless someone makes a point of recognizing and changing the field if housing was lost during an admission. Housing status needs to be a part of the admission processes so that the need for post-discharge housing can be quickly flagged and addressed. System improvements are certainly needed. As noted, this needs to include all levels of the government, people with lived experience as well as the health, housing/homeless and income support sectors.

It is important to understand the context of the disconnection across policy areas that intersect with the issue of discharge to homelessness. Otherwise, the risk is to see such discharges as solely a health issue and something that could simply be addressed by better hospital discharge planning. The problems have evolved from this disconnection of changes in housing, income and health policies. The solutions must reconnect these policy areas. In our work that has successfully reduced discharge to homelessness from psychiatric programs, we have brought housing and income supports into the hospital (Forchuk et al. 2013). Although the program was very successful and integrated into usual care, we found that several program and policy changes required an expansion of the community partners involved. In our current (still in process) study, this includes having a housing support worker whose role is to help find housing, an Ontario Works (OW) staff with on-site access to the OW database and a Housing Stability Bank staff to provide short-term loans to assist with rent and/or utility bill arrears. Additional assistance also includes access to furniture, moving and cleaning services. These are all resources normally available in the community. However, by the time a person is healthy enough to access such resources in the community, they are discharged. It is therefore important to bring these services into the hospital and to have them work as a team with the hospital before discharge. We have only begun working with medical wards but find that the largest challenge is the far shorter length of stay compared to that in psychiatric units. In some cases, a person with a decade of homelessness has a one-night stay. The odds of finding and maintaining housing with such a small window are not good. Although studies are still ongoing, our preventing-discharge-to-no-fixed-address team has managed to find housing for half the referrals on acute medical wards (far less than the almost 80% on psychiatric programs). To address this issue in our next phase of the research, we are integrating our program with municipal Housing First programs and providing even more direct hospital access to these services with a revised program that will be implemented and tested once new non-COVID studies can begin.

Conclusion

In conclusion, Jenkinson et al. (2020) highlight that discharge planning often assumes that there is a fixed address after discharge. However, this commentary needs to also consider the needs of people who have lost their housing during hospital admission as well as before admission. We need policies that clearly recognize that a shelter address is still no fixed address, and this means that the discharge to a shelter, or to a friend or family member's house, is, nonetheless, a discharge to homelessness. The example I provided regarding our work preventing discharge to homelessness supports the conclusion in the paper by Jenkinson et al. (2020), that "[g]reater coordination, communication and collaboration are required to rectify this policy gap and address health inequities for homeless populations" (2020: 19).

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RESEARCH PAPER

The Role of Social Workers in Interprofessional Primary Healthcare Teams

Rôle des travailleurs sociaux dans les équipes interprofessionnelles de soins primaires

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Abstract

Background: In Ontario, Canada, social workers are employed in a number of primary healthcare (PHC) settings such as Community Health Centres (CHCs) and Family Health Teams (FHTs). However, many aspects of social work practice within PHC settings are unknown.

Objectives: The objectives of our study are to determine the amount of social work services provided in CHCs and FHTs, identify the types of services that social workers provide in CHCs and FHTs and ascertain the methods social workers use to deliver services in CHCs and FHTs.

Method: An analysis of a cross-sectional data set obtained from a survey conducted in June 2016 in Ontario was performed.

Results: The majority of practices (84.2%) had a social worker, although several practices also hosted other types of mental health workers. In virtually all practices with social workers, they (and individuals designated as mental healthcare providers) were also involved in practice level efforts to support mental healthcare delivery. In several practices, the care they delivered extended beyond that related directly to mental healthcare, ranging from preventive care and health promotion (64.5%) to palliative care (16.8%). In several practices, these workers also offered group appointments related to healthy behaviour (43.6%) and self-management (~33%).

Interestingly, the role of social workers in practices where they were the sole designated mental healthcare worker was not meaningfully different from practices where other mental health professionals work.

Conclusions: In PHC, social workers deliver or support the delivery of mental healthcare, but their role extends beyond that domain to encompass a broader set of services that contribute to the individual's health and wellbeing.

Résumé

Contexte : En Ontario, au Canada, des travailleurs sociaux sont employés dans nombre d'organismes de soins de santé primaires (SSP) tels que les centres de santé communautaire (CSC) et les équipes Santé familiale (ESF). Toutefois, plusieurs aspects du travail social au sein des organismes de SSP demeurent inconnus.

Objectif : L'objectif de notre étude est de déterminer la quantité de services en travail social proposé dans les CSC et les ESF, d'identifier le type de services offerts par les travailleurs sociaux et de connaître les méthodes employées par ceux-ci pour offrir leurs services.

Méthode : Nous avons procédé à l'analyse d'un ensemble de données transversales obtenues au moyen d'une enquête menée en Ontario, en juin 2016.

Résultats : Il y a un travailleur social dans la majorité des organismes (84,2 %), mais plusieurs organismes comptent aussi sur la présence d'autres types d'intervenants en santé mentale. Dans pratiquement tous les organismes qui offrent des services de travail social, ces derniers – et les personnes désignées comme prestataires de services en santé mentale – sont aussi impliqués dans les efforts de l'organisme pour appuyer la prestation de soins de santé mentale. Dans plusieurs organismes, les services qu'ils offrent débordent les soins directement liés à la santé mentale, allant d'activités de promotion de la santé et des soins préventifs (64,5 %) aux soins palliatifs (16,8 %). Dans plusieurs organismes, ces travailleurs animent aussi des groupes pour favoriser les comportements sains (43,6 %) et l'autogestion (~33 %).

Il est intéressant de constater que le rôle du travailleur social n'est pas significativement différent entre les organismes où il constitue le seul travailleur désigné pour les services de santé mentale et ceux où travaillent aussi d'autres professionnels de la santé mentale. *Conclusion :* Dans les SSP, les travailleurs sociaux offrent des services de santé mentale ou y contribuent, mais leur rôle s'étend au-delà de ce domaine et comprend un plus large éventail de services qui favorisent le bien-être et la santé des individus.

Introduction

Canada has a universal healthcare system that covers the majority of healthcare costs, such as physician costs, hospital care and tests, but that public insurance system does not include services by most non-physician healthcare professionals. This lack of insurance for services provided by non-physician healthcare professionals is especially detrimental for those with mental healthcare issues (found in 17% of the Canadian population), the costs for which are often prohibitive to those without private insurance (Corscadden et al. 2019; Sunderland and Findlay 2013). Improving access to mental health services in primary healthcare (PHC) settings can improve care quality, coordination of care and outcomes for patients struggling with mental illnesses (Rush 2014). Team-based care also improves the prevention and management of chronic diseases and is linked to lower costs (Beaulieu et al. 2013; Kates et al. 2011; Kiran et al. 2015).

In Canada, Ontario has led the way in funding interprofessional PHC teams with the introduction of Family Health Teams (FHTs) in 2005 (Brown and Ryan 2018) – which now serve approximately three million Ontarians (22% of the provincial population; Glazier et al. 2012) – and by investing in the expansion of Community Health Centres (CHCs), a PHC model established in the 1970s that serves the more vulnerable segments of the population (Collins et al. 2014; Hastings 1972). Different PHC models are intended to serve different patient populations, community needs and provider preferences (Ashcroft 2015; Glazier et al. 2012; Hutchison and Glazier 2013). In Ontario, FHTs are an example of a professional PHC model that has physicians as the main providers who hold a high level of responsibility; care is preventative, diagnostic and curative; and, historically, FHTs have little community involvement, serving a limited number of enrolled patients (Ashcroft 2015). CHCs are an example of a community PHC model aimed to meet broad health needs of the population from a social determinants perspective and serve their respective neighbourhood catchments (Collins et al. 2014).

Although both FHTs and CHCs are designed to meet local community needs, CHCs have distinct services that enable them to address the broad health needs of the more vulnerable segments of the population that they provide care for (Glazier et al. 2012). For example, compared with FHTs, CHCs typically offer a broader range of health promotion services to address the social determinants of health faced by the disadvantaged populations that they serve and are involved in a range of community engagement activities outside of their practice organization (Glazier et al. 2012). FHTs were established with the intention to improve access to comprehensive healthcare services, interdisciplinary team–based care, patient-centred care and mental health services, as well as to improve services' continuity across other parts of the healthcare system (Ashcroft 2015; Aggarwal 2009; Brown and Ryan 2018). The interprofessional composition within FHTs and CHCs varies from practice to practice, but it typically comprises family physicians, nurses and nurse practitioners, as well as other allied health professionals, such as social workers, pharmacists and dietitians, who provide a range of health and mental health services without the burden of direct costs assumed by the patient (Glazier et al. 2012; Gocan et al. 2014; Marchildon and Hutchison 2016).

Integration of social work in PHC

The absolute numbers of social workers practising in primary care settings across Ontario are currently unknown. Yet, the surge in the emergence of interprofessional teams since the early 2000s has significantly increased the availability of publicly funded social workers in Ontario PHC settings (Ashcroft et al. 2018). For example, social workers now represent the third largest group of interprofessional health professionals in FHTs, following physicians and nurses (Ashcroft et al. 2018). The number of publicly funded social workers in FHTs ranges from approximately 0.4 to 56.7 FTE (Ashcroft et al. 2018), which suggests that some smaller FHTs have one part-time social worker and larger FHTs have hired multiple social workers across multiple sites (Ashcroft et al. 2018). Moreover, the actual number of social workers employed in interprofessional PHC settings is even more difficult to ascertain because some social workers are hired into roles that are explicitly titled "social worker," whereas other similarly trained social workers are employed in PHC settings as a "mental health counsellor" (Kates et al. 2002).

Social work's scope of practice in PHC settings

The biopsychosocial approach, person-in-context philosophy and clinical expertise of social work align well with those of PHC (Ashcroft et al. 2018; Mann et al. 2016; Rabovsky et al. 2017), particularly because patients in PHC settings are increasingly confronted with complex psychosocial and mental health problems that benefit from social work interventions (Mitchell 2008; Van Hook 2003). Social workers assist a range of patient populations and provide services in areas including mental health conditions and addictions, chronic disease, children and youth illnesses, geriatrics illnesses, grief, trauma, parenting issues, palliative care, dementia and other neurological issues, financial stressors, housing issues and a broad range of other general psychosocial issues (Ashcroft et al. 2018; McGregor et al. 2018; Sverker et al. 2017).

Patient care activities of social workers in PHC settings include providing psychosocial assessments and interventions, completing comprehensive risk assessments, providing psychotherapy as well as other types of counselling, making referrals to community resources, supporting medical provider interventions, conducting health promotion activities, engaging in systems navigation and care coordination, providing ongoing case management, improving relationships between the medical provider and the patient, assisting in team building and, at times, assisting in the education and training of other healthcare providers (Ashcroft et al. 2018; Horevitz and Manoleas 2013; McGregor et al. 2018; Sverker et al. 2017). The typical length of appointments with social workers in PHC settings is unknown, although sessions tend to be shorter than sessions in other mental health specialty care contexts (Horevitz and Manoleas 2013).

The delivery of social work services in PHC settings may take on various forms. For example, patient care may occur in-office via direct face-to-face individual, couple and/or family appointments (Kates et al. 2002; Sverker et al. 2017). Social workers in PHC settings may conduct home visits for homebound patients as in the case of palliative and end-of-life care and other types of complex biomedical and psychosocial situations (Reckrey et al. 2014; Steketee et al. 2017). Group services are an alternate mode of care, in which social workers in PHC settings may facilitate a range of different types of psychoeducation or therapeutic group interventions (Ezhumalai et al. 2018; Kates et al. 2002; Steketee et al. 2017). Indirect interventions are also used, where the need for face-to-face contact, such as with completion of referrals and other types of documentation, is less (Horevitz and Manoleas 2013). Social workers may also lead a range of activities within PHC contexts that are not direct patient care interventions such as community development and outreach, some health promotion activities, education and training, supervision and taking on various formal and informal leadership roles (Ashcroft et al. 2018).

Despite the rapid increase of social work services, there is limited information and research conducted on social work in the current PHC context (Ashcroft et al. 2018; Dinh and Bounajm 2013; Mitchell 2008). The purpose of this study is to determine the extent to which social work services are integrated into the current PHC context in Ontario, Canada. The research question guiding our study is as follows: What social work services currently exist in CHCs and FHTs in Ontario, Canada? The objectives of our study are to (i) determine the number of social work services in CHCs and FHTs, (ii) identify the types of services that social workers provide in CHCs and FHTs, and (iii) ascertain the methods social workers use to deliver services in CHCs and FHTs.

Method

Design and context

An analysis of a cross-sectional data set obtained from a primary care setting survey conducted in June 2016 in Ontario, Canada, was perfomed. In Ontario, the Ontario Health Insurance Plan covers most medical care facilities for the entire population, including the primary care services provided by family physicians, but it does not cover the services provided by allied health professionals, including mental health professionals, in the non-acute out-patient setting for most Ontarians. For this reason, and to determine the extent of services provided by allied health professionals, including social workers, a survey was considered as the appropriate method to reach a large number of primary care settings across Ontario. Only patients receiving care at a CHC or FHT may have free access to the services of a social worker or psychologist or other mental healthcare worker if that practice's team comprises such a professional. Thus, our survey targeted CHCs and FHTs because of the integration of allied health professionals within these PHC models.

Participant recruitment

The survey targeted all primary care settings that provide comprehensive care (i.e., excluding specialized and walk-in clinics) in the province of Ontario. Practice sites working together under a single organization across different geographical locations were considered unique practices and a questionnaire was sent to each. The survey was promoted through the Ontario College of Family Physicians, newsletter. Local Health Integration Network primary care leads were asked to promote the survey within their network of primary care providers. The survey was promoted by the INSPIRE PHC network through their e-mail listserv. Finally, the Ontario Association of Community Health Centres (now the Alliance for Healthier Communities [AOHC]) and the Association of Family Health Teams of Ontario (AFHTO) promoted the survey among their members each by way of membership listserv. The AOHC and AFHTO sent an invitation for their members to complete the survey on three separate occasions. This study is limited to the subset of practices in these interprofessional models. At that time, there were 184 and 73 CHCs and FHTs, respectively. One organization may have a single practice site or be composed of more than one practice site working collaboratively under the same management.

Data source

The research tool we relied on was an online survey developed to capture primary care attributes that could be studied for their relationship with the quality of care delivered. The survey was largely based on the "Measuring Organizational Attributes of Primary Health Care" survey developed by the Canadian Institute for Health Information and released in 2013 and the Evolution survey used in Quebec (Levesque et al. 2014; Pineault et al. 2012), and supplemented with additional questions to capture all required information.

Description of variables in the research tool

We assessed the practice's primary care model, team composition and services provided. For the last question, items were divided into services provided during individual appointments, group appointments and practice-level initiatives or programs. The respondent was asked to record whether that service was provided, and by whom. The options provided were doctor, registered nurse or registered nursing assistant, nurse practitioner, pharmacist, dietitian, mental health worker and other. These questions are provided in Appendix 1, available online at longwoods.com/content/26292.

For the question that captured team composition, respondents could identify the presence of social workers and other mental health workers separately. No definition was provided for either term. The section that captured services provided six specified categories (MD, RN/RNA, Nurse Practitioner, Pharmacist, Dietitian and Mental Health Worker) and an Other category for which the respondent was asked to provide details. We created a Social Worker category to capture the sites that had identified that the service was provided by a social worker in the "Other" category. Because there was no Social Worker category available to the respondents, some practices likely recorded the work performed by these professional under the category "Mental Health Worker". PHC practices that included social workers were identified based on the proportion of practices having reported that an activity was performed by an "other mental health worker" yet did not check "mental health workers" in their team profile. Considering the three most commonly reported services for that group, the proportion was as follows: psychosocial services, 69%; primary mental health care, 71%; and prevention and health promotion, 76%. Given that the majority of services captured under Mental Health Worker were likely performed by a social worker, we describe activities having been reported as performed by a "Mental Health Worker" or a "Social Worker" under the "Other (specify)" together for all 101 practices eligible for that analysis. As a sensitivity analysis, we also report on these activities in the subset of 68 practices having indicated that no other mental health workers or psychologists were present in the practice.

Study size

In total, 68 CHCs and 77 FHTs completed at least a portion of the survey. Of these, 10 CHCs and 14 FHTs did not complete the principal section of interest and were excluded, resulting in 58 CHCs and 63 FHTs included in the analyses. The analyses pertaining to a social worker's role are limited to 43 CHCs and 58 FHTs having reported the presence of these professionals.

Analyses

We reported on proportions and averages for various professionals or of activities performed. Although we provide the data by model, because the intent was to understand these practices' features in the different models, and not to identify differences, we did not conduct statistical comparisons between models.

Results

The survey was completed primarily by an administrative or clinical manager (57.0%) or executive directors (34.7%), although a practice physician, other managerial health professionals, or junior administrative staff were also involved (18.5%) in completing the survey.

Practice description

Of the 121 CHCs and FHTs, 53.7% were part of a multisite organization. Most respondents were from academic sites (70.0%) involved in teaching medical students or residents, situated in the community (93.4%) rather than attached to a tertiary care centre and established at least five years earlier (88%).

Staffing

The staffing profile in CHCs, FHTs and others is shown in Table 1. Family physicians, nurse practitioners and nurses were the most predominant health professionals at the sites. The majority of practices (83%) reported having at least one social worker on staff, and some practices (18%) had psychologists on staff. Social workers were slightly more common in FHTs, whereas other mental health workers were more common in CHCs. Thirty-one practice sites (approximately 25%) reported having an other mental health worker, a term the survey did not define in more depth. In total, 11 (35.5%) of these 31 practices did not report having a social worker on staff.

In the 101 sites that reported having a social worker on staff, the full-time equivalent ratio of social workers to primary care providers (i.e., family physicians or nurse practitioners) was 0.24, although this ratio was considerably lower in FHTs (0.16) than in CHCs (0.34).

Services provision

We limited our analyses to practices reporting having a social worker(s) on staff ($n = 101$). Among these, only 20 practices reported having Other Mental Health Worker on staff. Survey results strongly suggested that, in the absence of a Social Worker category, respondents most likely codified some activities performed by the social worker into the Other Mental Health Worker category. We show the results of the respondents that selected Mental Health Worker or specified that the activity was performed by a social worker under "Other: specify" combined. When the data set is limited to practices without any mental

TABLE 1. Human resources

Human resources	Practices with such a team member Number (%)			Full-Time Equivalent Average (*SD*)		
	CHC	FHTs	Overall	CHC	FHTs	Overall
Family Physicians	55 (96.5%)	63 (100%)	118 (98.3%)	3.0 (1.5)	7.8 (5.0)	5.6 (4.4)
Nurse Practitioners	57 (100%)	57 (90.5%)	114 (95.0%)	3.4 (1.8)	2.1 (1.2)	2.5 (1.5)
Registered Nurse	53 (93.0%)	63 (100%)	116 (96.7%)	4.1 (3.0)	3.8 (2.9)	3.9 (2.9)
Social Worker	43 (75.4%)	58 (92.1%)	101 (84.2%)	2.0 (1.5)	1.5 (1.0)	1.7 (1.3)
Psychologist	6 (10.5%)	16 (25.4%)	22 (18.3%)	0.5 (0.4)	0.6 (0.4)	0.6 (0.4)
Other Mental Health Worker	23 (40.4%)	8 (12.7%)	31 (25.8%)	1.7 (1.2)	0.8 (0.8)	1.5 (1.2)

Full-Time Equivalent is calculated for only practices where that team member is present. Registered Nurse includes registered practical nurses.

health professional other than the social worker (*n* = 68), the activities' profile is largely unchanged (Table 2). These professionals are commonly involved in direct, one-on-one patient service delivery, and they influenced the programs offered at the practice level. They were less likely to deliver group services.

Discussion

Amount of social work in PHC practices

There is a variation in the amount of social work services integrated across CHCs and FHTs. Although more FHTs are likely to have social workers on site (92.1% vs. 74.1%); however, the FTE is somewhat higher in CHCs than FHTs (2.0 vs. 1.5 FTE). In these practices, the ratio of social worker to FTE primary care providers was 0.24. Given the existing wait-list for social work services in many FHTs and CHCs (Ashcroft et al. 2018), determining the recommended ratio of social work services per family physician or nurse practitioner

TABLE 2. Services offered by social workers/mental health workers [practices with social worker(s) only]

	Percentage of practices offering the service			
	All practices (*N* = 101)			Practices (*N* = 68) without other mental health worker or psychologist
Services	**Overall**	**CHC**	**FHT**	**Overall**
Individual patient appointments				
Psychosocial services	95.0	97.7	93.1	92.6
Primary mental healthcare services	90.1	88.4	91.4	85.3
Prevention and health promotion	76.2	65.1	84.5	72.1
Liaison with other healthcare organizations	64.4	65.1	63.8	69.1
Home visits	39.6	48.8	32.8	35.3
Lifestyle counselling	35.6	34.9	36.2	36.8
End-of-life/palliative care	16.8	18.6	15.5	16.2
Group appointments				
Lifestyle and healthy living	43.6	39.5	46.6	41.2
Patient self-management plans	33.7	32.6	34.5	32.4
Chronic disease management	31.7	23.3	37.9	26.5
Practice-level initiatives/programs				
For patients with mental disorders	93.1	90.7	94.8	89.7

Group appointments = group appointments for education and self-management programs.

may help to meet patient care demands (Keefe et al. 2009). Organizational features of a PHC setting have a profound effect on patient care, including the degree to which healthcare providers such as social workers are integrated into the team (Ashcroft et al. 2018; Hogg et al. 2008). Knowing the recommended amount of social work services considered optimal to meet patient care demands in a given PHC setting, and in relation to organizational variations, will aid policy and decision-makers make evidence-based decisions about future resource allocation to meet patient care demands.

Type of services provided by social workers

Social workers provide a broad range of services, including psychosocial care, mental health care, patient education and sometimes end-of-life care, in CHCs and FHTs, with little differences across models. Given that social workers were not involved in the survey completion, we suspect that these represent underestimates of the actual numbers of the types of social work services. For example, given that all of social work services fall under the umbrella of psychosocial care, we would anticipate that psychosocial care would likely be reported at 100% if social workers completed the survey (Ashcroft et al. 2018; Mann et al. 2016; Mitchell 2008; Rabovsky et al. 2017).

Contextual variables such as patient population characteristics, geographical setting and availability of community resources understandably influence the types of services offered in PHC settings (Hogg et al. 2008), including social workers' scope of practice (McGregor et al. 2018; Mitchell 2008; Sverker et al. 2017). Social workers in CHCs and FHTs are providing services to Ontarians with mental health care needs, yet the range of other types of patient populations who are recipients of social work's services such as prevention and health promotion, home visits, lifestyle counselling and chronic disease management remains unclear. Variations exist in the types of social work services provided in different PHC settings in Ontario (Ashcroft et al. 2018), yet the differences that exist between northern and southern regions remain unknown. In addition, it is unknown how the scope of practice of social workers in CHCs and FHTs is developed in relation to existing resources in different communities and the mechanisms in which social workers are liaising with other health organizations.

Methods of care delivery

A range of modalities help deliver social work services in PHC settings (Kates et al. 2002; Sverker et al. 2017). According to our data, a majority of a social work services are being provided via in-office appointments, with the emphasis more on individual appointments than on group appointments. The average length of social work appointment is unknown and was not asked in our survey. The data showed that home visits are being offered by some social workers, although the types of clinical situations and patient characteristics to benefit most from home visits by social workers in CHCs and FHTs remain unknown. Less than half of the practices having a social worker(s) reported that these professionals offered group appointments for lifestyle and healthy living, patient self-management plans and chronic disease management. There may be even more opportunities for social workers to apply their expertise in group appointments than in what currently exists (Ashcroft et al. 2018). Future investigations will help determine the optimal modalities for practice in PHC settings to meet the high demands for social work services, given the increasing patient complexity (Ashcroft et al. 2018; Ashcroft et al. 2019).

Challenges to optimizing integration of social work in PHC

The inclusion of social work in CHCs and FHTs has made a range of services available to PHC that can help improve individual and population health outcomes. However, more data are needed to help demonstrate the impact of social work services on care processes and patient outcomes (Ashcroft et al. 2018). For example, research has shown that patients of FHTs experienced considerable improvement in diabetes care over time compared to patients of primary care physicians who were not a part of an interprofessional team (Kiran et al. 2015); yet contributions of social work, if any, to these or other types of patient outcomes despite their involvement in providing lifestyle counselling, helping with patient self-management planning and engaging in chronic disease management activities, are unknown. One of the challenges is that it is difficult to capture social work's contributions to care in administrative databases that are used to determine the population-based impact of care. Only recently has CHC interprofessional team data, including data on social work and the patients they serve, become available. Outcome data was beyond the scope of this study, although we recommend that leaders and social workers in PHC settings integrate the collection of data within the practice setting to help highlight the impact social workers are having on patient care and health outcomes. We encourage academic FHTs and CHCs to make this integration a priority, given their capacity for research.

POLICY IMPLICATIONS

The integration of social work in PHC has expanded substantially because of a systematic pan-Canadian PHC reform that began in the early 2000s (Ashcroft et al. 2018). Considerable investments have been made, leading to the accelerated inclusion of social workers in PHC settings in Ontario and elsewhere across Canada (Ashcroft 2015; Ashcroft et al. 2018; Hutchison et al. 2011). Now that social workers are flourishing in numbers in PHC settings (Ashcroft 2015; Ashcroft et al. 2018), our study suggests that there is an opportunity for key stakeholders to determine how best to sustain the social workers currently embedded in PHC practices, to maximize their contributions in patient care. This suggestion is particularly timely, given the recent provincial policy priorities to enhance patient access to mental health services, which directly align with social workers' scope of practice in PHC settings (The Canadian Press 2020).

In a previous study, social workers indicated that some leaders have a limited understanding of social workers' roles in PHC settings (Ashcroft et al. 2018). Despite the limitation, we felt that it was important to carry out this study because the participants who completed our survey are the same leaders in PHC settings making influential decisions on the number of social workers to employ in a practice, the types of activities that fall within a social worker's role within their practice setting and the modes of service delivery that are permitted and encouraged. Despite the gaps of having non–social workers as respondents, our survey provides an opportunity to provide an understanding from a perspective that highly influences social work's role in PHC settings (Ambrose-Miller and Ashcroft 2016; Ashcroft et al. 2018).

LIMITATIONS

There are two key limitations for consideration. Using a survey to answer our research question meant that the range of responses and the depth of understanding of social workers' roles are limited to categories within the survey itself. The second limitation is that the survey relied on participants who are non–social workers and who may not be able to fully articulate the amount, range or methods used to deliver social work services in PHC settings (Ashcroft et al. 2018).

Recommendations

Our study raises additional recommendations for social work practitioners, educators and researchers. Role clarity is essential for team collaboration and for ensuring that social workers in PHC settings are contributing to patient care at an optimal level by providing the most effective types of services (Ambrose-Miller and Ashcroft 2016). We encourage social workers to identify themselves as social workers even when not hired in the role that has the social work title (such as mental health counsellor). Doing so will help clarify the scope of practice to patients, other team members and administrators (Ambrose-Miller and Ashcroft 2016). We also encourage PHC leaders to hire social workers in roles using the formal title "Social Worker" instead of the general term "Mental Health Counsellor." Furthermore, where applicable, we advise that the job title of social worker be taken into consideration and included in collective agreements. Any person who uses the title "Social Worker" or "Registered Social Worker" is registered with a provincial social work regulatory body, which then provides some assurance for educational requirements and performance standards that guide scopes of practice (Collins et al. 2002). There is substantial value in having PHC professional organizations (e.g., AFHTO and the Ontario College of Family Physicians) and social work professional organizations (e.g., Ontario Association of Social Workers) collaborate to help determine how to maximize social workers' scope of practice in PHC settings. The reason for this is because healthcare is a complex system, and by effectively nurturing the ongoing integration of social work in PHC settings, local PHC leaders will benefit from ongoing direction and supportive infrastructure at a macro level (Corrigan et al. 2017; Sørensen et al. 2018).

Educators have a role to ensure that social workers are prepared to provide a range of services using multiple modalities that are required in comprehensive and fast-paced PHC settings (Horevitz and Manoleas 2013). Academic practice sites are well-positioned to facilitate educational opportunities for social work students, given their long history of training medical students and family medicine residents (Soklaridis et al. 2007). Early exposure to PHC teams, and learning in "real time" (with trainees from other disciplines), can increase the social work practice readiness in primary care settings (de Saxe Zerden et al. 2018). Further embedding social work within the training provided at academic practices will better prepare students from other disciplinary backgrounds for collaborative care practices inherent to PHC (de Saxe Zerden et al. 2018). When social work students are included in interprofessional training opportunities, students from other disciplinary perspectives gain a greater understanding of group process, improve communication skills for difficult conversations, feel more confident when encountering adversity and improve group decision-making abilities – which leads to better patient care outcomes (Charles et al. 2011; Reeves et al. 2017). We encourage the academic practice sites involved in our study to also prioritize education and training of social workers.

We recommend that researchers develop surveys in a way that can capture social workers' contributions in PHC settings. Complexities exist in doing so because of the many roles assumed by social workers in PHC settings. For example, many mental health worker positions are held by a social worker. It is challenging for surveys to capture person-centred, relational and multipronged approaches of social work unless these are designed from the outset with this particular intent. Future research can help determine the most optimal types of activities, approaches and delivery modalities for social workers to use, to best address the needs of increasingly complex patient issues within the current PHC context.

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RESEARCH PAPER

Prioritizing and Implementing Primary Care Performance Measures for Ontario

Priorisation et mise en œuvre de mesures de la performance des soins primaires en Ontario

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Abstract

In the fall of 2014, Health Quality Ontario[1] released *A Primary Care Performance Measurement Framework for Ontario*. Recognizing the large number of recommended measures and the limited availability of data related to those measures, the Steering Committee for the Primary Care Performance Measurement (PCPM) initiative established a prioritization process to select two subsets of high-value performance measures – one at the system level and one at the practice level. This article describes the prioritization process and its results and outlines the initiatives that have been undertaken to date to implement the PCPM framework and to advance primary care performance measurement and reporting in Ontario. Establishing a framework for primary care measurement and prioritizing system- and practice-level measures are essential steps toward system improvement. Our experience suggests that the process of implementing a performance measurement system is inevitably non-linear and incremental.

Résumé

À l'automne 2014, Qualité des services de santé Ontario[1] publiait le *Cadre de mesure du rendement des soins primaires en Ontario*. Conscient du nombre important de mesures recommandées et de la disponibilité limitée des données associées à ces mesures, le comité directeur pour la mesure du rendement des soins primaires (MRSP) a mis au point un processus de priorisation afin de sélectionner deux sous-ensembles de mesures de la performance à forte valeur ajoutée – le premier au niveau du système, l'autre au niveau des cabinets. Cet article décrit le processus de priorisation et ses résultats, puis souligne les initiatives qui ont été entreprises à ce jour pour mettre en œuvre le cadre de MRSP et pour favoriser, en Ontario, la mesure du rendement et la publication de rapports en ce sens. La mise au point d'un cadre de mesure du rendement des soins primaires et la priorisation de telles mesures au niveau du système et des cabinets sont des étapes essentielles pour l'amélioration du système. Notre expérience suggère que le processus de mise en œuvre d'un système de mesure de la performance est inévitablement non linéaire et incrémentiel.

Introduction

In the fall of 2014, Health Quality Ontario[2] released *A Primary Care Performance Measurement Framework for Ontario* (Health Quality Ontario 2014).The performance measurement framework had been developed by a steering committee representing 20 stakeholder organizations encompassing patients, family caregivers, healthcare providers, data holders, researchers, managers, policy makers and funders. The Steering Committee, supported by measures selection and technical working groups, identified 179 candidate system-level measures and 112 candidate practice-level measures across nine domains (access, patient-centredness, safety, effectiveness, efficiency, integration, focus on population health and appropriate resources, with equity as a cross-cutting domain) that were deemed valuable to have available on a regular basis to inform policy development, service planning, management and quality improvement.[3] A total of 92 candidate measures are common to both subsets. Details of the Primary Care Performance Measurement (PCPM) framework are described elsewhere (Haj-Ali and Hutchison 2017).

Recognizing the large number of recommended measures and the limited availability of data related to those measures, particularly at the practice level, the Steering Committee identified the need to undertake a prioritization process to select two subsets of high-value performance measures – one at the system level and one at the practice level – for which data are already available or could be made available in the short to medium term.

This report describes the process and its results and outlines the initiatives that have been undertaken to date to implement the PCPM framework and to advance primary care performance measurement and reporting in Ontario.

Methods

The system- and practice-level prioritization processes were conducted separately but in parallel and were guided by the PCPM Steering Committee. The Health Quality Ontario staff supported both processes, which engaged expert working groups that included primary care providers, policy makers, managers, researchers and patient representatives. Working group members were chosen to reflect different primary care organizational models and knowledge of health system issues and priorities, the PCPM framework, measures and relevant data sources and existing data and measurement capacity. The system-level working group consisted of 12 representatives of primary care stakeholder organizations (e.g., Ontario College of Family Physicians, Nurse Practitioners' Association of Ontario), healthcare decision-makers (Ministry of Health and Long-Term Care, Local Health Integration Networks), organizations with data collection and analysis expertise (e.g., Canadian Institute for Health Information [CIHI], Institute for Clinical Evaluative Sciences) and patients. The practice-level working group comprised 10 representatives of primary care provider organizations. The two expert panels used slightly different prioritization processes to reflect the focus on system or practice, but both applied pre-defined selection criteria and prioritized measures through consensus building. The criteria assessed importance, actionability, validity, data availability and alignment with other initiatives. The PCPM Steering Committee reviewed and approved the final subsets of system- and practice-level measures.

System-level prioritization

For the system-level prioritization, the panel was asked to prioritize the 87 candidate system-level PCPM measures for which data were currently available. The initial prioritization was limited to measures for which data were available to ensure that immediate measurement was possible. The process (Figure 1) included an independent online survey to rate measures against the selection criteria and in-person meetings to achieve consensus on the final set of recommended system-level measures. The panel focused on the validity, relevance and actionability of the measures to key audiences: patients, caregivers, primary care providers and decision-makers. To further aid the consensus process, the panel also considered alignment with other primary care measurement initiatives. The final set of system-level measures encompassed the eight domains of the PCPM framework. In addition, the panel recommended stratifications that should be included to measure performance across the ninth cross-cutting equity domain.

FIGURE 1. System-level prioritization

Practice-level prioritization

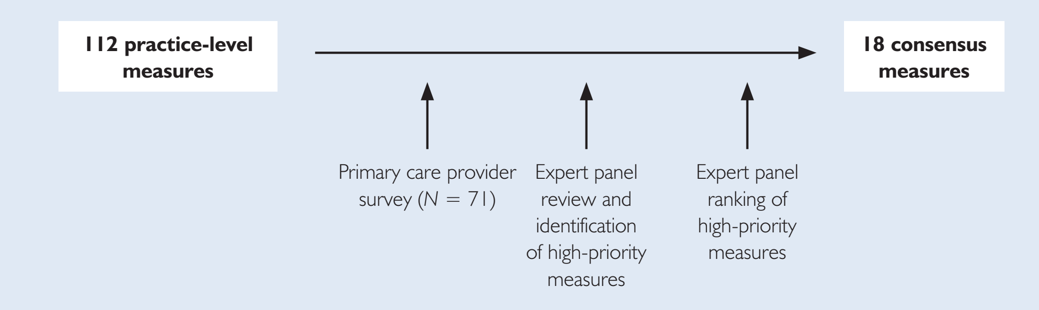
We enlisted front-line primary care providers to select (via an online survey) measures from the full list of 112 candidate measures. This approach differed from that of the system-level prioritization in that all measures were considered for prioritization, without restriction to measures for which data were available. The panel decided against restriction, given the limited availability of practice-level data (at the time, data were available for only 17 of 112 candidate practice-level measures).

The process we used for the practice-level prioritization is depicted in Figure 2. We surveyed approximately 400 providers, including *MyPractice: Primary Care* report (Health Quality Ontario 2020) users and attendees at a primary care forum convened jointly by Health Quality Ontario and the Ontario College of Family Physicians. A total of 71 providers completed the survey. The results informed the expert panel's discussion and identification of high-priority practice-level measures. Based on the review and discussion of the survey results, the panel ranked the measures in each domain. In an effort to balance measures across the framework, the panel recommended measures ranked high in each domain to the PCPM Steering Committee for practice-level prioritization.

Results

The system-level prioritization working group selected 12 system measures across eight domains of the PCPM framework, all of which were measurable with available provincial data. The practice-level prioritization working group selected 18 measures, 11 of which currently do not have a consistent data source, although some may be collected by individual practices through electronic medical records (EMRs) or practice surveys. Seven of the

FIGURE 2. Practice-level prioritization



measures were common to system- and practice-level measurement; all seven are available at the system level, and five are currently available at the practice level. In addition, the practice-level working group recommended the development of two practice-level safety measures, one related to polypharmacy among older adults and another related to up-to-date allergy status recorded in patient records. Table 1 lists the measures selected, by domain, for the system and practice levels.

The system-level working group recommended that all selected measures should be assessed from an equity perspective. In particular, the group identified attachment rate, colorectal cancer screening and diabetes complications as measures that vary significantly by sociodemographic characteristics. The practice-level working group discussed the role of population demographic measures at the practice level and recommended that such measures be included in future specifications for EMR systems to enable equity measurement at the practice level.

TABLE 1. Number and current availability of measures by domain

	System-level measures		Practice-level measures		Shared measures	
Domain	**Selected**	**Available**	**Selected**	**Available**	**Selected**	**Available**
Access	4*	4*	3	1	2	1
Integration	2	2	2	2	2	2
Efficiency	1	1	2	1	1	1
Effectiveness	2	2	3	1	0	0
Focus on population health	1	1	6	2	1	1
Safety	1	1	0**	0	0	0
Patient-centredness	1	0	2	0	1	0
Appropriate resources	1*	1*	0	0	0	0
Equity	Cross-cutting domain		Cross-cutting domain		Cross-cutting domain	
Total	12	11	18	7	7	5

*One system-level access measure was cross-referenced to the domain of appropriate resources.

**Two new measures not included in the current framework (polypharmacy among older persons and up-to-date recording of allergy status) were recommended for development.

The full report of the prioritization process, *Primary Care Performance Measurement: Priority Measures for System and Practice Levels*, including the rationale, existing or potential data source and technical specifications for each measure, is available at http://www.hqontario.ca/Portals/0/documents/system-performance/priority-measures-system-practice-primary-care-performance-measurement-ontario-en.pdf.

Appendix 1 describes the selected measures (available online at longwoods.com/content/26291).

System-level data gaps

The system-level working group identified data gaps (aspects of primary care performance for which either data sources or specific data are not currently available) in a number of measurement areas. To address the immediate need for comprehensive primary care measurement, one of the measure selection criteria was *currently available* measures and data. However, as new data sources become available, the selected measures will need to be reviewed at regular intervals to ensure that primary care performance measurement continues to evolve and grow. System-level primary care measurement gaps that were identified as most in need of data advocacy efforts include the following:

- mental health;
- provider-reported measures;
- comprehensiveness of care;
- health promotion including tobacco smoking, obesity, injury prevention and immunization;
- maternal health; and
- family and caregiver information.

Practice-level data gaps

Given the limited availability of data at the practice level, the practice-level prioritization was not restricted to measures with available data. Of the measures selected at the practice level, seven are currently available. Data advocacy and development of measures are needed for the remaining 11 prioritized measures. In addition, the practice-level working group identified possible measures interpretation issues or data gaps for a number of measurement areas. Practice-level primary care measurement gaps identified as most in need of data advocacy efforts include the following:

- mental health;
- safety;
- EMR specifications to capture and report more practice-level measures; and

- aligning measures that speak to the clinician's day-to-day pressure points with other, ongoing best-practice or improvement-advocacy campaigns (e.g., Choosing Wisely Canada).

Application of the PCPM framework

Following the release of the prioritization report, Health Quality Ontario began implementing the PCPM framework by embedding the recommended and currently available system- and practice-level measures in its yearly health system performance report, *Measuring Up*, in the *MyPractice: Primary Care* report, and in priority indicators for quality improvement plans submitted annually by Community Health Centres (CHCs) and Family Health Teams (FHTs).

In line with the PCPM Steering Committee recommendations, and informed by the identified set of system-level measures, Health Quality Ontario has publicly reported on primary care performance using an online reporting platform and released two specialized reports – *Quality in Primary Care: Setting a Foundation for Monitoring and Reporting in Ontario* (Health Quality Ontario 2015b) and *Connecting the Dots for Patients: Family Doctors' Views on Coordinating Patient Care in Ontario's Health System* (Health Quality Ontario 2016).

In 2017, the Office of the Auditor General of Ontario noted in a chapter on CHCs in its annual report that the Ministry of Health and Long-Term Care had informed the Auditor General's office that "this [PCPM] framework serves as the foundational component of provincial efforts to collect data and measure performance for primary care providers, including CHCs, and that it has prioritized the measures and adopted a subset of recommended measures – 18 of the 112 practice-level measures and 12 of the 179 system-level measures. (Office of the Auditor General of Ontario 2017: 207).

Health Quality Ontario publicly reports on primary care performance in two forms: its annual health system performance report, *Measuring Up*, and its online reporting of primary care performance (available at https://www.hqontario.ca/System-Performance/Primary-Care-Performance). In 2018, *Measuring Up* reported on six of the 12 prioritized PCPM system-level measures (Health Quality Ontario 2018a). None of the prioritized measures was included in the re-oriented 2019 report, but three new measures focused on primary care were added: satisfaction with waiting times to see a primary care provider, e-mailing a primary care provider with a medical question and primary care physician work stress (Health Quality Ontario 2019a). These changes reflected an effort to reduce the number of measures reported in response to feedback and the changing health delivery and policy landscape. Health Quality Ontario currently reports nine of the 12 prioritized system-level measures online. Ontario's quarterly Health Care Experience Survey (Ontario Ministry of Health and Long-Term Care 2019) collects data on four system-level priority measures. The survey provides results at the district and provincial levels and, for consenting respondents, is linkable to health administrative data. Selective results are publicly reported through reports such as *Measuring Up*.

In partnership with ICES (formerly the Institute for Clinical Evaluative Sciences), Health Quality Ontario makes practice-level performance data derived from health administrative data available to individual physicians, FHTs and CHCs through its *MyPractice* report (Health Quality Ontario 2020). The report tracks changes over time and presents district and provincial averages for comparison. The reports are available through voluntary sign-up to any primary care physician, FHT or CHC. They include all seven of the currently available practice-level priority measures. In response to the escalation of opioid overdoses and deaths in recent years, four measures related to opioid prescribing that were not identified as priorities in the 2015 prioritization process have been added to the *MyPractice* reports.

Ivers et al. (2018) used a selection of PCPM framework measures derived from administrative data in a Health Quality Ontario project designed to engage patients in selecting measures for a primary care audit and feedback intervention.

Through a process that engaged key stakeholders and technical experts, Health Quality Ontario developed a primary care patient experience survey designed for administration following an office visit (Health Quality Ontario 2015c). Health Quality Ontario makes the survey available for use by primary care practices and organizations but does not administer the survey or analyze the results. The questionnaire includes four of the 18 practice-level priority measures.

The Government of Ontario (through Health Quality Ontario) requires FHTs, CHCs, Aboriginal health access centres and nurse practitioner-led clinics to submit annual quality improvement plans and to report on their quality improvement results. Of the five priority quality measures identified for 2019/2020, three are PCPM practice-level priority measures (Health Quality Ontario 2019b).

Ontario Primary Care Reporting Alliance

Health Quality Ontario sunsetted the PCPM Steering Committee following the completion of the prioritization process and assigned responsibility for advancing primary care performance measurement to its Primary Care Quality Advisory Committee. In June 2017, Health Quality Ontario convened a roundtable of primary care partners and experts "to discuss the future of primary care audit and feedback (practice reporting) in Ontario, and opportunities for developing a shared vision and commitment towards aligned and/or integrated practice reports and other supports" (Ontario Primary Care Reporting Alliance 2019: 3). Meeting participants agreed to form a time-limited alliance to collaborate on improving primary care measurement and reporting in the province to support primary care clinicians' quality improvement efforts. The Alliance defined its purpose as "improv[ing] patient care and outcomes through increased alignment of reporting efforts across partner organizations, as well as improved provider experience, uptake and use of reports for quality improvement" (Ontario Primary Care Reporting Alliance 2019: 5)

Alliance membership included senior representation from the following performance report-producer and performance report-consumer organizations: Association of Family Health Teams of Ontario, Alliance for Healthier Communities, Canadian Primary Care Sentinel Surveillance Network, Cancer Care Ontario, Electronic Medical Record Administrative Data Linked Database, Health Quality Ontario, OntarioMD, Institute for Clinical Evaluative Sciences, CIHI, Ministry of Health and Long-Term Care, Primary Care LHIN Leadership, Nurse Practitioners' Association of Ontario, Ontario College of Family Physicians and Ontario Medical Association Section on General and Family Practice.

The Alliance reviewed seven reports targeting primary care clinicians for which its members were responsible and identified overlapping target audiences and purpose. "Overlap in purpose included improving data quality, team-level performance, population health, cancer screening and chronic disease management, and supporting accountability reporting and operational management. There is also a high degree of overlap – but not necessarily complete alignment in technical specifications and definitions – in many of the reported indicators" (Ontario Primary Care Reporting Alliance 2019: 4). Three of the reports drew on EMR data, and four are derived from health administrative data.

The Alliance released its report in February 2019. The report included a key recommendation to move from seven to two reports, noting that "family physicians, nurse practitioners and interprofessional teams feel overwhelmed by the number of reports and indicators" (Ontario Primary Care Reporting Alliance 2019: 6). Near-term tasks identified in the report included the following:

- "Develop[ing] a coordinated communication plan with regard to reporting and quality improvement …"
- "Implement[ing] a collaborative approach for clinical engagement …"
- "Develop[ing] a joint proposal for a cost-efficient provincial patient experience measurement approach that is meaningful to practices and patients/clients, with a mechanism for timely feedback to practices and clinicians."

Medium-term tasks include the following:

- "Develop[ing] and launching an integrated reporting format and platform …"
- "Develop[ing] a plan for allowing practices and clinicians to select measures from a suite of indicators that reflect their needs …"
- "Gain[ing] consensus on an approach to peer comparison …"

Identified longer term tasks include the following:

- "Plann[ing] and deliver[ing] integrated real-time EMR reports."

The report's final recommendation was to establish a partnered working group to implement its recommendations.

Health Quality Ontario assigned responsibility for implementing the recommendations of the Alliance to the Primary Care Quality Advisory Committee. The committee's revised terms of reference state that the committee "shall provide advice on the implementation and uptake of strategies to strengthen the quality of primary care practice … A key component of the committee is to advance the recommendations from the Ontario Primary Care Reporting Alliance" (Health Quality Ontario 2018b: 2). Committee membership includes Health Quality Ontario's Primary Care Clinical Lead (Chair) and senior leadership, primary care clinical leaders, measurement and data systems experts, Ministry of Health and Long-Term Care and public health representatives and patients and family caregivers.

Discussion

Alignment with Pan-Canadian Primary Health Care Indicators

In 2012, CIHI released its *Pan-Canadian Primary Health Care Indicator Update Report* (CIHI 2012). From the 105 indicators identified in the original 2006 report, the update identified two priority subsets "for measuring and improving PHC [primary health care] in Canada" – one intended to meet the needs of policy makers and one intended to meet the needs of primary healthcare providers – based on "broad stakeholder consultations." Only five of CIHI's 19 priority indicators for policy makers align with the PCPM system-level priority measures, and seven of 30 priority indicators for providers align with the PCPM practice-level priority measures. Interestingly, the Chair and one other member of the PCPM Steering Committee and a member of the Technical Working Group were three of the 12 members of the Advisory Panel for the CIHI indicator update project.

Primary care performance measurement in other provinces and territories

Canadian provinces and territories have all addressed primary care performance measurement to some extent, some minimally and others substantially. For example, Nova Scotia, Northwest Territories and Yukon have reported on primary care performance at the system level. Nova Scotia conducts and publicly reports on a patient experience survey that includes primary care content (Nova Scotia Health Authority 2019a). In 2019, the Nova Scotia Health Authority released *Current State Assessment of the Primary Health Care System in Nova Scotia*, which reported baseline data for 28 indicators selected by key stakeholders "through a multi-voting process" (Nova Scotia Health Authority 2019b). In 2014, the Yukon Government developed a health and social services performance measurement framework and reported on 14 of the 20 selected measures, several of which were relevant to primary care (Yukon Government Health and Social Services 2014). In 2015, Northwest Territories Health and Social Services developed a performance measurement framework (Northwest Territories Health and Social Services 2015a) and released reports in 2015 and 2016 on the 30 selected measures, five of which addressed primary care performance (Northwest Territories Health and Social Services 2015b, 2016). The Northwest Territories 2017 to 2018 report adopted a new framework, retained 16 of the original measures, dropped 14 and added 35 new measures (Government of Northwest Territories 2018).

Alberta makes primary care performance data available at both the practice and system levels. Beginning in 2016, the Health Quality Council of Alberta (HQCA) developed a primary care patient experience survey that was initially administered in self-selected primary care clinics (Health Quality Council of Alberta 2019a). In 2019, the survey was conducted province-wide, and in March 2019, data from the patient experience survey (eight measures) were added to the HQCA's Focus on Primary Healthcare website (Health Quality Council of Alberta 2019b), complementing seven measures of clinical care and care delivery derived from administrative data. The clinical measures are reported at the provincial, regional and primary care network levels; patient experience measures are reported only at the provincial level.

The Saskatchewan Health Quality Council (HQC) has developed two primary healthcare patient surveys: a short five-question version and a long 11-question version. The HQC supports health regions to administer and analyze the surveys with a "Getting Started Toolkit" and a Microsoft Excel tool "that generates graphs based on the survey data entered" (Saskatchewan Health Quality Council 2017: 5).

The Health Data Coalition (HDC) in British Columbia (BC) is a physician-led not-for-profit organization funded by the General Practice Services Committee, a partnership of the Government of BC and Doctors of BC (Health Data Coalition 2019). The HDC provides primary care physicians who use one of four EMRs and enroll with the HDC with no-charge access to approximately 250 EMR-based clinical measures for their patient population. Enrolled physicians can share and compare their data with other physicians in their clinic, Division of General Practice, Health Authority and province-wide. The Government of BC, Doctors of BC and the province's health authorities have partnered to develop the Measurement System for Physician Quality Improvement "to identify continuous quality improvement opportunities for individual physicians and value for money to the system" by providing physicians, health system managers and policy makers with relevant quality measures data (Doctors of BC 2019: 2). Initial development is focused on primary care and surgical care.

Although some primary care performance measures are consistent among the various provincial/territorial initiatives and with Ontario's PCPM priority measures, the degree of alignment is at most modest.

Challenges and Lessons Learned

Engagement and momentum

The implementation of a provincial system of primary care performance measurement is inevitably non-linear, incremental and protracted. It requires the engagement and re-engagement over time of a large and changing cast of players. Ontario has maintained stakeholder engagement and momentum over a period of more than seven years, first during the PCPM initiative, followed by the Ontario Primary Care Reporting Alliance and, currently, the Primary Care Quality Advisory Committee. Without the ongoing leadership, facilitation and staff support provided by Health Quality Ontario, the process would likely have faltered. Our sense is that continued stakeholder engagement reflects a sense of being heard and having influence and confidence that current efforts will lead to important benefits for the constituencies represented by the stakeholder organizations.

The influence of framing, context and participants

The marked variation in provincial/territorial primary care performance measurement frameworks and indicators and their limited alignment with CIHI's Pan-Canadian Primary Health Care Indicators suggest that factors such as the identified objectives and terms of reference for a performance measurement initiative, the health policy environment in which it occurs and who participates in the process substantially influence the outcome. Processes for the development of a performance measurement framework and the selection of performance measures that on the surface seem similar can produce quite different results.

Infrastructure

Ontario continues to have limited sources of primary care performance data, mainly health administrative and patient experience data. Practice-level performance measures (including peer group comparisons) derived from EMR data are available, but only to a relatively small subset of practices, due largely to a lack of sustainable infrastructure. Patient experience data are available through the Health Care Experience Survey, but only at the district and provincial levels. The net result is that most of what is important is not available. The problem is particularly acute for practice-level performance measures. To move beyond this dilemma, Ontario needs to develop and support infrastructure that would equip clinicians and practice managers with clinical and patient experience data for their practice population that is timely, supports planning and quality improvement and allows comparison with peer practices. This requires developing a mechanism to pool and analyze EMR data from across the province and to conduct a recurring provincial survey of patient experience that would provide patient-reported measures of performance at the practice level. The need for such a survey was highlighted in the report of the Ontario Primary Care Reporting Alliance (2019). Development and ongoing support of the needed infrastructure would require a substantial public investment.

The situation in other provinces and territories appears similar, although BC's Health Data Alliance appears to be a sustainable model that has the potential to make EMR-based performance measures available to any primary care provider who wishes to enrol.

Coordination across performance measurement and reporting initiatives

The work of the Ontario Primary Care Reporting Alliance demonstrates the effective use of a collaborative approach to problem identification and response, in particular the problem of multiple, overlapping performance reporting directed toward primary care clinicians. In its report, the Alliance mapped out an approach and secured a commitment from key stakeholders to address the issue. Although the goal of a common access point for all practice-level performance feedback and a consolidated report containing "information that is actionable and proven to support change" has not been achieved, a process has been established to move toward that goal.

Breadth of primary care performance measurement

Given the limits of existing data collection and analysis infrastructure and that data are currently available for only 13% of the practice-level measures and 41% of the system-level measures that were identified through the PCPM initiative as useful to measure on a regular basis to inform planning, policy and practice, the Steering Committee decided to undertake the prioritization process described earlier. However, as noted in the Ontario Primary Care Reporting Alliance report, ultimately clinicians and practices need to be able to "select measures from a suite of indicators that reflect their needs …" (Ontario Primary Care Reporting Alliance 2019: 6).

Interprovincial/territorial alignment of performance measures

The lack of alignment between CIHI's Pan-Canadian Primary Health Care Indicators, Ontario's priority primary care performance measures and those identified in other provincial frameworks suggests that agreement among the provinces and territories on a common set of primary care performance measures is unlikely to be achieved absent a shared federal/provincial/territorial commitment to that objective based on recognition of the value of national primary care performance reporting and interprovincial comparisons of primary care performance.

Conclusion

Establishing and implementing a framework and coordinated system for primary care measurement and reporting are challenging and inevitably protracted tasks. Although the PCPM framework and prioritized measures are Ontario specific, our methods, stakeholder engagement processes and lessons learned are potentially transferable to other provinces.

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The Methods section and the Results section to the end of the Data Gaps subsection

are an edited and expanded version of these sections from the 2015 Health Quality Ontario report, *Primary Care Performance Measurement: Priority Measures for System and Practice Levels*. Three co-authors of the present article participated in the preparation of that report.

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Notes:

1. As of December 2019, Ontario Health (Quality), part of Ontario Health
2. As of December 2019, Ontario Health (Quality), part of Ontario Health
3. Since then, Ontario Health (Quality) has adopted the Institute of Medicine's six domains of quality (safe, effective, patient-centred, efficient, timely, equitable) through the Quality Matters Framework (Health Quality Ontario 2015a).

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RESEARCH PAPER

Awareness and Use of Community Services among Primary Care Physicians

Connaissance et utilisation des services communautaires par les médecins de première ligne

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Abstract

Primary care physicians play an important role in care coordination, including initiating referrals to community resources. Yet, it is unclear how awareness and use of community resources vary between physicians practising with and without an extended healthcare team. We conducted a cross-sectional survey of primary care physicians practising in Toronto, Canada, to compare awareness and use of community services between physicians practising in team- and non-team-based practice models. Team-based models included Community Health Centres and Family Health Teams – settings in which the government provides funding for the practice to hire non-physician health professionals, such as social workers, pharmacists, nurse practitioners, registered nurses and others. The survey was mailed to physicians, and reminders were done by phone, fax and e-mail. We used logistic regression to compare awareness between physicians in team-based ($N = 89$) and non-team-based ($N = 138$) models after controlling for confounders. We found that fewer than half of the physicians were aware of five of eight centralized intake services (e.g., ConnexOntario, Telehomecare). For most services, team-based physicians had at least twice the odds of being aware of the service compared to non-team-based physicians. Our findings suggest that patients in team-based practices may be doubly advantaged, with access to non-physician health professionals within the practice as well as to physicians who are more aware of community resources.

Résumé

Les médecins de première ligne jouent un rôle important dans la coordination des soins, notamment en aiguillant des patients vers les ressources communautaires. Toutefois, on ne sait à quel point le degré de connaissance et l'utilisation des ressources communautaires varient entre, d'une part, les médecins qui exercent leur pratique au sein d'une équipe de soins multidisciplinaire et, d'autre part, ceux qui exercent leur pratique en dehors de tels équipes. Nous avons mené une enquête intersectorielle auprès des médecins de première ligne qui œuvrent à Toronto, en Ontario, afin de comparer le degré de connaissance et l'utilisation des services communautaires entre les deux modèles de pratique. Les modèles d'équipes comprennent les centres de santé communautaire et les équipes Santé familiale – des organismes dont le gouvernement finance le recrutement de professionnels de la santé non médecins tels que les travailleurs sociaux, les pharmaciens, les infirmières praticiennes, les infirmières autorisée et autres. L'enquête a été envoyée par la poste aux médecins, puis a fait l'objet de rappels par téléphone, par télécopie et par courriel. Nous avons employé la régression logistique pour comparer le degré de connaissance des ressources communautaires entre les médecins qui travaillent au sein d'équipes ($N = 89$) et ceux qui travaillent en dehors de ces équipes ($N = 138$), après contrôle des facteurs de confusion. Nous avons observé que moins de la moitié des médecins avaient connaissance de cinq des huit points d'accès centralisés (p. ex., ConnexOntario ou Telehomecare). Pour la plupart des services, les médecins qui pratiquent au sein d'équipes sont au moins deux fois plus susceptibles d'avoir connaissance d'un service, comparativement aux médecins qui n'œuvrent pas au sein d'une équipe. Nos résultats suggèrent que les patients qui consultent dans les pratiques où se trouvent des équipes bénéficient d'un double avantage, d'une part grâce à l'accès aux professionnels de la santé non médecins, et d'autre part grâce aux médecins qui sont plus au fait des ressources communautaires disponibles.

Introduction

It is well-accepted that systems with strong primary care have lower costs and better outcomes (Starfield et al. 2005). Starfield (1992) described four core elements of primary care, commonly referred to as the four Cs: provision of first *Contact* care, *Continuity* of care over time, *Comprehensiveness* or concern for the whole person rather than one organ system and *Coordination* with other parts of the healthcare system. Primary care's role in care coordination is particularly relevant, given the global rise in chronic disease prevalence and multi-morbidity (Starfield et al. 2003). Care coordination involves judicious referral to specialists for support in managing chronic conditions and also connecting with community and social services that enable patients and families to effectively self-manage their conditions. Effective coordination with social and community services has implications for health equity, given the intersection between multi-morbidity and social deprivation (Barnett et al. 2012).

In Canada, coordination between traditional healthcare services and community services can be challenging, given the sectors are largely funded and operated separately. There are also large gaps in public coverage for the latter (Martin et al. 2018). Every year, approximately one in five Canadians experience a mental health condition (Mental Health Commission of Canada 2013), yet timely access to community-based mental health services in Canada is a particular challenge (Brien et al. 2015; Kurdyak et al. 2017; MHASEF Research Team 2017). More than two thirds of the people with a mental health condition are seen by a primary care physician, either alone or by other additional health professionals (Jaakkimainen et al. 2006), underscoring the important role primary care physicians play in coordinating care for this group.

Primary care in Ontario and access to the extended healthcare team

Ontario is Canada's largest province. Primary care physician services are fully insured by the provincial health insurance plan and free at the point of care for all permanent residents. Public coverage for community supports varies, with some services being fully covered (e.g., diabetes education), some not covered (e.g., Meals on Wheels) and some covered through both public and private options (e.g., weight management). Over the past two decades, Ontario has invested considerable resources in reforming primary care. Ontario has introduced new types of practice models that incorporate aspects of the Patient Medical Home, including formal patient enrolment, blended capitation payment, coordinated after-hours' access and, in some cases, funding for non-physician health professionals, such as registered nurses, nurse practitioners, pharmacists or social workers (Hutchison et al. 2011).

There are two predominant team-based primary care models, Family Health Teams (FHTs) and Community Health Centres (CHCs). In these models, the practice receives dedicated government funding to hire non-physician team members. Members of the extended healthcare team work collaboratively with primary care physicians in the practice and provide a range of services at no out-of-pocket cost to patients (i.e., extended health team services in the practice are covered under provincial health insurance). Examples include nurse practitioners counselling for smoking cessation, pharmacists conducting medication reviews, dietitians and nurses supporting diabetes education and social workers providing cognitive behavioural therapy for depression or providing case management for supporting a housing search. There is heterogeneity between team-based practices in the mix of health professionals and the programs they offer. Patients who are not part of a team-based model generally do not have free access to non-physician health professionals within the provincial health insurance plan. For example, patients not in a team-based model would need to pay privately, through third-party insurance or out of pocket, to see a social worker for counselling or for case management support.

In other jurisdictions, team-based models have been shown to support more effective chronic disease prevention and management (Bodenheimer et al. 2002) and lower healthcare use and costs (Reiss-Brennan et al. 2016). However, only one quarter of Ontarians are attached to a physician practising in a team-based model (Peckham et al. 2018), and access varies 10-fold across regions in the province (Glazier et al. 2018; Green et al. 2017) and is variable even within a single health region.

Community services in the region

One strategy to address inequities in access to team-based care in Ontario has been to try and enhance community services, which would be available to all patients, regardless of their physician's practice model. At the time of study, the regional health authority directly funded many community services, including diabetes education programs, or programs to support healthy eating, employment support or smoking cessation. The health authority also developed centralized intake services – a central point of contact supporting navigation of community services for a population or condition, such as one number to call to access addiction support services. Some community and centralized intake services require a physician referral, whereas others do not. At the time of study, most centralized intake services had been operating for about five years, whereas most community services were long-standing, having been established for two or more decades. However, it was unclear how much these community services were being used by physicians and their patients and whether these services effectively mitigate inequities in access to team supports embedded in primary care practices.

Study objective

Research from three decades ago found low awareness of community services among family physicians overall (Craven et al. 1990). However, there has been little work to quantify the issue in the modern era, where there is easy access to information via the internet. Recent qualitative research suggested that it was still challenging for family physicians to keep abreast of available community services, for example, because of out-of-date resources or that non-physician team members helped facilitate linkages with community resources (Ploeg et al. 2017). Accordingly, our study aimed to better understand family physicians' current awareness and use of community resources and how these were influenced by access to non-physician team members.

We conducted a cross-sectional survey to understand awareness and use of community services among primary care physicians practising in an urban region of Ontario, including services for people with mental health and addictions, for seniors and for those requiring chronic disease prevention and management. We sought to understand whether awareness and use of community services were different for physicians practising in a team-based versus a non-team-based model. We defined FHTs and CHCs as the team-based models of interest because, in these models, the government provides the practice with dedicated funds to hire non-physician health professionals to work alongside primary care physicians.

Method

Setting and context

The study was conducted in the Toronto Central Local Health Integration Network (TC LHIN) health region, which encompasses downtown Toronto. Toronto is Canada's largest city, with a population of approximately 2.7 million residents in 2016. Approximately 17% of the patients in Toronto receive care from a physician practising in a team-based model, 15% in an FHT and 2% in a CHC (Glazier et al. 2018; P. Gozdyra, personal communication, August 21, 2019). CHCs were introduced in the 1970s; these have traditionally been located in areas with greater social deprivation, often have formal catchment areas or specific populations that they serve and are mostly governed by community-led boards. FHTs were introduced in 2005; few have catchment or specific population inclusion criteria, and many are governed by a physician-led board. Physicians in CHCs are employees and are paid on salary, whereas physicians in FHTs are self-employed and are paid through blended capitation.

Non-team-based models include ones with formal patient enrolment where physicians are either paid largely through capitation with some shadow billing (Family Health Network, Family Health Organization) or largely via fee-for-service with some capitation payments (Family Health Group, Comprehensive Care Model). Some physicians continue to practice outside a patient enrolment model and are paid solely through fee-for-service. Physicians practising in these models generally do not receive funding to hire non-physician health professionals as a part of their team, although they may use their own earnings to pay, for example, for a nurse or nurse practitioner to work in their team.

Study design and population

We conducted a cross-sectional survey of primary care physicians practising in the TC LHIN health region. Data were collected over six months, between October 2015 and March 2016. The study was initiated by the TC LHIN to better understand the behaviours, barriers and facilitators for community referrals among primary care physicians who practiced in the region. A "community referral" was defined in the study as the scheduling or arranging for a patient to attend a (non-physician) service in the community, either directly or via a centralized intake service. It did not include referrals to medical specialists, diagnostics, lab work or long-term care.

Survey participants were selected using stratified random sampling based on geographic subregions and neighbourhoods. The TC LHIN received a list from the Ontario Ministry of Health and Long-Term Care of physicians practising primary care in the health region, including their practice address. Physicians were included in the sample if they were practising in one of the TC LHIN neighbourhoods at the start of the study. Physicians were excluded if they were known to have a focused practice other than geriatrics (e.g., psychotherapy, sports medicine, etc.). The study received approval by the Research Ethics Board of St. Michael's Hospital in Toronto, Ontario.

Survey design

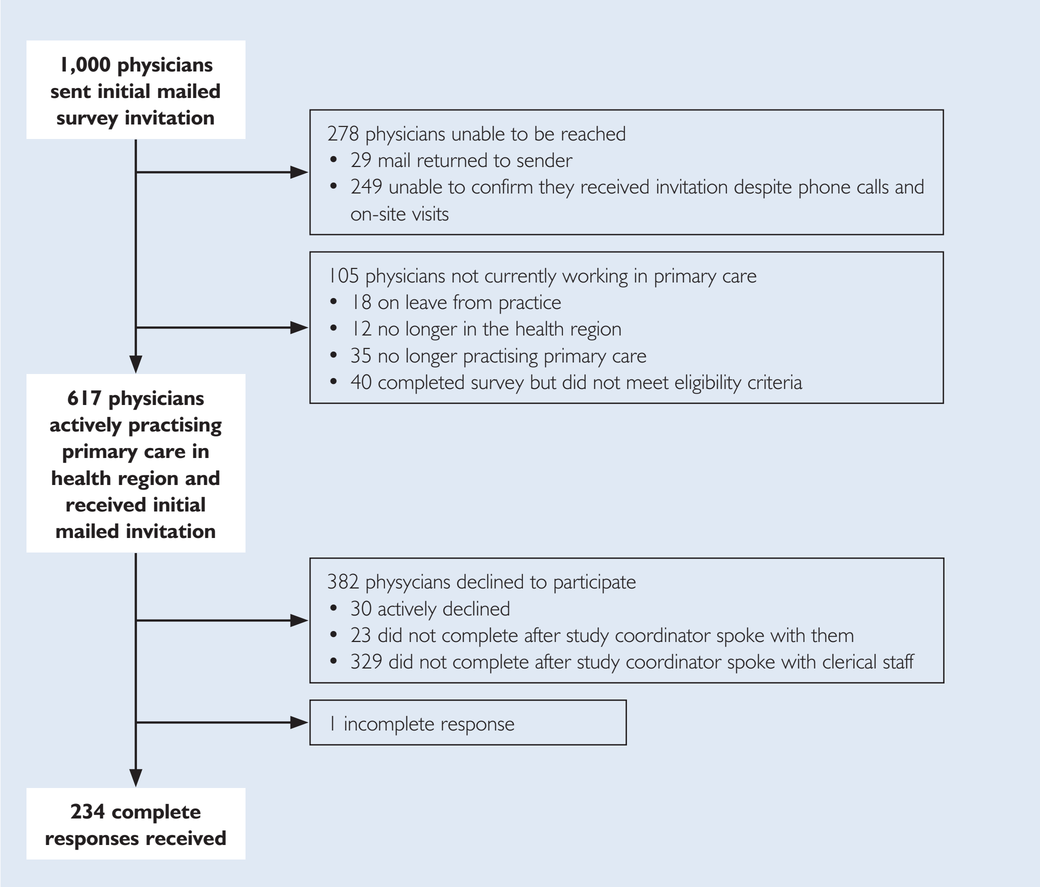
A literature search was conducted to inform the initial content of the questions. An academic librarian searched CINAHL, Medline and PubMed around the topic of primary healthcare providers and their referrals of patients to community services. Consultations were then conducted with primary care providers and other physicians based in Toronto, to compile a more comprehensive list of community services for the survey. Study staff met with these physicians in person to get their feedback on what was missing or duplicated in the list. Lead primary care advisors and other staff at the TC LHIN also reviewed the survey for content, and their feedback was given to the study team. The survey asked physicians about their community referral practices and related barriers and facilitators and asked them to provide demographic information, including their sex, age, practice size, practice location and practice model. The survey was then piloted with a small group of physicians for formatting and content before the survey was widely distributed for the project. Four physicians completed the survey on paper in the first round, and then two completed the web version in the second round of piloting. In both rounds, physicians were asked to complete the survey on their own and were then asked a series of questions by the study staff (e.g., "How did you come to your response and pick an option?", "How do you recall who makes the referrals in your practice?" "How do you recall overcoming barriers and making the referrals yourself?"). The survey questions are listed in Appendix 1 (available online at longwoods.com/content/26290). The final survey included 17 questions over four pages and was made available via mail, fax and web.

Participant recruitment

Approximately 1,700 physicians met the inclusion criteria. Over the course of two waves, 1,000 of these physicians were invited to participate in the cross-sectional survey (Figure 1). We originally aimed for a 50% recruitment rate. All sampled physicians were initially invited through mailed study materials in October 2015 (N = 500) and January 2016 (N = 500). All physicians were initially mailed an invitation and up to two follow-up reminders. All mailouts included a paper version of the survey with a postage paid envelope to return it to the study team as well as a web link if they preferred to complete the survey online. A recruitment database was set up to track completed surveys and returned letters, so physicians who completed the survey or were no longer eligible (e.g., inactive practice, change of practice location, etc.) did not continue to receive follow-ups. Phone, e-mail, fax and on-site follow-ups were conducted in between each mailout, the outcomes of which were all recorded in the recruitment database. If the study team had access to a fax number (publicly listed or provided during a phone follow-up), the team faxed a copy to the office. The majority of respondents completed the paper survey following the initial mailout. The web survey was the second most successful strategy, followed by fax. Some practices were selected to receive on-site visits by study staff in between the second and third mailout. Sites geographically closest to the study team with some of the highest numbers of outstanding surveys were chosen for on-site visits. Although this strategy was not successful in getting physicians to complete it on the spot, it did allow study staff to leave an additional copy of the mailed package with the clerical staff. At minimum, all physicians received at least one phone follow-up in addition to the mailouts, unless they completed the survey before the end attempt, refused to complete or were found ineligible.

We used the College of Physicians and Surgeons of Ontario public directory to update respondents' contact information and primary practice location throughout the study, ensuring currency of information and participant eligibility. Throughout the course of data collection, physicians who completed the survey were offered the opportunity to be entered into a draw for a tablet. Draws took place at three different time points in the data collection period, so the earlier a physician completed their survey, the more draws they were entered in. In the last few months of the study, additional tablets were added for administration staff at the winning physician's offices to further encourage timely completion, as physicians who completed the survey could have the chance to win a tablet for themselves and a clerical staff member. No honorarium was provided. After the invitations were mailed out, a total of 105 physicians were found to be ineligible (no longer practising primary care, relocated to outside of TC LHIN geography, on leave), whereas 278 physicians had no confirmed contact information, or there was no way to confirm we reached them (e.g., unable to leave a message

FIGURE 1. Flowchart of physicians invited to participate in the survey ($N = 1{,}000$)



about the study with anyone at the practice). Recruitment rates were calculated excluding these 383 physicians from the sample.

Analysis of responses

In the analysis, we stratified physicians by whether they practiced in a team-based model or not at the time of sampling. Team-based models included physicians practising in CHCs or FHTs. Non-team-based models included physicians practising in Family Health Organizations, in Family Health Groups and in the Comprehensive Care Model or those who were practising traditional fee-for-service. We included all data from surveys with partial responses as long as physicians identified their practice model and the number of patients in their practice. We used χ^2 tests to compare physician demographic characteristics (age, sex and years of practice in Toronto) between the team-based and non-team-based practice models. We examined respondents' practice characteristics (panel size, patient population and community referrals) using *t* tests.

We conducted binomial logistic regression analyses to determine the associations between a physician's practice models and their awareness and use of community services. We assessed awareness and use of 24 services designed to support (i) mental health and addictions, (ii) chronic disease and management and (iii) seniors within TC LHIN boundaries. Eight of these services were categorized as centralized intake services. For all models, we included the practice model, sex of the respondent and years practising as covariates. For models relating to (i) mental health and addictions and (ii) chronic disease prevention and management, we also included the physician's estimation of the prevalence in their practice (i.e., percentage of patients in their main Toronto practice with severe mental illness and/or addiction problems and percentage medically complex, respectively). We decided a priori not to make adjustments for multiple comparisons, given that our study was hypothesis-generating (not hypothesis-testing), and we worried that adjustments for multiple comparisons could inflate Type II error. Graphpad Prism 7 was used to plot the adjusted odds ratios. All other analyses were conducted using IBM SPSS Statistics, Version 24.

Results

In total, 234 of 617 eligible primary care physicians completed the survey (69.7% by paper, 20.5% by web and 9.8% by fax). Seven respondents were excluded from the analysis because they did not specify either a practice model or the number of patients in their practice. A total of 227 physicians were included in our analysis.

In total, 89 (39%) respondents identified practising in a team-based model (68 in an FHT and 21 in a CHC). The two most common non-team-based models were the Family Health Group ($N = 46$) and the Family Health Organization ($N = 61$). Physicians in team-based models were more likely to be female, to be less than 50 years of age and to report practising in Toronto for fewer than 15 years (Table 1).

The mean roster size of team-based physicians was almost half that of the non-team-based physicians (Table 2). Team-based physicians reported caring for a higher proportion of patients who were uninsured, medically complex, recent immigrants, dealing with poverty or had severe mental illness or addictions. Team-based physicians estimated that, on average, most community referrals were initiated by themselves (73%), with the next most common referents being social workers (18%). Non-team-based physicians estimated that a higher proportion of community referrals were initiated by themselves (93%) but also reported that other professionals initiated some of the referrals.

Figure 2 summarizes the awareness and use of community services among physicians in team-based versus non-team-based practice models. Fewer than half of physicians were aware of four of the five centralized intake services for people with mental health and addictions (Figure 2a); awareness was not significantly different between physicians in team-based and

TABLE 1. Characteristics of survey respondents ($N = 227$) by non-team-based and team-based practice model*

Physician provider demographics		Non-team-based ($N = 138$)	Team-based ($N = 89$)	p
Gender (N, percentage column)	Female	71	64	0.002
		51.4	71.9	
Age range (years) (N, percentage column)	<39	31	39	0.000
		22.5	43.8	
	40–49	23	23	
		16.7	25.8	
	50–59	27	13	
		19.6	14.6	
	60+	57	14	
		41.3	15.7	
Years practising in Toronto (years) (N, percentage column)	≤5	24	29	0.000
		17.4	32.6	
	6–14	24	28	
		17.4	31.5	
	15–29	32	19	
		23.2	21.3	
	30+	53	11	
		38.4	12.4	
	Missing	5	2	
		3.6	2.2	
Sub-LHIN region (N, percentage column)	East	23	14	0.000
		16.7	15.7	
	Mid-East	13	28	
		9.4	31.5	
	Mid-West	58	30	
		42.0	33.7	
	North	27	6	
		19.6	6.7	
	West	17	11	
		12.3	12.4	

*Non-team-based practice models include physicians in the Comprehensive Care Model, Family Health Groups, Family Health Organizations or fee-for-service model. Team-based models include physicians in FHTs or CHCs.

TABLE 2. Practice characteristics of survey respondents ($N = 227$) by non-team-based and team-based practice model[†]

Practice demographic		Non-team-based	Team-based	*p*
Panel size (*N*, *M* ± *SD*)	Average number of patients in main Toronto practice	110 1416.12 ± 982.99	77 776.16 ± 464.69	0.000
Percentage of patients in main Toronto practice who … (*N*, *M* ± *SD*)	… are uninsured (e.g., do not have OHIP)	131 2.87 ± 9.93	85 8.87 ± 17.32	0.004
	… are dealing with poverty and/or housing instability	134 10.82 ± 14.19	88 30.51 ± 28.26	0.000
	… are medically complex (e.g., multiple chronic health issues)	137 27.16 ± 22.95	89 38.02 ±24.31	0.001
	… have severe mental illness and/or addiction problems	136 11.47 ± 11.67	89 20.02 ± 17.01	0.000
	… are composed of recent immigrants (arrived in Canada within five years or less)	134 10.60 ± 13.86	88 16.78 ± 22.42	0.023
	… have language barriers	135 13.69 ± 21.54	88 13.45 ± 16.68	0.932
Percentage of community service referrals for your patients that are from … (*N*, *M* ± *SD*)	… yourself	76 92.88 ± 16.05	123 73.19 ± 22.39	0.000
	… nurse practitioner	42 2.12 ± 4.51	56 7.09 ± 8.29	0.000
	… social worker	51 7.41 ± 11.31	68 17.97 ± 18.02	0.000
	… other	40 12.73 ± 21.00	35 11.98 ± 10.79	0.845

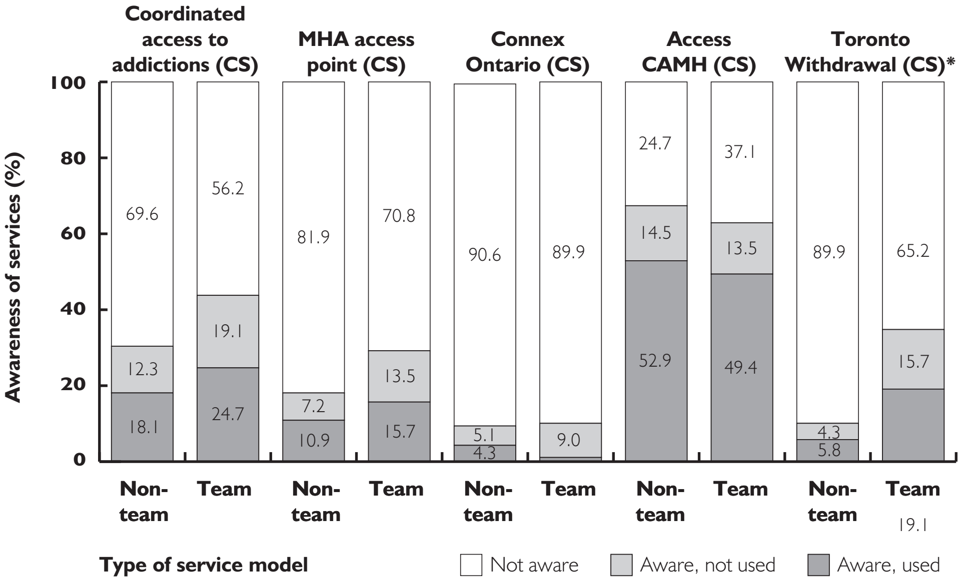
[†] Non-team-based practice models include physicians in the Comprehensive Care Model, Family Health Groups, Family Health Organizations or fee-for-service model. Team-based models include physicians in FHTs or CHCs.

non-team-based practice models, with one exception (withdrawal management services). The majority of physicians were aware of other community services for people with mental health and addictions (Figure 2b); for all of these services, team-based physicians had significantly higher awareness of and use of these services than non-team-based physicians.

Figure 2.
Proportion of primary care physicians who reported awareness of and use of community support services by non-team-based and team-based practice model.

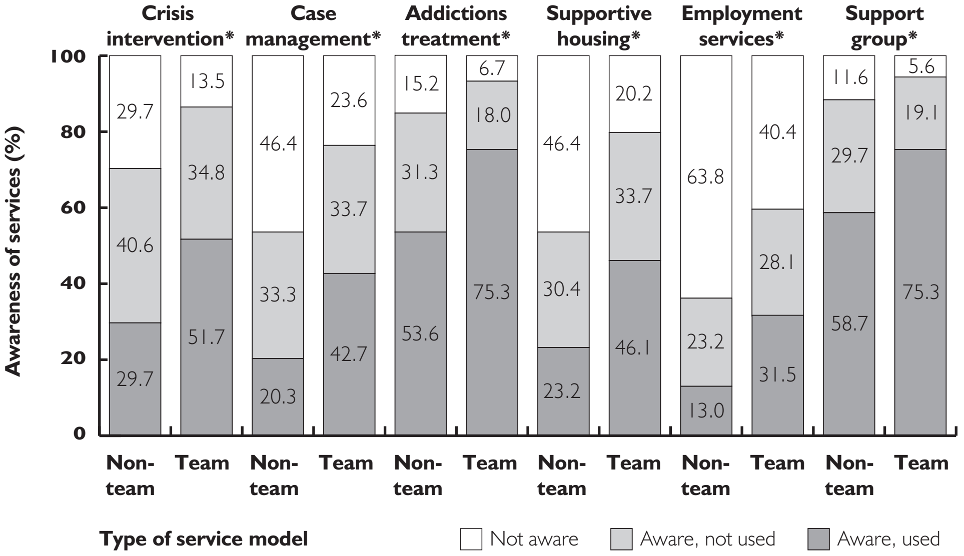
For each subset of community services, physicians reported being not aware, aware and not used services, or aware and used services. $N = 227$ for all services unless specified elsewhere. CS in parentheses refers to Centralized Intake Service. Non-team-based practice models include physicians in the Comprehensive Care Model, Family Health Groups, Family Health Organizations or fee-for-service model. Team-based models include those in FHTs or CHCs.

FIGURE 2A. Centralized intake services for people with mental health and addictions



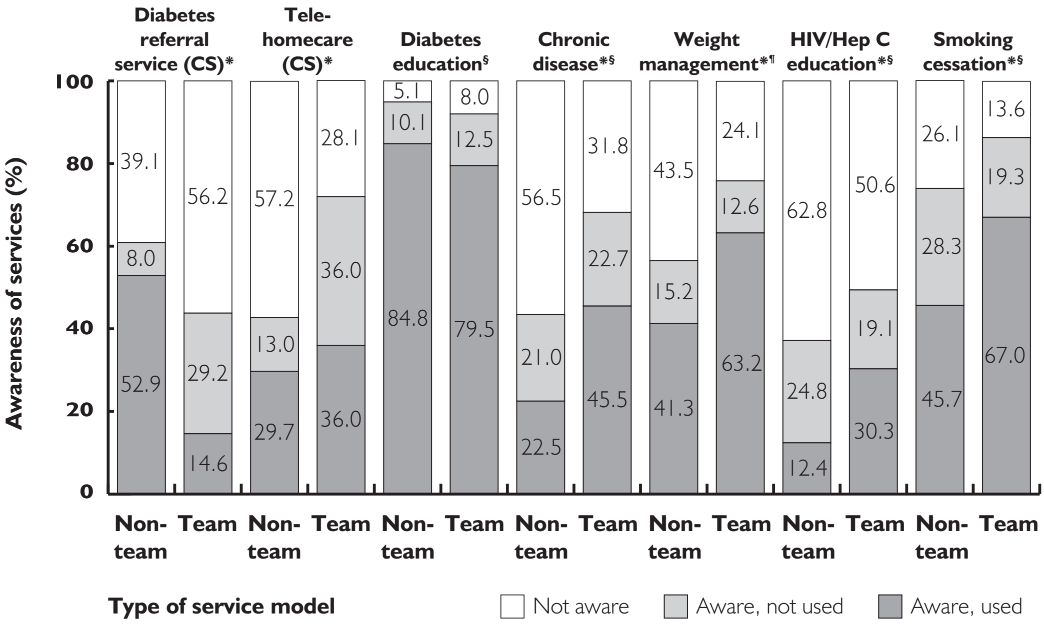
*$p < 0.05$.

FIGURE 2B. Other services for people with mental health and addictions



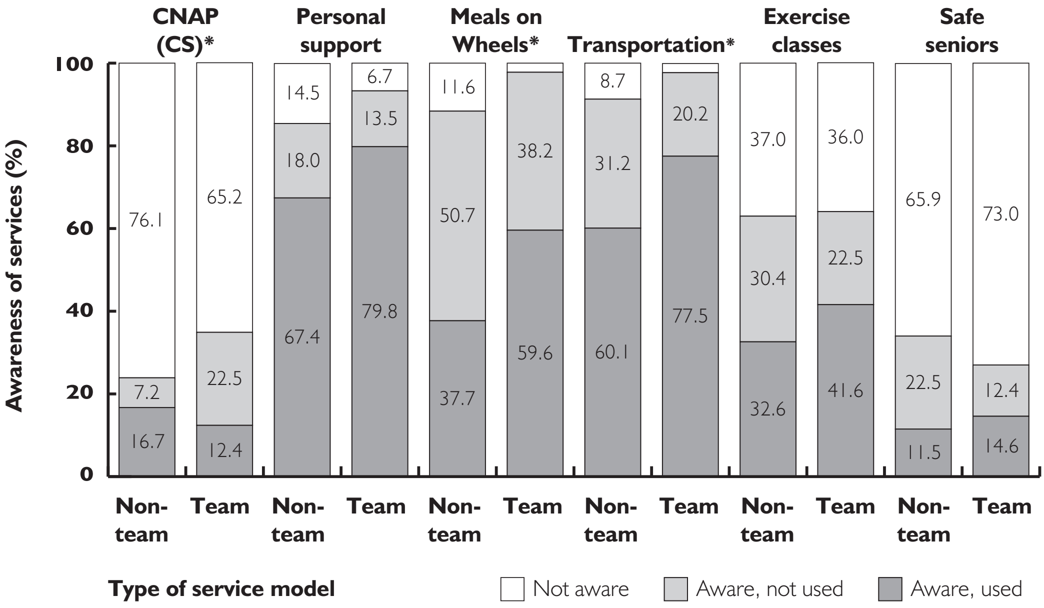
*$p < 0.05$.

FIGURE 2C. Services to support chronic disease prevention and management



*$p < 0.05$. § $N = 226$; ¶ $N = 225$

FIGURE 2D. Services to support seniors



*$p < 0.05$.

The majority of physicians were aware of chronic disease prevention and management services (Figure 2c); for most of these services, team-based physicians had significantly higher awareness of and use of the services than non-team-based physicians. There was relatively high awareness about some senior support services and low awareness about other services including the service coordinating centralized intake (Figure 2d); for half of the services, team-based physicians had significantly higher awareness of and use of the services than non-team-based physicians, and for the other half there was no significant difference.

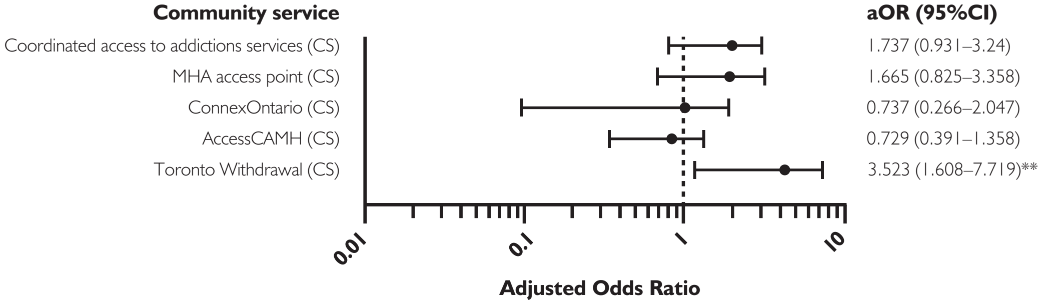
Figure 3 summarizes the odds that team-based physicians were aware of a community service compared to non-team-based physicians after adjustment for potential confounders. Overall, adjusted odds were similar to unadjusted odds. For most services, team-based physicians had at least twice the odds of being aware of the service compared to non-team-based physicians. There was only one service (centralized intake for diabetes services) where non-team-based physicians had significantly greater odds of awareness than team-based physicians (Figure 3c).

Figure 3.

Odds ratio (with 95% confidence intervals) comparing awareness of community services among physicians in team-based versus non-team-based practice models after adjustment for physician demographics (practice model, sex and years of practice) and relevant practice demographics (severe mental illness and/or addiction problems, medically complex patients)

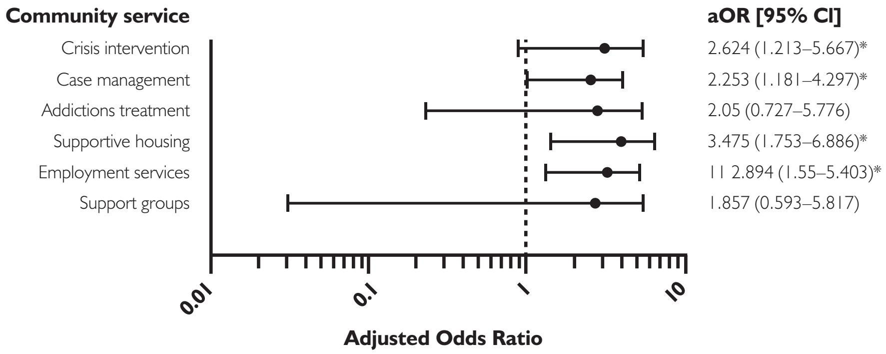
N = 227 for all services unless specified elsewhere. CS in parentheses refers to Centralized Intake Service. Team-based models include those in FHTs or CHCs. Non-team-based practice models include physicians in the Comprehensive Care Model, Family Health Groups, Family Health Organizations or fee-for-service model.

FIGURE 3A. Centralized intake services for people with mental health and addictions



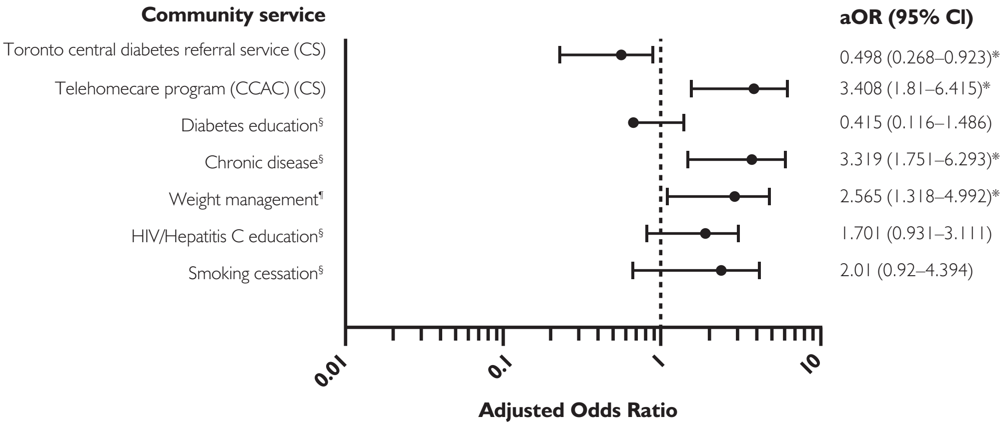
*$p < 0.05$.

FIGURE 3B. Other services for people with mental health and addictions



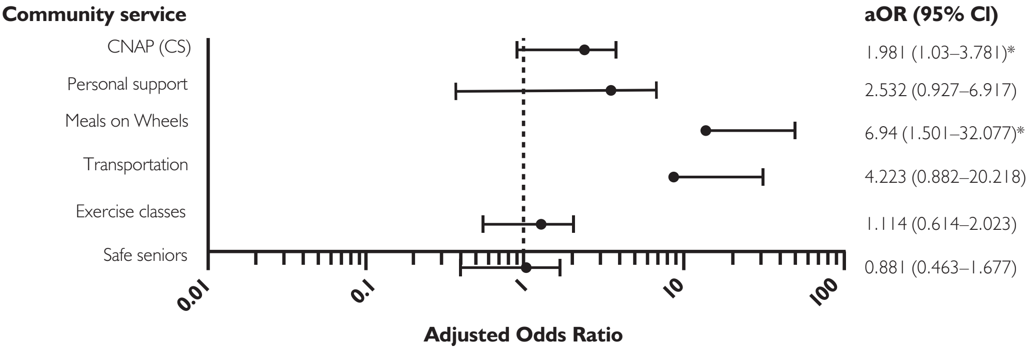
*$p < 0.05$.

FIGURE 3C. Services to support chronic disease prevention and management



*$p < 0.05$. § $N = 226$. ¶ $N = 225$.

FIGURE 3D. Services to support seniors



*$p < 0.05$.

Discussion

We found relatively low awareness among physicians of the Centralized Intake Services available in their region. Most physicians, however, were aware of specific services to support patients with mental health and addictions, chronic disease management and prevention and older adults. In general, awareness of centralized and specific community support services was more than twice as high among physicians practising in a team-based model than among those practising without the support of government-funded health professionals. Team-based physicians reported serving more patients with psychosocial and medical complexity than non-team-based physicians, but also had roster sizes about half as large as non-team-based physicians. Team-based physicians were more likely to be female, younger and with fewer years in practice. Team-based physicians continued to have higher odds of awareness of community services even after adjustment for differences in physician and practice characteristics.

There are several potential explanations for the low awareness of community resources. Services were likely to be ineffectively advertised, and physicians were likely to be unaware of regional websites summarizing available community resources. Physicians need to keep up with rapidly changing medical evidence, and in that context, staying abreast of changes in community services may be challenging and perceived as less important. Centralized Intake Services are meant to streamline and improve access, so low awareness of these is particularly troubling. Auto-integration of community referrals with electronic medical record systems is a promising approach offered by select third-party vendors for specific types of referrals (CognisantMD 2017). Awareness of the centralized diabetes referral was higher among non-team-based practices, and its relative success may offer potential insights for other community programs. More research is also needed to understand whether awareness of specific community resources relates to the perceived usefulness or efficacy of the resource among physicians.

Our findings suggest that patients who attend a team-based primary care model in Ontario may be doubly advantaged. Not only do they have easy access to social workers, dietitians, pharmacists and other health professionals free at the point of care, their physicians are more likely to be aware of existing community resources, including programs to support mental health and for chronic disease management. It may be that team-based physicians learn about community resources from their non-physician colleagues, for example, learning from social workers about available community mental health programs. They may also be more attuned to the benefits of interprofessional care.

Approximately three quarters of Ontarians are not part of a team-based primary care model, and these patients are more likely to be new immigrants, live in lower income neighbourhoods, and live in urban areas (Kiran et al. 2016). More needs to be done to improve their access to non-physician supports and their use of community resources. New Ontario Health Teams are meant to integrate care between primary care and other sectors including community mental health and addiction services (Ontario Ministry of Health and

Long-Term Care 2019). However, our study warns that these initiatives can potentially worsen inequities in access. For example, there is a risk that early adopters will largely include physicians practising in existing team-based models, providing more streamlined access to community resources for patients who already have better access to non-physician-based health professionals and physicians with more knowledge of community services.

Few other studies have assessed primary care physician awareness of community resources. A study done in another urban area in Canada many years ago also found low awareness of services (Craven et al. 1990). A recent qualitative study found that physicians in team-based models often relied on other team members to stay up-to-date on available community resources for seniors. Participants in that study recommended a central online database with current information on services and resources to enable patient self-referral (Ploeg et al. 2017). A study in British Columbia found that adding a nurse practitioner to a rural primary care practice improved community linkages (Roots and MacDonald 2014). Other recent studies suggest that community health workers may help patients successfully navigate community resources, acting as a bridge between the health system and the broader community (Cosgrove et al. 2014; Najafizada et al. 2015). High-performing practices in the US often have dedicated staff whose sole responsibility is care coordination (Bodenheimer et al. 2014). Qualitative findings from a recent initiative in our region emphasize the importance of providing support in a trusting, collaborative manner to counter feelings of isolation and burnout among community physicians (Lockhart et al. 2019).

Limitations

There are several limitations worth noting. First, similar to all surveys, ours is open to response bias. Specifically, most respondents in our survey reported working in a team-based model, yet, in the health region, most physicians do not work in a team setting. It is also plausible that physicians who responded to our survey were generally more engaged in the topic area or with the health region. However, these response biases likely underestimate the difference in awareness of community resources between team-based and non-team-based physicians, as we hypothesize that non-responders were disproportionately non-team-based physicians and that these physicians were likely more removed from communications from the regional health authority and less aware of community services. Further, our response rate was close to 40%, which is much higher than that of typical physician surveys (Canadian Medical Association 2018; National Physician Survey 2014). Second, it is possible that our survey underestimated awareness, overall. Respondents may have incorrectly written that they were not aware of a service because they were not familiar with the formal name of the service used in the survey – the survey did not offer a detailed definition for the services included. Third, potential confounders may have influenced our comparison of team-based and non-team-based physicians. Most FHTs in the surveyed region are affiliated with the university and act as training sites for family medicine residents. It is possible that some of the differences we found between team-based and non-team-based physicians relate to the presence of family medicine residents. However, the equity implications for patients in the team-based and non-team-based practices remain. In addition, variables such as panel size were self-reported and may not have been entirely accurate. Fourth, we decided a priori not to adjust for multiple comparisons. Doing so would have changed the threshold for statistical significance, but it would not have altered our overall conclusions related to low awareness, especially among non-team-based physicians. Finally, the study occurred in a large, urban area with a diverse population and a large number of community resources. Our findings of low awareness may not be generalizable to health regions encompassing smaller towns or rural communities.

Conclusion

In summary, we found low awareness of Centralized Intake Services for community resources among primary care physicians practising in an urban area. Physicians practising in team-based models were twice as likely to report awareness compared to those not in a team-based model. Our findings suggest that shared community supports are not a substitute for non-physician health professionals integrated into a team. The latter may play an important role in helping educate physicians and patients about available services. Future research should explore why primary care physicians do not know about services, particularly Centralized Intake Services designed to improve access, and what strategies may increase awareness and use. At the same time, healthcare administrators should consider direct advertising to patients of available community resources. Efforts to improve access to community services and non-physician health professionals should take an equity lens, deliberately targeting underserved groups, to avoid worsening inequities.

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Conflict of Interest

Tara Kiran was a primary care advisor with the Toronto Central Local Health Integration Network from 2015 to 2016. She has received grant funding from Gilead Sciences Canada.

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RESEARCH PAPER

Structural Facilitators and Barriers to Access to and Continuity of French-Language Healthcare and Social Services in Ontario's Champlain Region

Facilitateurs et obstacles structurels à l'accès et à la continuité en français des services sociaux et de santé dans la région ontarienne de Champlain

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Abstract

Purpose: The purpose of this article is to examine access to and continuity of French-language healthcare and social services in Ontario's Champlain region through an analytical framework that incorporates people seeking care, their caregivers and the linguistic component of care into a health and social service system bounded by community, organizational, political and symbolic structures.

Methods: Experiences of French-speaking seniors seeking care and those of health and social service providers and managers from two qualitative exploratory studies are used to describe trajectories through the system.

Results: Participants exposed how, together with community vitality, issues within each of the system's symbolic, political or regulatory and organizational structures influence these trajectories.

Conclusions: To meet the needs of francophone seniors, additional work is needed to increase French-language services coordination within the organizational, regulatory and policy structures of the health and social service system.

Résumé

Objectifs : Examiner l'accès aux services sociaux et de santé en français, ainsi que leur continuité, dans la région de Champlain en Ontario, à l'aide d'un cadre d'analyse qui inclut la personne qui demande des services, ses proches aidants et la composante linguistique des services, dans un système de services sociaux et de santé encadré par des structures communautaire, organisationnelle, politique et règlementaire, et symbolique.

Méthode : Les expériences de francophones ayant besoin de services, ainsi que celle de fournisseurs et de gestionnaires de services, tirées de deux études qualitatives exploratoires menées par notre équipe, sont utilisées pour décrire des trajectoires dans le système.

Résultats : Les participants démontrent comment chacune des structures symbolique, politique et règlementaire, organisationnelle, et communautaire influence ces trajectoires.

Conclusion : Pour répondre aux besoins des ainés francophones en situation minoritaire, la coordination des services sociaux et de santé offerts en français devrait être améliorée, tant au sein de la structure organisationnelle que de la structure politique et règlementaire.

Introduction

Living in a linguistic minority context has been identified as a social determinant of health (Bouchard et al. 2012). People in such contexts face major barriers when health and social services are only provided in the majority language (Bowen 2015; De Moissac and Bowen 2017; Lapierre et al. 2014). Language affects the development of a trusting relationship between the person and the provider, and the sense of comfort within that relationship, both of which are fundamental to person-centred services (Drolet et al. 2014; Irvine et al. 2006). Numerous studies outline the consequences of not receiving these services in one's chosen language (Bowen 2015; De Moissac and Bowen 2019; Flores et al. 2012; Madoc-Jones 2004).

Even in the case of bilingual individuals, one cannot assume that when dealing with affectively laden health and social issues, the person's linguistic competence is identical in both languages (Castaño et al. 2007; Pavlenko 2012).

Canada has two official languages, English and French. Within many provinces, legislative and policy provisions exist to ensure services to official language minority communities (OLMCs). Among Ontario's population of 14 million, 622,415 are francophone (Office of the French Language Services Commissioner 2018a). Following the enactment of the province's 1986 *French Language Services Act* (1990), in 2010, oversight of French-language health service delivery in designated areas of the province was assigned to six French-language health planning entities, working in conjunction with the local health integration networks (LHINs). Organizations or agencies are not automatically designated to offer health and social services in French; rather, the LHIN or the entities can identify an organization, or an organization can self-identify to begin the designation process. The steps are numerous, and many identified institutions are aiming for partial designation, that is, they may have committed to offer some services in French and not others (Office of the French Language Services Commissioner 2018b). The province's planning entities have endorsed the principle of Active Offer in French-Language Service (FLS) provision (Regroupement des entités de planification des services de santé en français de l'Ontario et Alliance des Réseaux Ontariens de santé en français 2015), that is, a written or verbal invitation to communicate in the person's preferred official language, preceding the request for services (Bouchard et al. 2012). Yet, obtaining healthcare and social FLS in Ontario is still reported as difficult by many: although there is regional variation, 40% reported that obtaining healthcare in French was very difficult or impossible, and only 33% of francophones in Ontario communicate in French with their family doctor (Gagnon-Arpin et al. 2014).

The purpose of this study is to examine facilitators and barriers to access to and continuity of French-language healthcare and social services in an OLMC: the Champlain region in Ontario. It presents a new analysis of a data subset from two interrelated qualitative studies: one examining care trajectories described by francophone seniors and their caregivers, as well as parents of children, living in the Champlain region[1] (Drolet et al. 2015, 2017), and the second exploring facilitators and barriers in FLS access and continuity in the Champlain region and in Winnipeg, Manitoba, with a wider diversity of actors – health and social service managers, providers, physicians, seniors and caregivers (Kubina et al. 2018). Data were analyzed with the help of an analytical framework inspired by models and concepts previously found in the literature. This analytical framework is outlined below, followed by a description of methods and results for the present analysis.

Analytical Framework

An analytical framework (Savard et al. 2020) was designed to organize our data and identify levers of action for improving FLS. It is inspired by Champagne and colleagues (2005), who proposed that health and social services are an organized system of actions, delimited by various structures. The system is intended to reduce illness intensity and duration. It comprises autonomous and interdependent structures (e.g., physical structures, including buildings, technical platforms and budgets; organizational structures or governance; and symbolic structures, including values and collective norms) within which actors, namely, professionals, managers, policy makers and vendors, interact to achieve the system's goals. The framework was adapted to the context of OLMCs by multiple iteration with our data: the structures influencing the provision of FLS include laws and regulations to promote linguistic rights (Foucher 2017), the organization of health and social services (Forgues and Bahi 2017) as well as the community structure and its vitality (Bouchard et al. 2006). These structures provide the actors with playing rules that guide their interaction along the care trajectories.

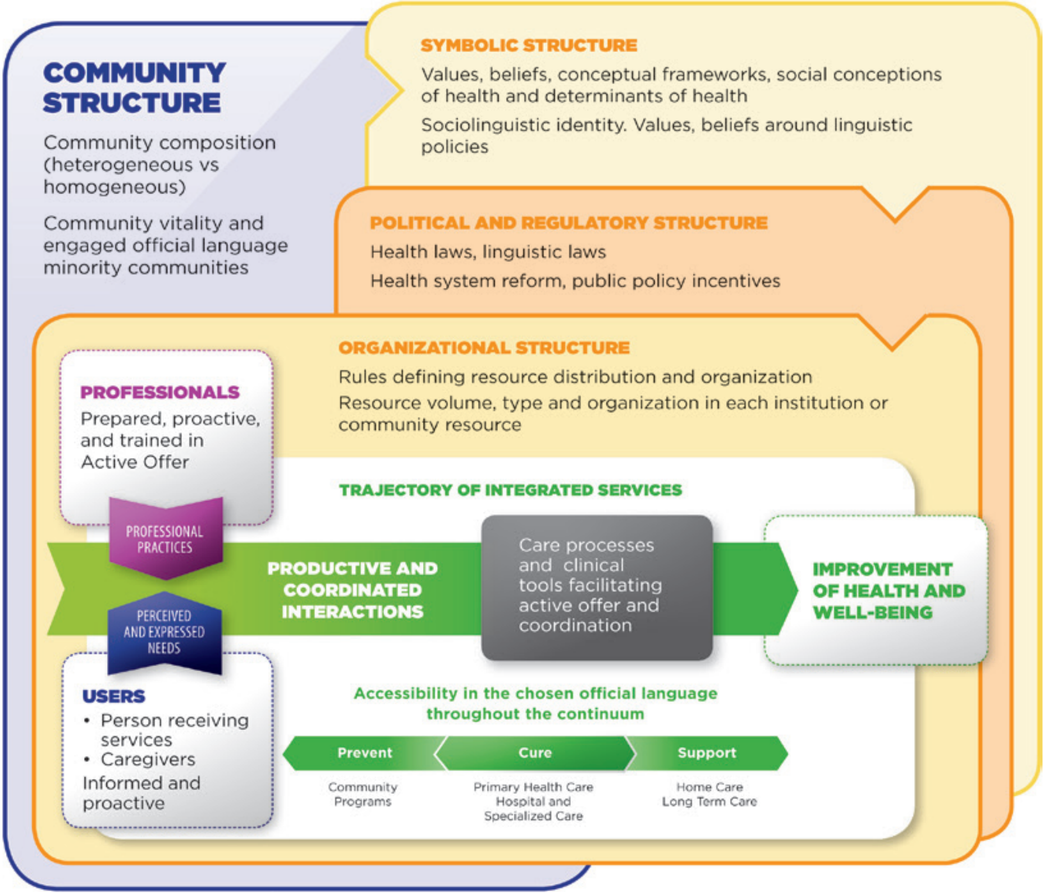
With a growing emphasis on person-centred care, the person seeking care plays an active role in the trajectory. As highlighted by Wagner and colleagues (1996) in the Chronic Care Model and its variations, health or social service providers, and the senior and the senior's caregivers, are central partners collaborating in the management of health conditions (Bodenheimer et al. 2002). Ideally, professionals are proactive, open to networking and to a multipronged approach. Seniors and their caregivers are better informed and empowered to initiate behaviour and lifestyle changes (Wagner et al. 2001). When surrounded by community resources and public policies conducive to health, professionals and seniors' interactions produce better outcomes (Barr et al. 2003; McCurdy et al. 2008).

Integration of these concepts is illustrated in Figure 1. At the centre of the illustration is the service trajectory consisting of the encounter(s) of one or more service providers and the person seeking care, supported by one or more caregivers. These actors evolve in a social space influenced by the following structures:

- a symbolic structure, comprising values, beliefs, social representations, perceptions around equity, bilingualism and francophone identity and perception of healthcare and social services;
- a political and regulatory structure, comprising laws, regulations, health and social service government policies and each province's or territory's official language policies;
- an organizational structure, comprising rules that determine resource distribution and organization and the volume and type of resources in each facility; and
- a community structure, including institutions, organized representations, support groups and community services that complement services offered from formal institutions.

The system also includes processes by which the resources are mobilized and used by actors to work toward the system's goals (Champagne et al. 2005). To ensure continuity of FLS during a care trajectory, the processes should include integration mechanisms such as coordination between service organizations (Couturier et al. 2013; Leutz 1999) and supports or resources to facilitate Active Offer (Savard et al. 2017).

FIGURE 1. Framework for the analysis of health and social services access and integration for OLMCs



Savard et al. (2020). www.grefops.ca/cadre_analyse_en.html.

Method

The present analysis used a data subset from two previous studies: (1) care trajectories of francophones in the Champlain region (Drolet et al. 2015; Dorlet et al. 2017) and (2) integration of services for francophone seniors in Eastern Ontario and Manitoba (Kubina et al. 2018), the subset consisting of the senior participants in the Champlain region. The region includes many health and social service providers designated under the Ontario *French Language Services Act* (Champlain LHIN 2014). Both studies and the data subset analysis followed a general qualitative design using content analysis. Methods are presented in more detail in three previous publications (Drolet et al. 2015, 2017; Kubina et al. 2018) and are summarized below. Both studies received ethics approval from appropriate research ethics boards and the participants' written informed consent.

Participants

Participants retained from the first study consisted of nine dyads, each having accessed at least one health and/or social FLS and comprising a francophone senior (65 years or older) living with a chronic illness affecting their communication skills, and their principal caregiver. Chosen for the complexity of their care trajectories, the seniors were living with dementia (*n* = 4), stroke (*n* = 4) or Parkinson's (*n* = 1). Participants' ages ranged from 51 to 94 years (seniors: 60–94; caregivers: 51–81). Seniors or caregivers predominantly self-identified as francophone, with varying degrees of comfort while communicating in English, from very little to fluently bilingual.

From the second study, we included four types of participants from four Champlain region areas (rural, urban and low- and high-density French-speaking populations): (1) service managers (*n* = 19); (2) health and social service providers who, formally or informally, offered services in French (*n* = 24); (3) physicians (*n* = 3); and (4) seniors or caregivers who preferred receiving services in French (*n* = 23).

Data collection

In the first study, information on care trajectories was collected through two in-depth, semi-structured interviews (Seidman 2006) with seniors and caregivers, covering participants' trajectories through health and social services and their experiences in receiving linguistically appropriate services. The second interview allowed for member checking of previously collected data. The third author conducted all interviews in French from 2012 to 2014, and these were audio-recorded and transcribed verbatim.

In the second study, questions and case studies depicting complex situations inspired by data from the first study were formulated to encourage discussions of integrated practices in general, and in French, in individual interviews or focus groups with managers, providers and physicians. Current collaboration between actors and organizations as well as favourable moments for FLS integration were also addressed. Focus groups with seniors and caregivers focused on FLS access facilitators, service navigation and communication of personal information along the service trajectory. Interviews and focus groups were co-conducted by two team members (Lucy-Ann Kubina and Jacinthe Savard or Lucy-Ann Kubina and Sébastien Savard) from 2015 to 2016, in French or English, audio-recorded and transcribed verbatim. Saturation of data was achieved in this study.

Analysis

For both studies, we performed transcript content analysis to identify code categories and emerging themes (Paillé and Mucchielli 2012). Research team consensus and code validation were obtained. Interrater agreement was sought on 20% of the coded transcripts (Huberman and Miles 2002). The remaining data were coded using this validated list, while allowing for the emergence of new codes.

For the first study, we transposed each interview's findings onto a schematic diagram depicting both the chronology and the complexity of the senior's service utilization, illustrating general and linguistic service discontinuities. In the second study, we explored factors leading to service continuity or discontinuity.

Finally, multiple iterative comparisons of the data from both studies with the evolving analytical framework were done to analyze systemic barriers to and opportunities for service provision in a linguistic minority context within the current health and social service system.

Means to increase trustworthiness included data triangulation (consistent questions posed to different sources: managers, care providers, seniors and their caregivers), data saturation, some member checking and peer debriefing at many points during analysis.

Results

Analysis of care trajectories from the first study shed light on instances of service discontinuity, some inherent to the healthcare and social service system's limited resources and others specific to limited access to FLS. The second study provided a more varied perspective to explain the barriers related to FLS.[2] Results are presented according to our analytical framework.

Regarding the *service trajectory*, participants living in the highly bilingual eastern part of the Champlain region were frequently able to access FLS, such as family physicians, geriatric assessment clinic, diabetic clinic, seniors' day program and a university rehabilitation clinic operating in French. A positive encounter between a senior or a caregiver empowered to request services in French and a proactive provider aware of available resources can lead to a satisfactory service trajectory.

> An Anglophone called me. I told her I was Francophone and preferred things in French, and she said, "I will give your name to a Francophone here right away." And [a Francophone] called me back in 5 minutes to chat. (RO-1, caregiver)

However, the opposite was also the case. Even in the presence of bilingual personnel, the environment may not be conducive to providing services in French. One senior reported being spoken to in English by a francophone provider, suggesting a lack of awareness of Active Offer.

Instances of FLS access variability occurred with acute care, in- and outpatient rehabilitation, community-based home support, community or peer support groups and respite services. This inconsistent access along the trajectory was manifested within the various structures, illustrating where access to FLS could be improved.

In the *symbolic structure*, values and beliefs influence both the demand for and offer of FLS. Several participants reflected on their reluctance to request services in French.

> I don't think I have ever asked for service in French, because I don't want to be too demanding. I don't want to start with anything negative with the doctor or the physiotherapist. (RO-80, senior)

Some seniors did request services in French, which usually increased FLS access. Yet, this access is mediated by service availability; thus, highly valuing services in French alone is insufficient. This is illustrated by one participant, whose ability to comprehend and speak English was significantly diminished by illness. The participant reported insisting on services in French but having to accept services in English, such as home-based physiotherapy services and driving evaluation.

Another barrier to requesting services in French is the perception that service will be delayed. Several participants noted that they were unwilling to wait for FLS, preferring to be seen more quickly in the language of the majority.

> I'm not ready to go with a delay. If I have a problem, since I can manage in English, I'd as much have the treatment as soon as possible. (RO-87, senior)

This perception may not hold true for a particular service: at the symbolic level, it may reflect past experiences. Or it may be real for the requested service, and thus be a barrier within the organizational structure.

Yet, despite not always asking for FLS, some participants highlighted the difficulty of expressing themselves in English.

> It's harder to speak English. … I don't find the words anymore. It's harder and harder as you get older. (RO-85, caregiver)

Some managers were unaware of these difficulties; one stated that francophones their organization serves are bilingual and, therefore, do not require services in French. When provided with examples drawn from actual health and social service encounters, she grasped the connection between linguistically appropriate services and values such as safety and quality of care.

> You brought forward in my mind some things I haven't really thought about that much, you know, especially your stories that you … that you told. It's like, oh, awareness is the first step, right? (RO-31, manager)

With respect to the *political and regulatory structure*, participants' encounters reflected Ontario's FLS legislative framework. In the first study's detailed trajectory analysis, services from fully designated institutions were almost always received in French. In contrast, in partially designated institutions, participants almost always experienced some disruptions in the supply of FLS, whether these services were available in French at certain times or days and not others, or that some services were offered in French and not others. However, the choice to go to a designated facility is often not within the control of the senior or the referring provider. Some services are not available in designated facilities. For example, during a cerebrovascular accident, one participant went to the designated hospital, where treatments required for hemorrhagic stroke were unavailable. The participant was transferred to a partially designated hospital; there, neurology services were not offered in French.

A designated institution also serves the surrounding community, without priority for those with a linguistic preference. Instances of francophones being denied access to existing designated institutions or programs occurred for emergency care as well as in outpatient rehabilitation as demonstrated in the following cases.

> I had to go to the emergency room by ambulance, and I said "I want to go to the Montfort (a designated hospital), I want to go to the Montfort," and he said, "No. The Montfort is too busy. We will take you …" They took me to the [non-designated hospital]. (RO-66, senior)

> She [the doctor] had sent the request to the Montfort because she knows it's important to me, services in French. But Montfort, they said they had reached their quota. (RO-65, senior)

> Me, it's my physiotherapy issue that I specified [I wanted the Montfort] and they called me back to send me to [a non-designated hospital in the city's West end]. And they told me they do a geographic triage. (RO-66, senior)

These examples highlight how designation and regional policies, or institution-specific practices, can interact to produce a disruption in FLS access.

In addition, many respondents turned to private services or community organizations to meet needs that are unmet in the publicly funded system. These services appear less likely to request designation, although some that are owned or operated by francophones do offer FLS. Nonetheless, participants reported that searching for French service providers was challenging, and many respondents had no choice but to accept services in English, such as private night help, private physiotherapy, respite accommodation and personal care, even when this caused some difficulty.

With respect to the *organizational structure and care processes*, study participants identified specific gaps in FLS access such as a lack of programs in certain geographic areas and access to specialists, fewer of whom speak French.

Managers and providers noted difficulty hiring French-speaking and bilingual personnel. This shortage of linguistically competent resources creates significant communication barriers for those seeking care.

> … the secretaries [at the neurologist's office] … speak English and want nothing to do [with French]. They don't even want to let us talk. I understand that the neurologist doesn't have time to talk to every patient, but when you don't speak English, what do you do? (RO-77, senior)

Participants also suggest insufficient formal structural mechanisms to facilitate FLS access. In one underserved region, there had been a recent increase in bilingual physicians. Participants noted no increased access to these physicians. There seemed to be no intentional pairing of bilingual physicians with francophones. When the pairing did occur, it appeared to be due to proactive providers rather than structural mechanisms.

> There's no difference. They don't say, that's a Francophone, we'll put the Francophones with the bilingual doctor. No. (RO-93, senior)

> … for my francophone clients, we have here [at the community health centre] francophone physicians, and I direct them to the French. Even if I often hear [from staff] "yes, but she [client] understands English," I say: "No, you don't understand. Once again, I tell you, when I am in pain, I am in pain in my first language." (RO-35, provider)

Furthermore, referring francophones to francophone providers was limited by the absence of a comprehensive directory of francophone providers, or unfamiliarity with existing directories.

> We need better lists of what's available [in French] and I think that's lacking sometimes (…) that's unfortunate, because when we don't know, we can't offer or we can't recommend. (RO-28, manager)

If the provider does not facilitate FLS continuity, the burden is placed on the senior, as in the case of one senior who was provided with a list of English-speaking physiotherapists by a francophone physician, and told to "look in the phone book" to find a French-speaking therapist.

The *community structure* can play an important role in FLS access. Community support groups act as networking sites for francophone seniors and caregivers, providing them with peer support and information.

> We have meetings [in French], and there we talk, we chat … of our problems, so it helps. (…) It gives you courage to carry on longer. [And] if there is something new, we are [made] aware. (RO-13, caregiver)

Even when a support group is conducted in English, francophone members will seek and connect with francophones in the group. Participants underscored how such groups can offer them opportunities to exchange information regarding available FLS.

Formal health and social service organizations can also link with community groups to increase the visibility of FLS.

> So, we go into the buildings … there's a large population of seniors, [our service] will enter and do a general presentation of the care program, services in their community, and they reach more francophones (…) it's a smaller francophone population here [Ottawa West], but there are more there [in the buildings]. (RO-25, manager)

The presence of institutions in the community is also an asset that can facilitate the recruitment of French-speaking or bilingual personnel, as explained by RO-16, manager:

> The University of Ottawa now offers the dietician program in French. Now, we easily recruit a dietician. It makes a big difference.

Discussion

In this study, we sought to characterize disruptions in health and social service access and continuity within an official language minority context. As described by study participants, an uninterrupted care and service trajectory in French requires collaboration between the person seeking care, their caregivers and the service providers, and is facilitated by the health and social service system's organizational, political and regulatory as well as symbolic structural contexts.

As found previously (Drolet et al. 2015, 2017), this interaction will be positive when, on the one hand, service providers are proactive and capable of offering services in French or can direct the person to an appropriate resource. On the other hand, individuals and caregivers are sensitive to the importance of communication for quality and safe health and social services and affirm their need to obtain certain services in their preferred language. However, some were reluctant to do so. Being part of a minority culture can lead to feelings of inferiority (Drolet et al. 2017; Forgues and Landry 2014), triggering concerns that the relationship with the health provider could be jeopardized by requesting services in French.

Individuals seeking care and service providers do not operate in a vacuum. Consistent with previous studies, community vitality, including both formal and informal resources such as a local university or support groups, emerged as a factor supporting both supply and demand of FLS. Community vitality enhances communities' capacities to not only compensate for service gaps and facilitate information sharing but also articulate service requests to decision-makers (Bouchard et al. 2006). This is illustrated by the francophone community's response to threats to their institutions: Montfort in 1995 and Office of the French Language Services Commissioner in 2018 (Assemblée de la francophonie de l'Ontario 2018). Community vitality contributes to a sense of pride in an individual's cultural and linguistic community (Forgues and Landry 2014) and to providers' sensitivity to the importance of speaking one's preferred language. Thus, the community and symbolic structures mutually influence each other.

Study participants reported difficulty accessing French-language providers, which reflects a general shortage of such providers (Drolet et al. 2014). However, the number of French-speaking providers does not always translate into FLS, as mechanisms to pair francophones with French-speaking providers are inefficient and often left to the initiative of proactive individuals. The public hardly understands the designation process and which services to expect in partially designated institutions. Such flaws previously identified by service users (Drolet et al. 2015, 2017) were, in this analysis, confirmed by service providers.

Providers supported by their organizations will find it easier to implement Active Offer principles (Savard et al. 2017). In this sense, the *French Language Services Act*'s designation mechanisms seem to affirm providers' FLS offer. In this study, receiving care from a fully designated institution ensured better access to and continuity of care in French, in contrast to non-designated or partially designated institutions. Although generalization would be premature, an examination of designation policies found few mechanisms to ensure that conditions present at the time of designation are maintained over time (Office of the French Language Services Commissioner 2018b).

Furthermore, with the increase in chronic diseases, individuals are more likely to juggle interventions from several social and health service providers from various institutional and community networks. For such a trajectory to be seamless, collaboration and coordination mechanisms among several service providers must not only be present but also account for the linguistic variable (Tremblay et al. 2012). In Ontario, the LHIN is mandated to coordinate services from various provider organizations (OMHLTC 2017a); in collaboration with the entity, they work to identify which agencies should aim for designation to ensure a greater range of FLS (OMHLTC 2017b). This is certainly a positive development, but further coordination is needed.

The findings of this analysis led to some recommendations. Strategies for intentional pairing of francophones to French-speaking providers should be explored within both the organizational and regulatory structures. There is a need for further policies including systematic collection of service users' linguistic preference to facilitate service planning according to francophones' identified needs,[3] referral mechanisms that account for linguistic needs and greater communication between health and social services. Policies limiting francophones' access to designated institutions (such as geographic triage or quota) should, when no other FLS are available, be eliminated. Another important strategy includes adequate training in

Active Offer of FLS, which includes reinforcing awareness of the link between linguistically appropriate services and current values such as safety and quality of care (Bowen 2015). This training can be left to individual organizations or could be mandated by a governing body. Services in the official language of choice throughout the continuum of care cannot be the responsibility of a single individual or organization; both organizational and policy and regulatory structures must facilitate this coordination.

We acknowledge that linguistic barriers may compromise access to quality healthcare and social services for others whose first language is not the same as the one commonly used in their living area and institutions. However, only English and French are protected by Canadian language laws, thus favouring creation or improvement of FLS. Health and social service professionals have access to resources to learn both official languages, professional training programs offered in both French and English, support from OLMC institutions, etc. Solutions for other linguistic minority communities will differ, opening a range of research possibilities.

Study limitations

The choice to present the results by structure allowed to bring attention to the multiple levers of action for improving FLS. This classification may only be imperfect, as there are interactions between each structural element. Another limitation comes from the data subset: it refers to the Champlain region only and service users of age 65 years and older. Some facilitators and barriers to FLS continuity may be specific to this geographic area or population group. The 65 years and older population is one that presents more complex needs, increasing the importance of improving service access for them. Difficulties in access to linguistically appropriate services has been reported for a different population (Tempier et al. 2015), in other Canadian provinces (Carter 2012; De Moissac et al. 2015; De Moissac and Bowen 2017; Forgues and Landry 2014) and other countries with two official languages such as Wales in the UK (Madoc-Jones 2004; Martin et al. 2018; Roberts and Burton 2013) or Finland (Eriksson-Backa 2008). The proposed framework could be used in future studies for national or international comparison of access to and continuity of health and social services for OLMCs.

Conclusion

Examining the health and social services system's structures revealed complex and unexpected ways in which health policy and institution-specific resource allocation interact to create disruptions in FLS continuity. Our analysis highlights possible points of action for implementing Active Offer principles and health and social service continuity in the official language of choice.

The designation of individual institutions is a good starting point to increase the provision of FLS. However, it does not ensure continuity of FLS for seniors with complex needs requiring many providers. Including service accessibility in the official language of choice as a feature of integrated health services would help meet their needs. It would require additional actions to increase FLS coordination within each of the organizational, regulatory and policy structures of the regional or provincial health and social service system.

Conflict of Interest

The authors have no conflicts of interests to declare. Funding agencies were not involved in data collection and analysis.

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Notes

1. The Champlain region is in Eastern Ontario. See http://www.champlainlhin.on.ca/AboutUs/GeoPopHlthData/Geography.aspx.
2. The present analysis focuses on the structural factors influencing access to and continuity of FLS. Previous descriptions of the care trajectories and the way key facilitators (caregivers or professional service providers) had solved problems around obstacles have already been published (Drolet et al. 2015, 2017). See also http://www.grefops.ca/uploads/7/4/7/3/7473881/les_trajectoires.pdf for the schematic representation of the nine service trajectories studied in more detail (in French) and http://www.grefops.ca/complementary-results.html for more citations and citations in the original French where applicable.
3 At the time of writing, a motion was voted by Ontario Legislature asking the government to add linguistic identity to the data contained in the Ontario Health Insurance Plan (OHIP) card. See Office of the French Language Services Commissioner (October 5, 2018). Linguistic variable for patients: the OHIP card could become smart! Retrieved November 28, 2018. <https://csfontario.ca/en/articles/6554>.

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RESEARCH PAPER

Exploring the Results of the Ontario Home Care Minimum Wage Change

Aperçu des résultats liés au changement du salaire minimum concernant les soins à domicile en Ontario

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Abstract

Background: In 2014, Ontario increased its "minimum wage" for personal support workers (PSWs) in publicly funded home care.
Objective: The objective of this article is to determine the short-term results of this policy for home care PSWs' wages, hours and job stability.
Methods: This study uses descriptive graphs and ordinary least squares and unconditional quantile regressions, using PSWs across Canada as comparison groups.
Results: Pre-policy nominal wages for Ontario home care PSWs stagnated, whereas real wages declined. The policy increased home care PSWs' wages without noticeably affecting hours or job stability. However, wages were already increasing for low-wage home care workers in the rest of Canada.

Conclusions: Ontario exercises monopsony power in the home care market and, before the wage increase, kept nominal wages stable compared to rising real and nominal wages in the rest of Canada. This PSW-specific wage increase did not represent a drastic change relative to market conditions.

Résumé

Contexte : En 2014, l'Ontario a augmenté le « salaire minimum » des préposés aux services de soutien à la personne (PSSP) dans les soins à domicile financés par les deniers publics.
Objectif : L'objectif de cet article est de dégager les résultats à court terme de cette politique sur le salaire, l'horaire et la stabilité d'emploi chez les PSSP.
Méthode : Cette étude fait appel aux graphiques descriptifs ainsi qu'aux méthodes des moindres carrés ordinaires et de la régression quantile non conditionnelle, en utilisant des PSSP de partout au Canada comme groupe témoin.
Résultats : Avant la mise en œuvre de la politique, les salaires nominaux des PSSP des soins à domicile en Ontario stagnaient, tandis que les salaires réels affichaient un déclin. La politique a permis d'accroître les salaires sans affecter de façon notable les horaires ou la stabilité d'emploi. Cependant, dans le reste du Canada, les salaires des travailleurs des soins à domicile à faible salaire commençaient déjà à augmenter.
Conclusion : L'Ontario exerce un pouvoir monopsonistique sur le marché des soins à domicile et, avant l'augmentation des salaires, maintenait une stabilité des salaire nominaux, comparativement à l'accroissement des salaires réels et nominaux dans le reste du Canada. Cet accroissement propre aux PSSP ne représente pas un changement catégorique comparativement aux conditions présentes sur le marché.

* * *

Introduction

Personal support workers (PSWs) are unregulated healthcare and social service providers who provide clients with supportive care such as dressing and eating. They work in environments such as long-term care (LTC) and hospitals and supply 70%–80% of paid home care services in Ontario, Canada (Denton et al. 2018). As such, they are central to both the Ontario Government's healthcare strategy and many individuals' care plans. Keefe et al. (2011), Lilly (2008) and Zagrodney and Saks (2017) noted that PSWs in home care usually earn lower wages than PSWs in hospitals or LTC. In 2014, as part of an attempt to "attract and retain the best PSWs" in home care, Ontario announced it would increase the minimum wage for PSWs in publicly funded home care from $12.50 per hour to $16.50 per hour in three stages over three years (MOHLTC 2015). This policy was developed without clearly defining "home care PSWs" or indicating which home care PSWs would be eligible for the increased wages. Furthermore, in January 2018, Ontario increased its general minimum wage from $11.60 per hour to $14.00 per hour, which, by improving workers' outside options, likely attenuated the potential effects of this home care–specific wage increase on attraction and retention.

We investigate the short-term effects of this policy on Ontario home care PSWs' (the affected groups') wages, weekly hours of work and job turnover/tenure (the number of consecutive months in the same job). We use non-home care PSWs in Ontario (e.g., PSWs who work in LTC or hospitals) and PSWs in the rest of Canada as comparison groups. We first present time-series plots and describe wage trends across the income distribution, and then analyze the policy's heterogeneous effects on wages, hours and turnover using ordinary least squares (OLS) and unconditional quantile regression (UQR) with a difference-in-differences (DID) model. Our findings suggest that this policy increased home care PSWs' nominal and real wages without significantly affecting hours of work or job turnover. However, we find that wages for most home care PSWs in the rest of Canada were already rising relative to the affected group before the policy was implemented. If, prior to the 2014 policy change – which is itself evidence of monopsony – the Ontario Government had not been exerting monopsony power in the home care labour market through the letting of contracts, increased demand for home care workers would likely have similarly increased Ontario wages without government intervention. This article has implications for home care human resource planning and the effectiveness of targeted wage interventions.

PSWs and the Ontario Home Care Minimum Wage

Descriptive statistics from the Canadian Labour Force Survey (LFS), presented in Table 1, compare home care and non-home care PSWs in Ontario and the rest of Canada. Notably, compared to all PSWs in the rest of Canada and non-home care PSWs in Ontario, home care PSWs in Ontario are less likely to be full-time, public sector or unionized workers, and more likely to work in establishments with greater than 500 employees. Also, PSWs in Ontario are more likely to have community college degrees.

The Ontario Government finances public home care services through managed competition contracting. It is the dominant payer for home care in Ontario. In comparison, home care PSWs have little bargaining power, meaning the government holds monopsony power in this market. Ontario uses competitive bidding to award contracts to large home care agencies (Abelson et al. 2004). Those agencies are then responsible for hiring staff, including PSWs, and delivering services. A PSW working for an agency may work some publicly funded hours and some privately funded hours. Furthermore, some PSWs are hired directly by clients and their families.

Ontario established a $12.50 minimum wage for publicly funded PSWs in 2006.[1] We know of no PSW-specific minimum wages in provinces other than Ontario, and it reflects Ontario's distinctive approach to managed care in this sector. There was no change to this minimum until 2014, when the Ontario Government announced the policy under

TABLE 1. Descriptive statistics for PSWs, 2007–2018

	Home care PSW, Ontario	Non-home care PSW, Ontario	Home care PSW, Rest of Canada	Non-home care PSW, Rest of Canada
Female (%)	93	88	90	85
Immigrant (%)	38	36	23	28
Age (mean)	45	43	45	43
Urban (%)	86	85	73	79
Community college degree (%)	57	56	34	35
Bachelor's degree (%)	10	11	9	10
Mainly full-time (%)	60	67	65	74
Union or collective agreement coverage (%)	37	71	45	74
Public employer (%)	6	38	27	57
Workplace has 500+ employees (%)	54	42	41	52

Authors' calculations. Statistics Canada's Labour Force Survey, 2007–2018. Survey weights were used.

study. It would subsidize a wage increase of $4.00 in three stages over three years for publicly funded home care PSWs, both raising the minimum wage from $12.50 to $16.50 per hour and similarly increasing the wages of other home care PSWs who were already making more than $12.50 by $4.00. The government was hoping to "attract and retain the best PSWs in the home and community care sector" (MOHLTC 2015). Previous research has found that increased wages are sometimes associated with decreased job turnover, though the strength of this relationship and the mechanism through which it operates remain disputed.[2] Local context, including the nature of the wage increase and the state of the labour market, all affect the relationship.

The eligibility criteria for the Ontario PSW wage increase were complicated and ambiguous. The increase only applied to PSWs working publicly funded hours at publicly funded agencies. It did not apply to home care PSWs working privately funded hours at the same agencies or to PSWs hired directly by home care clients. Further, it did not apply to PSWs in other sectors, most of whom already had higher wages. Home care PSWs were only eligible to receive the increased wage for hours spent performing specifically defined "personal support services", effectively, hours spent looking into "the whites of the client's eyes" (Grant and Church 2015). During a home care PSW's workday, they might prepare food for their client, help the client take medication and change bedsheets. However, actions such as preparing food were not eligible (Grant and Church 2015). Therefore, some publicly funded home care PSWs' work hours continued to be reimbursed at the lower rate, and privately funded PSW hours were not directly affected. We therefore expect the median wage to increase by less than $4.00 per hour.

The implementation process faced several challenges. Initially, there was no limit to the wage increases. A PSW earning \$12.50 and a PSW earning \$19.50 were both eligible to receive the first wage increase. In the first year, 27 (out of approximately 500) agencies refused to increase their home care PSWs' wages, citing concerns of overpayment relative to non-PSW staff (Church 2015). At least one large employer "cut what it [paid] in mileage and travel time" (Grant and Church 2015). Furthermore, in the first year, Ontario spent \$77.8 million subsidizing the increase instead of the projected \$50 million (Church 2015). To address some of these concerns, the government introduced a \$19.00 per hour cap in the second- and third-stage increases. In the end, each implementation stage was delayed by two to four months and lump sum back-payments were made. We, therefore, do not expect to see immediate wage changes in the empirical analysis.

Data and Sample Selection

Statistics Canada's 1997–2018 LFS accessed at the Research Data Centre at McMaster University is analyzed. The entire time frame is presented in time-series plots, but because of the structural change associated with Ontario's introduction of the PSW-specific minimum wage in 2006, we focus on 2007–2018 in the regression analyses.[3] Two occupational groupings are identified in the data: home care and non-home care PSWs. Most non-home care PSWs are employed in LTC or hospitals. Two geographies are central to the analysis: Ontario and the rest of Canada. However, in the regressions, we disaggregate the rest of Canada and control for each province individually (the territories are not included in the sample). The affected/treated group is Ontario home care PSWs, and we use non-home care Ontario PSWs, and both categories of PSWs in the rest of Canada, as comparison groups. Details of the sample selection are in Appendix 1 (available online at longwoods.com/content/26288).

Methods

We analyze the effects of the policy on four dependent variables: nominal wages, real wages, hours of work and job tenure (a proxy for worker turnover). Real wages are inflation-adjusted using the provincial or national consumer price index (CPI), with January 2019 as the base for the main results, as indicated in table and figure notes. (There are no meaningful differences between results using either CPI.) Hours of work are measured as actual hours worked in the respondent's main job in the previous week. Tenure is measured as the number of consecutive months that a worker has been with their current main employer.

We first create time-series plots of each dependent variable at the 25th, 50th and 75th percentiles to examine unconditional changes from 1997 to 2018. Then we run DID regressions for all four dependent variables from 2007 to 2018. We define five policy stages in Table 2.

TABLE 2. Policy stages

Stage	Event	Effective date	Time range
Stage 0, S0	*Pre-policy*		January 2007–April 2014
Stage 1, S1	First \$1.50 increase (from \$12.50 to \$14.00 per hour)	April 29, 2014 (retroactive to April 1, 2014)[6]	May 2014–July 2015
Stage 2, S2	Second \$1.50 increase (from \$14.00 to \$15.50)	August 1, 2015 (retroactive to April 1, 2015)	August 2015–June 2016
Stage 3, S3	Final \$1.00 increase (from \$15.50 to \$16.50)	July 1, 2016 (retroactive to April 1, 2016)	July 2016–December 2017
Stage 4, S4	Ontario raises general minimum wage to \$14.00	January 1, 2018	January 2018–October 2018

We estimate a difference in differences (DID) model (Figure 1) where Y is one of hourly wage, tenure or actual hours of work in the reference week. *Aff*, short for *affected*, is an indicator variable that equals 1 if the individual is a home care PSW in Ontario. (S_1 through S_4)* *Affected* are interaction terms between the Affected indicator and the policy stages. X_c is a vector of control variables that include month and year fixed effects, variables for gender, immigrant status, education level, urban/rural residence, public/private employment, firm size, a third-order polynomial in age and, where relevant, province.[4] The βs on these interaction terms are often interpreted causally; however, this is only valid if the dependent variables exhibit a conditional common trend across the affected and comparison groups (Smith and Sweetman 2016). Based on a series of placebo tests that interacted pre-intervention time trends with the treatment group, we do not believe that the common trend assumption is satisfied in our case. This accords with the Ontario labour market being more monopsonistic than other provinces. We, therefore, do not interpret these coefficients as causal effects. Instead, these represent the change in the affected group's outcome variables relative to the reference group. All regressions are weighted to give population estimates.

FIGURE 1. DID model

$$\begin{aligned} Y = {} & \beta_0 + \beta_1 S_1 + \beta_2 S_2 + \beta_3 S_3 + \beta_4 S_4 + \beta_5 \mathrm{Aff} + \beta_6 (S_1 * \mathrm{Aff}) \\ & + \beta_7 (S_2 * \mathrm{Aff}) + \beta_8 (S_3 * \mathrm{Aff}) + \beta_9 (S_4 * \mathrm{Aff}) + \beta_c \mathbf{X_c} + \epsilon \end{aligned} \tag{1}$$

We run a separate DID regression with each comparison group, using both OLS and UQR (UQR, specifically re-centered influence function regression or RIFReg; Firpo et al. 2009). OLS coefficients represent average marginal effects for a hypothetical PSW with mean characteristics. However, we are interested in documenting potential heterogeneity in policy effects across the wage, hours of work and tenure distributions. The impact of this policy might be quite different for high-earning PSWs (e.g., 80th percentile of wages) than for the "mean" PSW as estimated by OLS. UQR calculates the marginal effect of the policy change at various quantiles of the distribution of the unconditional dependant variable (e.g., wages). UQR coefficient estimates should be interpreted locally to the relevant unconditional quantile, but otherwise can be interpreted as in OLS.[5] We did not find any important differences across quantiles for hours of work or job tenure, so to save space, we present UQR results for wages and OLS results for hours of work and tenure.

In DID analyses with one affected group and few comparison groups, inference with analytical cluster–robust standard errors will likely fail (MacKinnon 2019). To address this, we provide wild cluster bootstrapped p values for OLS DID regressions and pairs bootstrapped standard errors for UQR DID regressions (both with 999 replications). In the OLS DID regressions, the unrestricted and restricted wild cluster bootstrap p values are similar. As discussed in the article by MacKinnon and Webb (2018), this provides evidence that the inferences drawn from these values are not wildly misleading.

Results

Hourly wages – before and after

Figure 2 presents time-series plots of the affected group's wages at the 75th (top line), 50th (middle) and 25th (bottom) percentiles from 1997 to 2018. Panel A shows nominal wages and Panel B shows real wages. The three solid vertical lines indicate the three stages of the 2014 Ontario home care wage policy. The dashed vertical lines represent the 2006 home care minimum wage and the 2018 general minimum wage changes.

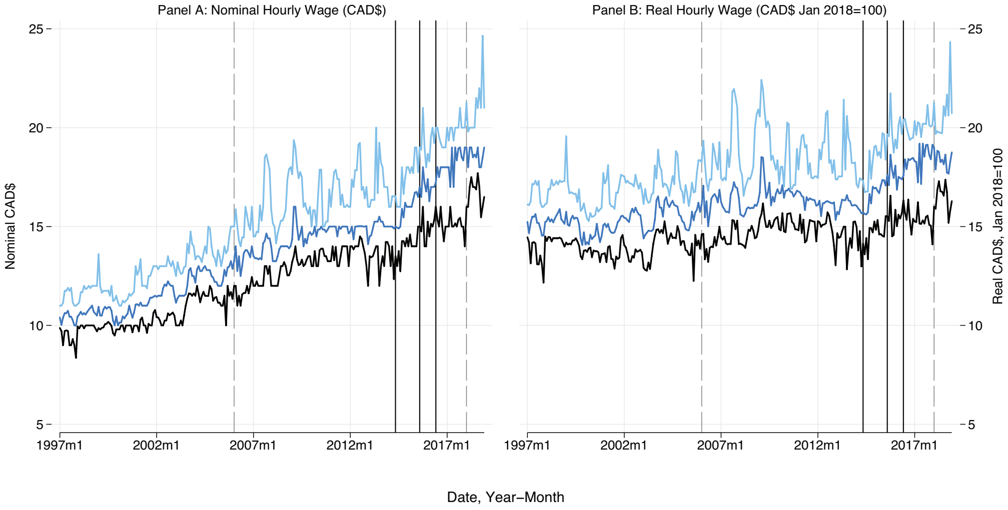
PSWs' wages in Ontario were stagnant in nominal terms and decreasing in real terms in the five years before Stage 1, especially for workers at the 25th and 50th percentiles. During Stage 1, we see that nominal and real wages increased sharply for all PSWs. In Stages 2 and 3, wages continued to increase at the median and 75th percentile. However, the lower paid 25th percentile of the workforce showed little or no reaction until Ontario increased the general minimum wage in 2018, so income inequality among home care PSWs increased. Low-wage PSWs appear to work more non-eligible publicly or privately funded hours, and/or our sample may include some low-wage non-home care workers. After the final (Stage 3) wage increase, nominal wages at the 50th percentile increased to just above the new $16.50 per hour PSW minimum wage and nominal wages at the 75th percentile rose to just above the $19.00 per hour cap.

Hourly wages – relative to comparison groups

Figure 3 builds on Panel B of Figure 2. It plots real hourly wages for the affected group (thick solid line) and each of the comparison groups (thin and dashed lines) for the 25th (upper), 50th (middle) and 75th (bottom) percentiles of each.

Across all three panels, home care PSWs earn less on average than non-home care PSWs. Comparing real wages for the affected PSWs in Ontario and the two non-home care PSW groups across all three panels, it appears that affected PSWs' real wages did increase relative to non-home care PSWs' during Stages 1 to 3. This relative increase is more pronounced at the 50th and 75th percentiles. Real wages for non-home care PSWs stayed flat

FIGURE 2. Monthly averages of nominal and real (national CPI-adjusted, January 2018 = 100) hourly wages for home care PSWs in Ontario (affected group) from 1997 to 2018, at the 25th, 50th and 75th percentiles



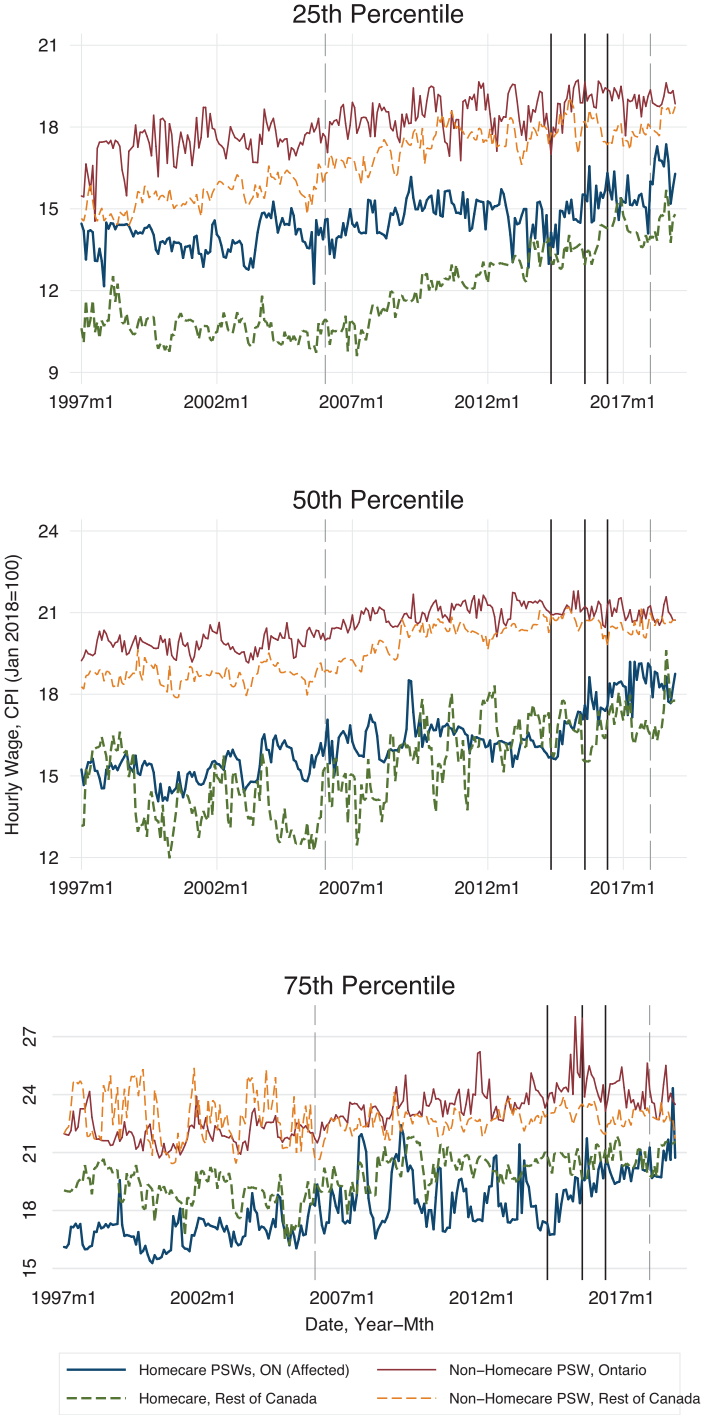
Note: Solid vertical lines indicate the start of policy Stages 1, 2 and 3 (wage increases for home care PSWs in Ontario). The dashed vertical lines represent the 2006 PSW minimum wage change and the 2018 general minimum wage increase. We attempted to de-seasonalize these time series; however, we found that there is no significant seasonality (in a regression of hourly wages on months).
Source: Authors' calculations from the LFS

or decreased slightly after 2014. It appears there were no large policy spillovers to non-home care PSW wages in Ontario.

We next look at each panel in Figure 3 to compare the affected group to home care PSWs in the rest of Canada. Interestingly, comparing across the three panels, there is a smaller wage gap from the 25th to the 75th percentile of the home care wage distribution in Ontario than in the rest of Canada. We see that low-wage home care workers were historically paid more in Ontario than in the rest of Canada, but high-wage home care PSWs were historically paid less in Ontario. If institutions face a constraint on the total wage bill, this could mean that because Ontario agencies paid more at the 25th percentile, they must pay less at the 75th percentile. Agencies can adjust along other margins to meet budget constraints, but PSWs make up a large percentage of total costs, so high-paid workers will be affected by low-paid workers receiving a higher wage if the total wage bill is approximately equal.

In the bottom panel, we see that, for both home care groups, real wages at the 75th percentile remained flat in the decade before the 2014 policy change. However, from Stages 1 to 3, the affected Ontario group experienced a relative increase in wages. At the 50th and 25th percentiles, that pattern is, however, quite different before 2014; home care workers

FIGURE 3. Monthly averages of real (national CPI-adjusted, January 2018 = 100) hourly wages for home care PSWs in Ontario and comparison groups from 1997 to 2018, at the 25th, 50th and 75th percentiles



25th Percentile

50th Percentile

75th Percentile

Solid vertical lines indicate the start of policy Stages 1, 2 and 3 (wage increases for home care PSWs in Ontario). The dotted grey lines represent the 2006 PSW minimum wage change and the 2018 general minimum wage increase.

Source: Authors' calculations from the LFS outside of Ontario saw real wages increase markedly, whereas these were flat or decreasing in Ontario. During Stages 1–3, at the 50th percentile, the affected group experienced a relative increase in wages, whereas at the 25th percentile, they did not. The pre-policy upward trend in wages for home care workers in the rest of Canada at the 25th and 50th percentiles accords with an aging Canadian population demanding more home care services. Differences across regions may also reflect local labour supply, perhaps driven by different immigration rates, and the local opportunity costs faced by PSWs considering employment in other occupations. Whereas wages for home care workers in the rest of Canada were rising, Ontario PSWs' wages, though initially high, seemed to have been frozen in the half decade before 2014.

Hourly wages – plots of difference-in-differences unconditional quantile regression coefficients

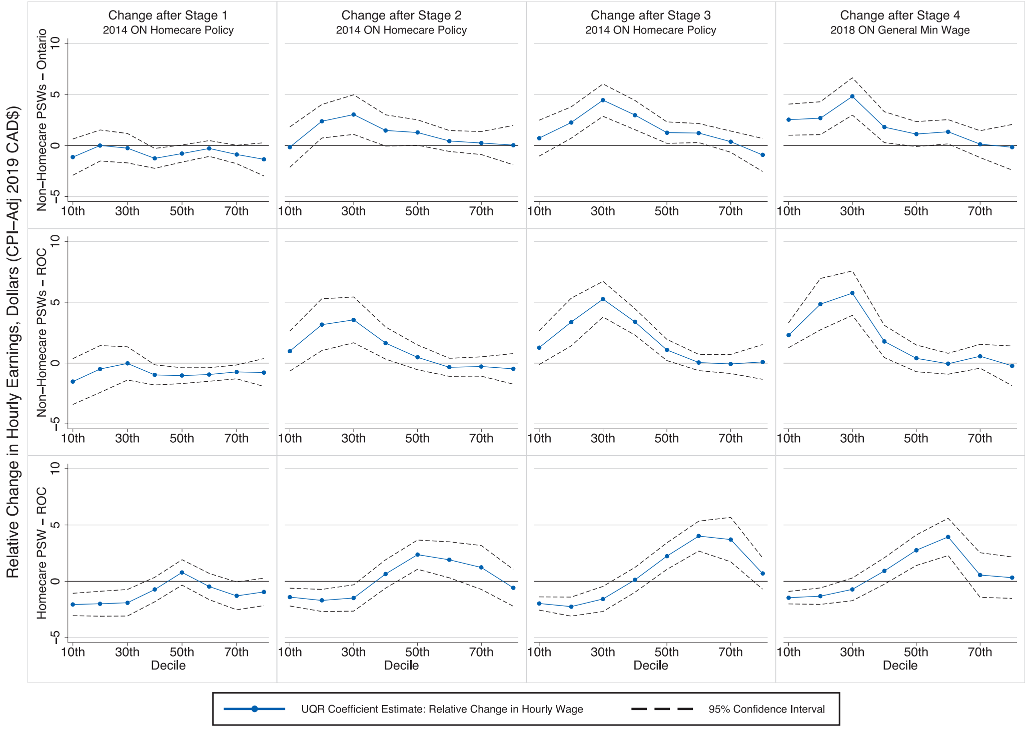
Figure 4 is a graphical representation of UQR coefficients on the interaction terms in the above equation for real hourly wages from 2007 to 2018. Each row of Figure 4 represents a different comparison group, as labelled on the left-most y-axes, with (i) non-home care PSWs in Ontario in the top row, (ii) non-home care in the rest of Canada in the middle and (iii) home care in the rest of Canada on the bottom. From left to right, each column plots policy Stages 1 through 4 (coefficients $\beta6$ through $\beta9$), with Stage 0 as the comparator. Each individual plot depicts eight estimates, at the 10th through the 80th percentiles of earnings, for a single policy stage and comparison group. To save space, discussion and the regression output are presented in Appendix 2, available at longwoods.com/content/26288.

For DID, UQR coefficients are calculated relative to the relevant unconditional quantile of the joint distribution of the dependent variable for the affected and comparison groups. For example, if "wage" is the dependent variable and we estimate an UQR at the 20th percentile, a coefficient of 2.376 on the S2*Affected variable implies that during the second stage of the policy, the wages of individuals in the affected group at the 20th percentile of the joint wage distribution increased by an estimated $2.38 more than the wages of similar PSWs in the comparison group. The impact of this policy might be quite different for PSWs at different quantiles of the wage distribution or for the "mean" PSW as estimated by OLS.

The DID model displays well-controlled conditional changes. However, we could not find support for a common trend between the affected and comparison groups – the required identifying assumption for the DID coefficients to be interpreted as causal impacts. This is likely because of Ontario-specific policies, including the PSW-specific minimum wage introduced in 2006, so these coefficients should not be interpreted as providing estimates of causal impacts (Smith and Sweetman 2016). Nevertheless, we argue that given the structure of the Ontario home care market, this policy had causal impacts for which we provide a sense of the direction if not unbiased estimates of the causal magnitudes.

Because each row of graphs in Figure 4 represents a different comparison group, each has a different joint distribution of wages. Especially, the top two rows show changes for home care PSWs in Ontario relative to non-home care PSWs. Home care PSWs earn less

FIGURE 4. Quantile plots: Real hourly wages for Ontario healthcare PSWs relative to comparison groups



Interaction terms from the DID UQRs for real hourly wages. These represent changes in the hourly wage in each policy stage for the affected PSWs in Ontario relative to each comparison group. The top row plots changes relative to non-home care PSWs in Ontario, the middle relative to non-home care PSWs in the rest of Canada and the bottom relative to home care PSWs in the rest of Canada. We plot points from the 10th to 80th percentiles to avoid the effects of the large skew above the 80th percentile. Real wages are inflation-adjusted using the provincial CPI with January 2018 as the base.
Source: Authors' calculations from the LFS.

than non-home care PSWs, and so, affected home care PSWs' wages are expected to be concentrated in the lower deciles of these joint wage distributions. In contrast, in the bottom row, the comparison group is home care PSWs in the rest of Canada. Ontario home care PSWs' wages are concentrated in the mid-to-high end of the national home care wage distribution. Therefore, in contrast to the upper rows, we expect changes to occur further up the wage distribution.

Consistent with expectations based on the comparison groups, we see changes from the 20th to 50th percentiles in the top two rows of Figure 4. After Stages 2–4, real wages for affected PSWs increased relative to those for non-home care PSWs. That is, wages for those in the affected group grew more quickly than wages for their analogues in the comparison groups. This matches the pattern in Figure 3. There are few affected PSWs with wages above the 50th percentile in these joint distributions, and maximums were imposed following Stage 2; there is consequently almost no statistically significant relative change at or above the 50th percentile. Also, we do not observe significant changes for low-wage-affected workers at the 10th percentile until the 2018 general minimum wage increase. Individuals in this group typically report being paid at the provincial minimum wage rather than the Ontario home care minimum wage.

In contrast, the pattern in the bottom row reflects the fact that home care PSWs in the rest of Canada have lower wages than the comparators in the two upper panels, and that they experienced faster wage growth in the lower quantiles of the distribution. The effect of Ontario's policy is evident toward the middle of the joint wage distribution. In contrast, wages for affected PSWs from the 10th to 30th percentiles decreased relative to wages for home care workers in the rest of Canada. Consistent with Figure 3, wages at the low end of the home care distribution were growing much faster in the rest of Canada than in Ontario pre-policy, and these results show that conditional on other covariates, home care PSW wages at the low end of the distribution were not able to keep up with those in the rest of Canada even during the policy implementation. Wages for similar workers in the rest of Canada, though initially lower, rose more swiftly than for those in Ontario. This may have been because of differences in the rate of increase in the demand for their services due to population aging, local changes in potential PSWs' supply (perhaps by virtue of local immigration) or changes in the relative opportunity cost of employment in alternative occupations.

Hours of work and tenure

We did not find any statistically significant coefficients for hours of work or tenure from either OLS or UQR – see Appendix 3 – so we present only OLS results (available online at longwoods.com/content/26288). This may be influenced by the high variance in hours and tenure, but any large coefficients would be statistically significant. If the policy had caused hours to decrease, that might have indicated negative employment effects. If it had caused tenure to decrease, that might have indicated either increased hiring or increased worker turnover.

Discussion

The provincial government is the dominant payer for home care services in Ontario, and home care PSWs do not have strong collective bargaining power. Therefore, the home care PSW labour market can be characterized as monopsonistic. Ontario, through government contracts to large firms, seems to have used this monopsony power to effectively maintain nominal wages near its 2006 PSW-specific minimum wage, causing the real wage decline observed among home care PSWs in Ontario before the mandated 2014 increase. However, other than through the general minimum wage, the Ontario Government appears to have less influence in the lowest deciles of the PSW wage distribution.

We observe clear changes in home care PSWs' wages following Ontario's PSW-specific minimum wage increases and, as expected, we observe differential impacts across the wage distribution. Despite the common trend assumption of DID not being satisfied, the home care market is sufficiently driven by government funding that this policy, and not external factors, is very reasonably what caused relative wages to increase at each policy stage. However, this argument applies only to the direction of the effect; the coefficients are not unbiased estimates of the magnitude of these impacts.

Compared to home care PSWs and the rest of Canada, Ontario's PSW minimum wage policy had no effect at the very top of the wage distribution (80th percentile and above). However, it did significantly increase wages for PSWs in Ontario in the middle and upper-middle of the distribution. In stark contrast, at the bottom of the wage distribution, without conditioning on other variables (Figure 3), the policy change in Ontario only seems to have increased the rate of wage growth in Ontario to match that in the rest of Canada. Moreover, once we control for observed differences across Ontario and the rest of Canada, the policy in Ontario was not even sufficient to make the rate of wage growth in the lower deciles in Ontario as steep as the growth elsewhere. All these changes occurred without a noticeable effect on hours of work or job tenure for home care PSWs in Ontario.

These results point to the importance of looking for policy effects across the wage distribution. It also suggests that demand and supply for PSWs in Ontario is evolving quite differently than in other provinces. On the demand side, this may be because of different rates of population aging or policies regarding seniors. On the supply side, there may be a relatively larger supply of potential PSWs in Ontario, perhaps because of differences in immigration or fewer alternative jobs for this skill group.

Our analysis is specific to this 2014 Ontario home care policy and thus may not translate to other jurisdictions where home care services are structured differently. For example, it would not be directly applicable to jurisdictions where these services are provided by a means other than managed competition.

Conclusion

In the years prior to the 2014 policy, the government would have noticed increasing demand for low-wage home care workers, complaints from increasingly poorly paid workers and (perhaps) rising home care wages in the rest of the country. As such, it would have likely felt pressure to increase its existing minimum wage. This policy was simply a particular and public way for the Ontario Government to address increased demand and stagnant wages in a monopsony market. Whether this policy succeeded in improving retention and in attracting new workers to home care is unclear. It may have prevented impending "quits" from a disgruntled workforce but had no measurable effect on hours or tenure. Overall, the Ontario Government's policy seems to have formalized what less-controlled markets accomplished on their own in the rest of Canada.

Conflict of Interest

The authors have no conflicts of interest to declare.

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Notes

1. The general provincial minimum wage was $7.75 in 2006 and $11.00 in 2014 (ESDC 2018).
2. For an analysis of potential effects of wage increases on nurses, see Ahlburg and Mahoney (1996), Buchan and Black (2011), Condliffe and Link (2016), Ellenbecker et al. (2007), Gray et al. (1996) and Holmås (2002). For LTC workers' compensation and minimum wages, see Baughman and Smith (2012), Martin and Ramos-Gorand (2017), and Powers and Powers (2010). For an analysis of the UK's minimum wage laws in LTC homes, see Georgiadis (2006, 2012), Giupponi and Machin (2018), de Linde Leonard et al. (2014), Machin et al. (2003), Machin and Wilson (2004), and Metcalf (2004). For an analysis of wage changes for home care workers in Canada and the US, see Butler et al. (2014), Denton et al. (2006), Faul et al. (2010), Howes (2005), and Morris (2009).
3. We tested various start dates from 1997–2010 and did not find meaningful differences in the results.
4. We ran the regressions with and without year fixed effects and found no significant changes in the coefficients of interest.
5. UQR coefficients [i.e., $\partial Qp(Y)/\partial Xi$, where p indexes quantiles and i indexes observations] must be distinguished from traditional conditional quantile regression, which focuses on the quantiles of dependent variable conditional on covariates [i.e., $\partial Qp(Y|X)/\partial Xi$]. An observation might be at very different locations in the unconditional and conditional wage distributions (e.g., a young female part-time worker's wage might be at a low wage quantile unconditionally, but compared to other young female part-time workers, her conditional wage quantile might be high).
6. Retroactive means that even though the first change was implemented on April 29, 2014, the affected home care PSWs received back pay to April 1, 2014.

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RESEARCH PAPER

Informing Canada's Health System Response to COVID-19: Priorities for Health Services and Policy Research

Éclairer la réponse du système de santé canadien à la COVID-19 : priorités pour la recherche sur les services et les politiques de santé

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Abstract

To inform Canada's research response to COVID-19, the Canadian Institutes of Health Research's Institute of Health Services and Policy Research (IHSPR) conducted a rapid-cycle priority identification process. Seven COVID-19 priorities for health services and policy research were identified: system adaptation and organization of care; resource allocation decision-making and ethics; rapid synthesis and comparative policy analysis of the COVID-19 response and outcomes; healthcare workforce; virtual care; long-term consequences of the pandemic; and public and patient engagement. Three additional cross-cutting themes were identified: supporting the health of Indigenous Peoples and vulnerable populations, data and digital infrastructure, and learning health systems and knowledge platforms. IHSPR hopes these research priorities will contribute to the broader ecosystem for collective research investment and action.

Résumé

Afin d'éclairer la réponse du Canada en matière de recherche sur la COVID-19, l'Institut des services et des politiques de la santé (ISPS), des Instituts de recherche en santé du Canada, a mené un processus d'identification rapide des priorités en matière de recherche. Sept priorités pour la recherche sur les politiques et services de santé liée à la COVID-19 ont ainsi été identifiées : adaptation du système et organisation des soins; éthique et prise de décision en matière d'allocation des ressources; synthèses et analyses comparatives rapides des résultats et des politiques d'interventions face à la COVID-19; personnel de la santé; soins virtuels; conséquences à long terme de la pandémie; et engagement de la population et des patients. Trois thèmes transversaux supplémentaires ont été identifiés : soutien à la santé des Peuples Autochtones et des populations vulnérables; données et infrastructures numériques; et systèmes de santé apprenants et plateformes de connaissances. L'ISPS souhaite que ces priorités de recherche contribuent à enrichir l'écosystème de l'investissement et des initiatives de recherche collective.

Background

The coronavirus disease 2019 (COVID-19) pandemic has had devastating consequences worldwide and revealed the underpreparedness of systems (health, political, economic) to respond swiftly. Health systems are grappling with how to rapidly mobilize, organize and deploy resources to provide effective COVID-19 care while simultaneously attempting to reorganize the provision of non-COVID-19 care effectively and safely. The Government of Canada's top priority throughout the pandemic has been to keep Canadians healthy and safe (Government of Canada 2020), and one mechanism to achieve this has been to mobilize Canada's health research community to respond to the COVID-19 crisis.

As Canada's federal health research funder, the Canadian Institutes of Health Research (CIHR) has played an active role in the COVID-19 health research response along with its tri-council partners, Canada's broader health and science portfolios, provincial and territorial research funders and health systems, charities and hospitals, as well as local, academic, private sector and other funders. On February 10, 2020, CIHR, together with funding partners, launched its first rapid research response funding opportunity (CIHR 2020a), which resulted in 99 funded research projects totalling $54.2 million (CIHR 2020b). The Government of Canada then allocated an additional $115 million to CIHR in March for a second round of rapid research funding (CIHR 2020c). Beyond these, CIHR has led several other COVID-19 funding calls, including the COVID-19 Clinical Epidemiology Research Rapid Response, World Health Organization Solidarity Trial and opportunities focused on mental health and substance use. Additional investments are under way to further support research teams with expiring grants, to maintain income support for trainees whose research has been delayed by the pandemic and to support the retention of research staff at universities and health research institutes.

The CIHR's Institute of Health Services and Policy Research (IHSPR) is one of 13 virtual institutes and one of many players in the health research ecosystem. IHSPR is aiming to create a shared understanding of health services and policy research (HSPR) COVID-19 priorities across the country to help align resources with the most important evidence needs for policies and interventions that contribute to improved health and health system outcomes. IHSPR identified COVID-19 priorities for HSPR through a rapid and iterative process that included literature and media scans, an environmental scan of COVID-19 research priorities in other countries (Table 1), input from leading HSPR experts in Canada and a brief survey of the HSPR community. Data from these sources were triangulated, analyzed and summarized to distill core and cross-cutting HSPR COVID-19 priorities and validated with the Institute Advisory Board. Detailed methods are available in Appendix 1, available online at longwoods.com/content/26249.

COVID-19 Health Services and Policy Research Priorities

IHSPR's rapid-cycle priority identification process resulted in seven core priority areas and three cross-cutting themes relevant for research and policy analysis within and across each priority.

System adaptation and organization of care

Research that informs system adaptation and organization of resources and care in the COVID-19 era is urgently needed as many sectors have been ill-equipped to meet COVID-19 care needs, with community care homes (including long-term care [LTC] homes) being hardest hit. Areas of focus include hospitals and the primary, home and community care (including LTC) sectors (Basky 2020; Cadogan and Hughes 2020; Coccolin et al. 2020; Glauser 2020; Grabowski and Joynt Maddox 2020; Lin et al. 2020). Predictive and optimization modelling is needed to inform system resilience, resource planning, disease testing and surveillance systems, patient flow and continuity of care. Also critically needed is research that both evaluates innovations in the organization and delivery of care that were catalyzed as a result of the COVID-19 pandemic, and analyzes the policy options and levers that would support the scale and spread of these innovations.

Resource allocation decision-making and ethics

COVID-19 has revealed shortages of capacity and resources, including personal protective equipment (PPE) and, in some settings, intensive care unit (ICU) beds and ventilators (Emanuel et al. 2020; Gostin et al. 2020; Phua et al. 2020; Ranney et al. 2020; Truog et al. 2020; Wang et al. 2020). Non-urgent surgeries have been cancelled, and as reopening commences, decisions will be made about prioritization for care. Research, policy analyses and ethical frameworks are required to inform allocative decision-making and the consequences of those decisions (Antommaria et al. 2020; Emanuel et al. 2020; Fritz et al. 2020; Gostin et al. 2020; Rosenbaum 2020a). Further analyses are needed to examine the ethical implications of restrictive public health and social distancing measures, use of technology and data for contact tracing and the equity consequences for vulnerable populations (Laupacis 2020; Mazumder et al. 2020; Mulligan et al. 2020; Smith and Judd 2020; Van Dorn et al. 2020; Wang and Tang 2020).

Rapid synthesis and comparative policy analysis of the COVID-19 response and outcomes

There has been considerable heterogeneity across countries and Canadian jurisdictions in the response and timing of policies enacted to flatten the curve (e.g., social distancing, school closures) and reopen society (e.g., non-essential services, return to school). Rapid knowledge syntheses and comparative policy analyses are needed to document and understand responses, analyze their intended and unintended consequences and develop response options to inform future planning and preparedness. As COVID-19-related policies have been enacted at municipal, provincial/territorial and federal levels and implemented by systems, organizations and individuals, analyses will require appropriate targeting to reach policy and decision-makers with differing mandates, accountabilities and contexts (Gibney 2020).

Healthcare workforce

The healthcare workforce has needed to adapt quickly to the COVID-19 landscape. Enormous pressure due to a lack of PPE, high workloads and safety concerns (Xiong and Peng 2020) has added considerable stress to healthcare workers (Greenberg et al. 2020; Zhou et al. 2020), many of whom had high levels of burnout prior to the pandemic (Canadian Medical Association 2019). Research is needed to analyze how the healthcare workforce was deployed and supported to provide COVID-19 care, understand the facilitators and barriers to a coordinated and effective response (Basky 2020; Coccolin et al. 2020; Fraher et al. 2020; Lake 2020), evaluate the impacts on COVID-19 and non-COVID-19 care, and consider the strategies and policies that could be implemented to improve workforce planning, capacity and safety. Research is also needed to understand the role that family and other informal caregivers played, the supports and resources they used and/or needed, the impact that COVID-19 had on their health and mental health and the policy options for supporting informal caregivers in the future.

Virtual care

COVID-19 crystallizes the importance of virtual care to meet patient needs and reduce the risk of disease transmission (Bhatia et al. 2020; Greenhalgh et al. 2020; Hollander and Carr 2020; Smith et al. 2020; Webster 2020). Research is needed to analyze and compare the extent and type of virtual care used across jurisdictions, who provided and received virtual care and for what purpose, the payment policies implemented and the intended and unintended consequences of expanded use. As well, research that analyzes the impact of virtual care on key outcome measures such as access, utilization, continuity, quality and safety, equity, cost and health is important to inform the design of future virtual care models.

Long-term consequences of the COVID-19 pandemic

To respond to COVID-19, healthcare resources were rapidly redeployed, reducing access to routine and ongoing care and leaving many with cancelled referrals, tests and procedures (Angelico et al. 2020; Carter et al. 2020; Rosenbaum 2020b; Salako et al. 2020). Due to fear of infection, many Canadians did not seek healthcare even when needed. Certain sectors, such as LTC, and certain populations, such as the homeless and incarcerated, were disproportionately impacted. Gendered consequences include balancing work, childcare and household duties, which fall disproportionately on women (Kitchener 2020; Minello 2020). Longitudinal research is needed to study the long-term and far-reaching effects of the pandemic on health, health equity and health system outcomes, as well as the post-COVID-19 health, social and economic policies that are created. Policy analysis is imperative to shed light on why the consequences emerged, why they had a disproportionate impact across sectors and populations and to inform future policy development.

Public and patient engagement

Citizen response to public health advice and restrictions has profound effects on viral transmission and therefore the COVID-19 pandemic itself. Research and policy need to meaningfully engage with the public and patients, including vulnerable and at-risk populations. Priorities need to be established through understanding the experience and perspectives of the public and patients with the pandemic, the COVID-19 and non-COVID-19 care received (or not received), caregiver needs and supports and the supports and tools needed as the crisis subsides (e.g., mental health supports and spiritual care). Public and patient engagement is also critical for decision-making about removing restrictions and what the "return to the new normal" should look like (Immonen 2020).

Cross-cutting themes

Through IHSPR's rapid-cycle priority identification process, three cross-cutting themes were identified that intersect each of the seven priority areas:

1. *Supporting the health of Indigenous Peoples and vulnerable populations:* First Nations, Inuit and Métis populations are at high risk of COVID-19 acquisition and severe disease in both rural/remote and urban settings. People who are homeless, incarcerated and living in poverty are also at high risk. HSPR is needed to analyze the impacts of COVID-19 on Indigenous Peoples and vulnerable populations and the factors that exacerbated those impacts. Policy research is also needed to inform the development of post-pandemic health and healthcare policies that are culturally safe and grounded in Indigenous Knowledges.
2. *Data and digital infrastructure:* COVID-19 has highlighted the importance of timely access to data for researchers, decision-makers and front-line providers to inform policy and care delivery decisions. Access for researchers to linkable data from diverse sources (e.g., COVID-19 testing data linked with clinical and administrative data, consumer wearables, social media and patient reports) and digital infrastructure is needed to enable rapid analysis of the impacts and evidence-informed response strategies. COVID-19 has also revealed critical gaps in data. For example, the lack of race and ethnicity data, and measures and data about racism, hinders researchers' ability to decipher differential impacts of the pandemic and inform targeted policy responses, which risks further exacerbating existing inequities in health and outcomes.
3. *Learning health systems and knowledge platforms:* Knowledge platforms are needed that provide seamless and rapid access to high-quality research studies, synthesize the volumes of research that COVID-19 has spurred and tailor the evidence in ways that meet the diverse needs of policy and decision-makers. COVID-19 illuminates the ability of healthcare delivery systems (e.g., a health authority) and organizations (e.g., a hospital or LTC home) to use COVID-19 and other data to support real-time decision-making, foster continuous learning and evidence-informed planning and implement policies and interventions across the system.

Discussion and Conclusion

IHSPR is one of many organizations in a broader ecosystem that funds research and is dedicated to contributing to the COVID-19 research response. The priorities identified in this paper are intended to help align collective HSPR investment, activity and collaboration in areas where COVID-19 evidence is critically needed and where it has the most potential to improve the lives of people, the health of populations and the performance of healthcare systems.

As shown in Table 1, the seven priorities are not unique to the Canadian context and conform closely with priorities identified in other jurisdictions. Common priorities include: clinical and health system innovations in the delivery, management and organization of care; deployment of the healthcare workforce and addressing workforce needs; access to care by vulnerable populations; digital health and technological innovations; addressing mental health needs and challenges; and patient and community engagement. Canada's HSPR community has capacity, expertise and leadership in each of these common priorities. This presents an opportunity for Canadian researchers to leverage the community's strengths to lead or engage in international HSPR collaborations and cross-jurisdictional research.

Who is best poised to conduct the research? The impact of research on the COVID-19 response will be enhanced if the interdisciplinary nature of the HSPR field is harnessed. The health policy and care delivery solutions needed are multifaceted and will need to draw on the interdisciplinary expertise of Canada's health services researchers, epidemiologists, political scientists, economists, lawyers, healthcare providers, embedded scientists, policy and decision-makers and patient partners. Their skills in evaluation, health law and policy analysis, health economics, clinical and health informatics, organization and management of care, implementation science and other domains are critical to generating evidence in the identified priority areas that accounts for the complexity of the context and problem and has the potential for real-world impact.

Who is the COVID-19-related HSPR intended for? Given IHSPR's mandate, the research evidence is intended to inform COVID-19-related policy making within ministries of health and professional associations and decision-making within health authorities and healthcare delivery organizations. The goal is to equip health policy and decision-makers with evidence they can use to design and implement effective policies, programs and interventions that improve the organization, delivery and outcomes of healthcare. The CIHR COVID-19 rapid response and mental health knowledge synthesis funding calls included an objective to provide evidence to inform decision-making and the health system response. The calls also ensured that peer review criteria assessed the impact of the research and the quality of the proposed knowledge translation plan, but did not require decision-maker involvement on the research teams (CIHR 2020c; CIHR 2020d). To inform policy and decision-making, effort will be needed once the research is funded to meaningfully engage decision-makers in the work and develop effective knowledge mobilization strategies. IHSPR is committed to this effort.

In addition to relevant research as a lever for change, impact within several of the identified priorities will require the use of legislative, regulatory, funding and other policy levers. For example, addressing the COVID-19 crisis that has played out in Canada's LTC homes (Brown 2020) will require timely and relevant research evidence, plus attention to accreditation, regulation and inspection, staffing levels and working conditions, government funding levels and the expansion of public reporting efforts to include measures such as staffing and ownership type.

Importantly for the HSPR community, these COVID-19 priorities are not intended to serve as the sole focus of IHSPR or CIHR. Although CIHR's Spring 2020 Project Grant competition was delayed until summer 2020 and the institutes' strategic funding initiatives

TABLE 1. Comparison of COVID-19 health services and policy research (HSPR) priorities

Organization	**HSPR-related research priorities***
Jurisdiction: Canada	
Canadian Institutes of Health Research (CIHR 2020a, 2020c, 2020d)	As per *Operating Grant: Canadian 2019 Novel Coronavirus (COVID-19) Rapid Research Funding Opportunity* (January 2020), HSPR-relevant research priorities include: • Medical countermeasures: » Clinical management • Social and policy countermeasures: » Coordination, governance and logistics As per *Operating Grant: COVID-19 May 2020 Rapid Research Funding Opportunity*, HSPR-relevant research priorities include: • Clinical management and health system interventions • Social, policy and public health responses and related indirect consequences As per *Operating Grant: Knowledge Synthesis: COVID-19 in Mental Health and Substance Use*, HSPR-relevant research priorities include: • Knowledge translation approaches, practices and platforms applied to inform both population-level and targeted mental health and substance use responses during the pandemic • Population-based interventions to reduce potential mental health and substance use impacts of COVID-19 • Targeted interventions to address the mental health and substance use issues and needs of high-risk groups • Innovative surveillance and monitoring in both the general Canadian population and among high-risk groups to assess mental health and substance use needs and system transformations (including the use of learning health systems, other modes of service delivery [e.g., virtual care], alternate remuneration models, etc.)
Jurisdiction: Global	
World Health Organization (WHO 2020)	As per *A Coordinated Global Research Roadmap: 2019 Novel Coronavirus (March 2020),* HSPR-relevant priorities include: • Clinical care and health systems • Engagement • International coordination
World Health Organization/ Global Research Collaboration for Infectious Disease Preparedness (GloPID-R) (WHO 2020)	
Jurisdiction: UK	
National Institute for Health Research (NIHR)	As per the joint NIHR/UKRI *COVID-19 Rapid Response Rolling Call*, HSPR-relevant research priorities include: • Health and care delivery • Clinical management • Optimized use of personal protective equipment and other infection prevention and control measures in healthcare and community settings
Medical Research Council (MRC)/UK Research and Innovation (UKRI) (MRC 2020)	
Jurisdiction: US	
AcademyHealth (AcademyHealth 2020)	As per *Health Systems Respond to COVID-19: Priorities for Rapid-Cycle Evaluations (2020),* there are six HSPR-relevant categories of rapid-cycle research and evaluation priorities: • Patient and community experience, engagement and outcomes • Care delivery, management, decision-making and operations • Workforce needs, training and policies • Technology, data and telehealth • Policies, including payment policy • Collaboration and coordination

Organization	HSPR-related research priorities*
Jurisdiction: US (continued)	
Agency for Healthcare Research and Quality (AHRQ 2020)	As per AHRQ's *Novel, High-Impact Studies Evaluating Health System and Healthcare Professional Responsiveness to COVID-19 (R01),* HSPR-relevant research topics include: • Research to improve the quality of care received and patient outcomes during and following the COVID-19 pandemic • Research to improve healthcare patient safety during and following the COVID-19 pandemic • Research to understand how the response to COVID-19 affected socially vulnerable populations and people with multiple chronic conditions during and following the COVID-19 pandemic • Research to understand how digital healthcare innovations contributed to the health system response to COVID-19, outcomes and unintended consequences • Research plans and dissemination of findings
Patient-Centered Outcomes Research Institute (PCORI 2020)	PCORI's COVID-19-targeted funding opportunity specifies three priority areas: • Adaptations to healthcare delivery • Impact of COVID-19 on vulnerable populations • Impact of COVID-19 on healthcare workforce well-being, management and training
National Institutes of Health (NIH 2020)	As per individual institutes' *Notice of Special Interest*, examples of HSPR-relevant research objectives or questions include: • National Institute on Drug Abuse: how potential overcrowding of emergency departments and health services will impact the treatment of opioid overdoses and opioid use disorder • National Institute on Aging: studies in prehospital, emergency or critical care settings to improve screening, risk stratification, care delivery decisions, resource allocation and clinical outcomes for older adults exposed to COVID-19; evaluating strategies used by health systems to reallocate resources, rapidly train practitioners, communicate preventive practices and maintain adherence to public health and clinical guidelines, with a particular interest in those who serve high-risk groups (e.g., nursing homes) and resulting racial, ethnic or regional disparities in access/care • National Institute of Mental Health: studies on the impact (e.g., access, quality, and clinical outcomes) of state, local, federal and guild-specific guidelines and policies around telehealth services and of changes in those policies, with specific attention on the risks and benefits of relaxing those guidelines or policies • National Institute on Minority Health and Health Disparities: examine the effects of the COVID-19 outbreak on disparities in healthcare utilization and health outcomes among medically and socially vulnerable populations • National Cancer Institute: impact on cancer-related care delivery due to the COVID-19 pandemic • National Institute of Biomedical Imaging and Bioengineering: the NIBIB is seeking applications to develop life-saving technologies that can be ready for commercialization within one to two years; for example: rapid point-of-care and home-based testing/diagnostics; digital health platforms and models that integrate data, assess risk and provide illness surveillance and management tools • National Institute on Alcohol Abuse and Alcoholism: what workforce development and deployment strategies are needed to address emerging challenges in mental health/alcohol use disorder treatment during the pandemic?

*Not exhaustive; intended to be a snapshot only.

were temporarily put on hold, the CIHR Project Grant budget and the institute's budgets have been preserved, and CIHR's open funding programs have reopened. The time horizon for the reopening of CIHR's strategic funding programs is evolving. There is recognition that although concerted attention and resources were required to enable CIHR's rapid response to the COVID-19 crisis, non-COVID-19-related research cannot stop as a consequence.

Within IHSPR, we are actively engaged in CIHR's broader COVID-19 efforts (including our work to identify HSPR COVID-19 priorities) and will continue to finalize our next five-year strategic plan and initiate planning for large-scale funding programs in areas that align with our institute's mandate. The implications of this for the HSPR community are important: *there is space and resources for researchers to lead COVID-19-related research, pivot their existing research to contribute to COVID-19 and/or continue with their core HSPR programs of research.*

In the face of a pandemic that has placed tremendous demand on resources and generated a significant human toll, HSPR is critically needed to inform the path forward. Research that evaluates the health system response, analyzes and informs policy options and identifies how to improve the design and delivery of health services is essential for many reasons, including successful navigation out of the current pandemic, improving health system preparedness for future outbreaks and ensuring that the Canadian healthcare system that reopens is stronger, resilient, and more accessible, more equitable and of higher quality than the one that existed before the onslaught of COVID-19.

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