Rapid Synthesis

Intersections between Ontario Health Teams and Long-Term Care

29 March 2022

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Rapid Synthesis:
Intersections between Ontario Health Teams and Long-term Care
30-day response

29 March 2022

McMaster Health Forum

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Timeline

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

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Conflict of interest

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

Merit review

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

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KEY MESSAGES

Questions

- What can we learn from initiatives similar to Ontario Health Teams (OHTs) that have operationalized their partnerships with long-term care?
  - How can each OHT building block be leveraged to support this aim?
- What equity considerations should be top of mind when planning for the intersections between OHTs and long-term care?

Why the issue is important

- At maturity, OHTs, a pillar of Ontario's current health-system transformation, will be clinically and fiscally accountable for delivering a full and coordinated continuum of services based on population-health needs of their attributed populations.
- This transformation represents an important opportunity for addressing key challenges faced by long-term care in Ontario, but requires careful consideration about how the intersections between OHTs and long-term care homes will operate.

What we found

- We identified six initiatives with population-health-management approaches similar to OHTs from Quebec (Canada), Portugal, the Republic of Ireland, the United Kingdom and two from the United States.
- We identified four ways that initiatives similar to OHTs operationalized intersections with long-term care homes that were either built into the initiatives or adapted as the initiatives evolved:
  - dedicating primary-care practices to commonly serve the residents of a long-term care home, for example through weekly long-term care rounds
  - creating preferred provider networks with specific hospitals and specialists to preserve relationships between them and ensure smooth referrals
  - capitalizing on digital health to support provider consultations and patient care
  - establishing risk-sharing contracts between primary-care organizations and long-term care homes.
- These approaches were often linked with other tangible elements touching all eight OHT building blocks that may help OHTs meet the needs of patients and partners in long-term care.
- We also identified factors that support intersections of these initiatives with long-term care, including:
  - the creation of explicit rationale and related incentives for long-term care homes to participate in OHTs
  - clarifying implications of fiscal and clinical accountability of long-term care homes' involvement with OHTs
  - clear expectations and messaging about OHTs between the Ministry of Health and the Ministry of Long-Term Care
- Several considerations related to equity were highlighted when planning for the intersection between OHTs and long-term care, including:
  - integrating social factors into individualized service plans to facilitate access to care
  - reassessing care needs more frequently for people whose care needs may change to avoid gaps or delays in care
  - using structured communication mechanisms to promote cross-sector collaboration between long-term care homes and social service agencies
  - stratifying data when monitoring service access and quality to allow the identification of potential biases in service provision and quality improvements to better support underserved populations living in long-term care homes
  - engaging long-term care home residents from underserved communities to ensure that planning, development and monitoring of care meets the needs of underserved populations.

QUESTIONS

1. What can we learn from the experiences of Ontario Health Teams (OHTs) that have already begun planning for the intersections with long-term care?
   a. How have initiatives similar to OHTs operationalized partnerships with long-term care homes?
   b. How can each OHT building block be leveraged to support this aim?
2. What equity considerations should be top of mind when planning for the intersection between Ontario Health Teams and long-term care?

Box 1: Background to the rapid synthesis

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

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

This rapid synthesis was prepared over a 30-business-day timeframe and involved five steps:
1) submission of a question from a policymaker or stakeholder;
2) identifying, selecting, appraising and synthesizing relevant research evidence about the question;
3) conducting key informant interviews;
4) drafting the rapid synthesis in such a way as to present concisely and in accessible language the research evidence; and
5) finalizing the rapid synthesis based on the input of at least one merit reviewer.

WHY THE ISSUE IS IMPORTANT

Health organizations in Ontario are in the process of implementing a transformative change that could one day be seen as a landmark development in Ontario's health system. The centre piece of this transformation is the development of Ontario Health Teams (OHTs), which are groups of providers and organizations that, at maturity, will be clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined population.(1) In 2019, the Ontario Ministry of Health launched OHTs to transition towards integrated care and a population-health-management approach (2) that allows patients, families, and cross-sectoral groups of organizations and providers to coordinate care delivery to better meet the needs of patients and local communities (3).

So far, 51 teams have been approved, which at maturity will care for over 95% of Ontarians.(4) To be considered an 'approved OHT', partner organizations must include representation from a minimum of the following three sectors: primary care, acute care (hospital), and home and community care.(5) Many OHTs went above and beyond this call, creating partnerships with long-term care, public health, social-service organizations and/or municipal governments. As all OHTs mature, however, they will work towards being able to deliver the full continuum of care to meet the needs of their attributed populations.

The global COVID-19 pandemic has placed a spotlight on long-term care in Ontario and the imperative for greater coordination across providers and sectors,(6) improved care provided in long-term care homes, and where possible, to promote alternatives to long-term care that better align with patient and family values. The transformation towards OHTs may be one opportunity to accomplish these aims, however, it requires careful thought as to how the intersections between OHTs and long-term care homes will operate.

Ontario is not alone in identifying the need to work with long-term care homes in moving forward similar approaches to integrated networks of care. Other countries and provinces have worked to develop integrated care initiatives that incorporate long-term care homes, and while these may not be identical to the OHT model, they share important features such as being multi-sectoral, employing a population-health-management approach, and including some degree of shared financing. Examining the experiences of other

jurisdictions can help us learn about how initiatives similar to OHTs have operationalized partnerships with long-term care homes and how these partnerships have been supported to meet the needs of patient and community partners. We can then assess whether similar approaches would be right for Ontario, or how they may need to be adjusted prior to adoption.

This synthesis includes findings from the best available research evidence, key informant interviews, and a jurisdictional scan of six initiatives with the aim of identifying how population-health-management initiatives similar to OHTs have operationalized partnerships with long-term care homes, as well as what considerations and supports are relevant to such partnerships, and what equity considerations should be kept in mind when planning for the intersection between OHTs and long-term care.

Box 2: Identification, selection and synthesis of research evidence

We identified research evidence (systematic reviews and primary studies) by searching (in February 2022) Health Systems Evidence (www.healthsystemsevidence.org) and PubMed.

The results from the searches were assessed by one reviewer for inclusion. A document was included if it fit within the scope of the questions posed for the rapid synthesis.

For each systematic review we included in the synthesis, we documented the focus of the review, key findings, last year the literature was searched (as an indicator of how recently it was conducted), methodological quality using the AMSTAR quality appraisal tool (see the Appendix for more detail), and the proportion of the included studies that were conducted in Canada. For primary research (if included), we documented the focus of the study, methods used, a description of the sample, the jurisdiction(s) studied, key features of the intervention, and key findings. We then used this extracted information to develop a synthesis of the key findings from the included reviews and primary studies.

WHAT WE FOUND

For this rapid synthesis, we searched for research evidence addressing partnerships between OHT-like initiatives and long-term care homes, and identified one systematic review and 14 primary studies (see Appendices 1 and 2).

We also examined six initiatives similar to OHTs.
Considerations for selecting initiatives included that it:

- took place at the level of the health system (e.g., was not a one-off model or program);
- is cross-sectoral and focuses on improved coordination or integration of care;
- includes a population-health-management component; and
- includes an element of shared fiscal accountability.

Initiatives were identified through a jurisdictional scan of comparator countries and other Canadian provinces and territories, and were confirmed through conversations with integrated-care experts. We also conducted targeted literature searches related to each of the specific initiatives and identified 10 primary studies, two evaluations, and two technical reports.

To provide additional insights to complement the research evidence, we conducted three key informant interviews with a total of five stakeholders including OHTs and long-term care home leaders in Ontario.

Question 1: What can we learn from initiatives similar to OHTs that have operationalized their partnerships with long-term care?

To answer this question, we drew on the experiences of six initiatives, including one each from Quebec (Canada), Portugal, Republic of Ireland, and United Kingdom and two from the United States. A description of each of these initiatives is provided in Table 1.

Initiatives similar to OHTs operationalized intersections with long-term care homes that were either built into the initiatives or adapted as the initiatives evolved. The three key approaches used by these initiatives include:

- strategies and arrangements for increasing multidisciplinary collaboration across primary care, specialized care, and social services in long-term care homes, including
  - increasing primary, specialized or social-support capacity among staff in long-term care homes
  - introducing multidisciplinary support through dedicated service teams or scheduled visits in long-term care homes

- creating preferred provider networks of high-quality and low-cost long-term care homes to guide discharge and referral practices of hospitals and other providers
- establishing risk-sharing contracts between primary-care organizations and long-term care homes.

How can each OHT building block be leveraged to support this aim?

In reviewing the literature for each of these initiatives, we found two types of insights. The first type of insight focused largely on structural or procedural elements that were built into the initiatives or were adapted as the initiative evolved. The second type of insight focused on factors that supported the intersection between OHTs and long-term care homes.

With regards to structural and procedural elements identified, these insights are often tangible elements that those involved in the development of OHTs could deliberate about whether they would help to strengthen intersections between OHTs and long-term care homes. Common findings across initiative and OHT building blocks (referred to by their numbers below and further specified in Table 1) include:

- initiatives variously defined patient populations according to age, care needs such as chronic disease or disability, and geographic location *(*building block #1, or *BB#1)*
- in-scope services for initiatives frequently included primary care, specialty care, as well as select home- and community-care services, whereas long-term care homes are frequently seen as 'optional' add-ons to larger reforms rather than central partners from the outset *(BB#2);*
- assessment tools are important to ensure a common approach to care planning and coordination among partner organizations *(BB#4)*
- initiatives almost universally employed care coordinators or navigators to assist in bridging gaps between sectors *(BB#4)*
- establishing channels for structured communication between long-term care homes and other sectors is important for coordinating care, especially with specialty services *(BB#5);*
- though structural integration was not seen as necessary in many of the reforms, additional digital supports – including shared electronic health records and online data-management platforms – were critical to enable sharing of information and consultations *(BB#5);*
- supports including tailored coaching, provider training, and additional technical expertise were needed in many of the initiatives to support effective implementation *(BB#6);*
- financing models were frequently based initially on existing financial models, however, over time as the initiatives matured, they often incorporated elements of risk sharing in efforts to align incentives for providers and organizations *(BB#7*)
- validated, risk-adjusted quality measures are needed to better facilitate OHTs' engagement with long-term care homes and track quality-improvement efforts *(BB #8).*

The second type of insight are reflections from key informants and from the literature on success factors that may better support intersections between OHTs and long-term care homes. These insights can be used both by approved and in-development OHTs when considering areas where they may wish to focus their efforts in the early stages of development, as well as by provincial decision-makers when considering the types of factors that could lead to success when supporting partner organizations to come together as an OHT. These include:

- additional incentives may be necessary for OHTs to form effective partnerships with long-term care homes, such as aligning funding incentives (e.g., shared savings incentives);
- organizational mergers or other forms of structural integration are not always necessary or desirable for improving integration of care and collaboration across sectors;
- establishing trust across organizations and providers is an important prerequisite for successful partnerships;
- long-term care homes may face uncertainties around future funding and capacity requirements for providing quality care as a result of partnering with OHTs, and such concerns should be addressed and clarified; and

- OHTs' relationship with the Ministry of Long-Term Care could be clarified, along with expectations from both ministries about long-term care homes' participation in OHTs given that OHTs are overseen by the Ministry of Health while long-term care homes are overseen by the Ministry of Long-Term Care.

Table 1: Description of included initiatives

Initiative	About the initiative	Outcomes and key building blocks leveraged
Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) [Quebec, Canada] (7-10) *Population:* Elderly people with chronic conditions in three areas of the Estrie region [Sherbrooke (urban), Granit (semi-rural) and Coaticook (rural)] of Quebec	*Sectors and settings involved* • Home and community care • Primary care (e.g., individual primary-care providers) • Specialized care • Rehabilitation • Long-term care • Social services *Objective* • Improve continuity of care experience by older people with chronic conditions through an integrated service delivery network *Description of initiative* • Based on a three-tiered governance model which includes: o a strategic level made up of directors and representatives from participating organizations o an operational level made up of managers of the service agencies and are responsible for the administration o a clinical level where local clinicians form multidisciplinary teams to manage client care, ensure the care plan is being followed and make adjustments based on client needs • If eligible for the program, each client is assigned a case manager who in collaboration with a multidisciplinary team of providers, develops an individualized service plan based on the results of an assessment tool, as well as a management plan for each provider (which lays out their individual role and responsibility with respect to patient care) • Case managers are assigned between 45 and 60 clients and are responsible for referring clients to services within the network and for making adjustments to the care plan • Importantly, these case managers, who are often nurses or social workers, are accountable to the local governance table and not to individual agencies/providers • Funding for the initiative comes through traditional mechanisms from the Ministry of Health and Social Services, with little effort having been put in place to consolidate or pool funds	*Outcomes* • Significant reductions in the prevalence and incidence of functional decline, fewer unmet needs, and reduced emergency-room visits • Increased client satisfaction and empowerment with no significant increase in the cost of services • Lack of pooled funding and no dedicated funding stream for care coordination have created challenges with faithfully scaling up the initiative across Quebec, and has created waitlists for clients to enter into the service networks *Key building blocks leveraged* • BB #4: through the use of a consistent assessment tool, development of a care plan, and assignment of case managers to each resident • BB #5: developed a common computerized clinical chart to facilitate information flow within the network, however, accessing the computerized system among independent physicians remains an issue • BB#6: use of a three-tiered governance model with clear roles and responsibilities

	Description of how initiative works with long-term care (if applicable) • Long-term care homes operate as part of the care network, with residents assigned to a case manager who undertakes an assessment, and in collaboration with the care home and rest of the multidisciplinary team agree on an individualized care plan • Services provided within the long-term care home are included alongside those provided externally, with the case manager supporting coordination between services • The initiative benefits from a reform which took place in 2004, which saw the development of integrated health and social-service centres, which developed networks including the local hospital, publicly owned long-term care facilities, and home-care programs	
Long-term care Accountable Care Organization [U.S.] (19-21) *Population:* Residents of facilities attached to the accountable care organization	*Sectors and settings involved* • Primary care (e.g., individual primary-care providers) • Specialized care • Long-term care • Social services *Objective* • To provide coordinated care to residents in long-term care homes, while avoiding unnecessary duplication of services and preventing medical errors *Description of initiative* • Long-term care homes have traditionally been left out of accountable care organizations (ACO) as Medicare does not cover the costs of long-term stays • The long-term care ACO was originally started by Genesis HealthCare, a provider of long-term care services in the U.S., but has grown the ACO beyond their facilities • Participation in the ACO provides long-term care homes the opportunity to be financially rewarded for improving the quality and cost of care delivered to their Medicare fee-for-service long-term care residents • Partners within the ACO share patient information and use dedicated staff to coordinate care for each patient • Scorecards and leading indicators are predefined by the Centre for Medicare and Medicaid Services and are used to evaluate the ACO and demonstrate change within each organization *Description of how initiative works with long-term care (if applicable)* • Long-term care homes participate in Medicare shared-savings ACOs to coordinate care	*Outcomes* • After four years of operating, the long-term care ACO saw a savings rate for costs under management of 19.6% with a 94.5% quality score • Additional quality indicators were not found *Key building blocks leveraged* • BB #5: Sharing of Medicaid claims data among all partners to use to improve care pathways for residents • BB #7: Participation of long-term care homes entitles them to earn 25% of the savings generated based on the specific patient population, with no downside risk

	• Long-term care facilities have no 'downside risk' and are not required to contribute capital to participate • Provides access to Medicare claims data for all Medicare services provided to residents	
Enhanced Health in Care Homes [U.K.] (24) *Population:* Residents of Care Quality Commission-registered care homes attributed to local Primary Care Networks (representing 30,000 to 50,000 people)	*Sectors and settings involved* • Primary care (e.g., individual primary-care providers) • Specialty care • Long-term care • Social services *Objective* • Set a minimum standard for care provided within care homes and ensure that each care home is connected and integrated within the local health system *Description of initiative* • New Care Model Vanguard program was an integrated care program developed by the English NHS to test out new integrated ways of working with the goal of rolling out the successful approaches, supported by standard approaches and products and replicable frameworks • Five types of vanguards were established, one of which, the Enhanced Health in Care Homes model, had the specific aim to improve the health and care provided in care homes • The Enhanced Health in Care Homes model includes four clinical elements: enhanced primary-care support, multidisciplinary team support, re-ablement and rehabilitation, and high-quality end-of-life and dementia care for everyone living permanently in care homes, by explicitly linking each care home (and its residents) to a network of primary care that is responsible for delivering a consistent set of services to all residents • The focus of the model is on developing partnership between the care home, primary care, and a multidisciplinary team that may include community service providers, local authority staff, and voluntary sector workers • Due to challenges experienced in care homes during the COVID-19 pandemic and ease of replicability of the framework, this approach is now being rolled out into primary-care networks that participate in the U.K.'s integrated care systems beginning in 2020, to be operational by 2024 • The care model has been included in the Network Contract for Direct Enhanced Services (DES) and Standard Contract for Primary Care Networks, which sets out the minimum service requirements that must be met to be eligible for NHS funding	*Outcomes* • None identified *Key building blocks leveraged* • BB #4: collaboration between primary-care networks and care homes to bring healthcare services and other social-care supports to the residents • BB #5: access to patient care records and secure email ensures connection between primary-care network providers and care homes • BB #7: use of existing financial mechanisms (network contracts) and additional incentive

	Description of how initiative works with long-term care (if not clear from the above description) • Local Primary Care Networks work with care homes to deliver the following services to their residences: o Enhanced primary care, which includes leading weekly multidisciplinary rounds, medicine reviews, hydration and nutrition support, oral health-care, and coordinated access to out-of-hours/urgent care o Multidisciplinary team support including coordinated health and social care for complex needs, continence promotion, flu prevention, wound care and additional navigation o Falls prevention, re-ablement and rehabilitation o High-quality palliative and end-of-life care including coordination with mental health and dementia services • Primary Care Networks are paid through their Network Contract plus an additional payment of 120 pounds per care home bed served	
National Network for Long-term Integrated Care [Portugal] (11-14) *Population:* People of all ages in a situation of physical or cognitive impairment, or requiring continuous health monitoring and social support	*Sectors and settings involved* • Home and community care • Primary care (e.g., individual primary-care providers) • Rehabilitation • Long-term care *Objective* • To provide long-term and integrated healthcare and social support to people in a situation of dependency *Description of initiative* • Assessment of the burden of disease, dependence level or social enrolment is completed by hospitals (following an episode requiring admission) or primary-care providers, and are used to rank the recipients of care and ascertain levels of long-term care needs • Needs are determined by providers who refer the client to the best setting of care, which may include long-term care homes • Services are provided and coordinated through local coordination teams consisting of health providers, social workers and representatives of the Ministry of Labour, Solidarity and Social Security, who review and confirm referrals to the network • Governance of the initiative takes shape over three levels – central government, regional government and local – where primary-care trusts are responsible for providing home care and refer patients to long-term care homes	*Outcomes* • Implemented and scaled-up services including 8,400 publicly funded long-term care beds made available through the network from 2006 to 2016, an increase from 1.1 to 4.03 beds per 1,000 inhabitants 65 years of age and older • Improvements in the availability of care, both in terms of home and community care and in long-term care homes, as a result of a sustained increase of referrals and admissions to the National Network for Long-term Integrated Care. • Reductions in hospital bed use as a result of the different types of nursing homes addressing different needs (i.e., convalescence units, medium-term and rehabilitation units, and long-term and maintenance units) *Key building blocks leveraged*

	• Integrated funding model is used which includes public funding allocated from the state budget, profits from social gambling and betting (e.g., national lottery), means-tested co-payments *Description of how initiative works with long-term care (if not clear from the above description)* • Primary-care trusts or local hospitals complete assessment and refer to the appropriate setting of care • If that setting is a long-term care home, services are coordinated and provided within the care home	• BB #4: use of a consistent, holistic assessment tool to determine the most appropriate setting and pathway for care • BB #5: online data-management platform and interoperable and patient accessible electronic record allows timely information sharing between providers within the network • BB #7: financing model was based on the number of days of care provided, but began shifting towards patients' dependence levels and risk adjustment models to avoid incentivizing unnecessary care and bed occupancy of people who no longer need care
Medicaid Managed Long-Term Services and Supports (MLTSS) [U.S.] (22; 23) *Population*	*Sectors and settings involved* • Home and community care • Primary care (e.g., individual primary-care providers) • Long-term care *Objective* • Improving the consumer experience, quality of life and health outcomes of long-term care recipients while increasing budget predictability and managing costs *Description of initiative* • An arrangement between state Medicaid programs and managed care plans (led by long-term care providers) through which the care plans receive capitated payments for long-term care services and supports • Capitated payments for long-term care services are combined with payments for primary, acute, and behavioural health services to offer a fully comprehensive set of services • Providers of long-term care services are accountable for the delivery of the continuum of services and supports (though they may contract some of these out) that meet quality and other standards set in the contract with the state Medicaid program • There is significant variation in programs as it is up to the long-term care provider (the contractor) and their network to manage how they provide and coordinate care for residents	*Outcomes* • In a 2018 Interim Evaluation Report on New York's and Tennessee's MLTSS programs, findings indicated that Home and Community-Based Services made up nearly 70% of total MLTSS expenditure and enrollment in these programs, and was associated with lower use of institutional services in New York but more use of personal care services and hospitalization stays in Tennessee *Key building blocks leveraged* • BB #7: use of combined capitation payment and risk-sharing incentives to align goals of the program with outcomes • BB #8: use of a strict performance measurement and quality-improvement framework to ensure timely and quality service delivery

Integrated Care Program for Older People [Republic of Ireland] (15-18) *Population:* Older adults with complex health and social care needs (e.g., frailty, falls, high levels of acute hospital use, and history of cognitive vulnerability) in Ireland	*Sectors and settings involved* • Home and community care • Primary care (e.g., individual primary-care providers) • Specialized care • Long-term care *Objectives:* • To improve the lives of older adults in Ireland by providing access to integrated care services that are centred around their needs and choices, so that they can live well in their homes and communities *Description of initiative* • The initiative is developing 12 pioneer sites nationally that adopt a population-health-management approach to care for older adults • Each pioneer site has been asked to develop a local governance committee and working groups, which include members of the priority population as well as representatives from local service providers • The governance committee has been asked to assess the characteristics of the population for each of their local communities, map local care resources that are critical to the care of older adults, and develop services and care pathways • Care pathways must include a geriatric assessment, a case manager to act as a named point of care, and ultimately the implementation of multidisciplinary teams that act as a 'hub' for older adults *Description of how initiative works with long-term care (if not clear from the above description)* • As there is significant variation in how this initiative is operationalized, long-term care may play a range of different roles, including as part of the governing committee or a partner more broadly • While the initiative aims to maintain independence as long as possible, there has been an explicit emphasis on ensuring that care pathways are developed for those who need long-term care to ensure residents receive coordinated services from the primary-care and acute-care sectors	*Outcomes* • Preliminary results of this initiative have shown positive outcomes for older persons (e.g., admission avoidance and reduced length of stay) and benefits to the health system (e.g., improved use of resources) • A sample of early data highlighted a return of investment of 8.7 million euros in national savings due to bed-days saved and hospital admissions avoided *Key building blocks leveraged* • BB #3: older adults are engaged as mandatory members of the local governance committees • BB #4: care pathways for population segments are co-developed with care partners and implemented with the support of case managers • BB #6: local governance structures are supported by national level leadership which has developed a governance framework to guide the work of local communities, and ensures the experience of local implementation is reflected in national strategic developments

Question 2: What implementation considerations have been built into or adopted to support equity-seeking populations?

Across the six initiatives examined in this review, few explicitly adopted tailored approaches to better meet the needs of underserved people and communities within their attributed populations. Additionally, none of the research evidence included in the review explicitly discussed tailored approaches to support underserved populations. However, the few approaches used in some of the initiatives and additional insights from the included research evidence can provide some potentially important considerations about how to support underserved populations when designing intersections between OHTs and long-term care homes. These considerations are organized by relevant initiatives described in Table 1 (above), supplemented with additional discussion based on insights from included research evidence where relevant.

In Quebec, the PRISMA initiative connects older people with chronic conditions (including those living in long-term care homes) and with different levels of care needs to the services they need.(7; 10) Individualized service plans based on a standardized assessment tool are used to identify relevant services and help facilitate coordination across providers. For older adults with heavier care needs, these individualized service plans are assessed more frequently in order to ensure that their needs continue to be met through services made available to them. Although frequent reassessment of service needs allows providers across PRISMA to better identify care needs and coordinate care, it has been noted that digital supports such as computerized client charts are not available to providers who are not associated with PRISMA, potentially limiting communication and coordination across providers.(9) Similarly, findings from the research-evidence search highlight the importance of sharing EHRs across providers to improve care for underserved populations with complex care needs.(28)

The Portuguese National Network for Long-term Integrated Care (Rede Nacional de Cuidados Continuados Integrados, RNCCI) provides integrated healthcare and social support for people who are in a situation of dependency, including those living in long-term care homes.(13) In addition to assessing healthcare needs, the individualized service plans consider income, social exclusion, and availability of social support. RNCCI also works closely with the Network of Social Services which works to better meet the needs of individuals facing poverty and social exclusion. Despite a great deal of overlap in the populations for which they are responsible, RNCCI's online data-management platform is not accessible by providers within the Network of Social Services, greatly limiting the extent to which providers across RNCCI and the Network of Social Services can coordinate services targeting underserved populations.(13) Additionally, an evaluation of the RNCCI has noted that efforts to monitor service access, utilization and care quality is not stratified, making it difficult to identify potential biases in service provision and monitor quality-improvement efforts to better meet the needs of underserved populations (14).

Finally, the Integrated Care Programme for Older People (ICPOP) works to engage citizens as equal partners to ensure that the planning, development and monitoring of care is better able to meet the needs of underserved people and groups.(18)

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APPENDICES

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

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

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

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

McMaster Health Forum Rapid Response Program
Summary Table of Relevant Literature

Appendix 1: Summary of findings from systematic reviews about strengthening partnerships between OHTs and long-term care homes

Question addressed	Focus of systematic review	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)	Year of last search/ publication date	AMSTAR (quality) rating
Q1	Evaluation of integrated approaches to healthcare services supporting older people in long-term care homes (25)	*Publication date:* 2011 *Jurisdiction studied:* Australia, Sweden, United States, United Kingdom *Methods used:* Systematic review/Narrative synthesis	Initiatives supporting continuity and integration of care services for older people living in long-term care homes	Strategies for increasing multidisciplinary collaboration across providers Introduction of multidisciplinary dedicated service teams	This review included studies that were heterogeneous in terms of interventions and outcomes, with most studies reporting limited effects of the intervention under investigation. Studies with longer follow-up periods tended to demonstrate greater potential for integrated care models. The review found that barriers to integrated care included: 1) a lack of trust between long-term care home staff and other service providers; 2) limited access to services outside of long-term care homes; 3) high staff turnover and lack of access to training; 4) lack of staff knowledge and confidence; 5) professional isolation; and 6) lack of teamwork in long-term care homes. Facilitators for integrated care efforts included: 1) long-term care homes valuing service-provider training and input; 2) bottom-up approaches that involve all levels of staff in training; 3) service providers advocating for care in long-term care homes; 4) sharing best practices and networking among service providers and long-term care home staff; 5) service providers promoting better access to services for long-term care homes; and 6) long-term care home managers supporting access to training for staff such as through learning contracts.	4	2009	7/9

Appendix 2: Summary of findings from primary studies about strengthening partnerships between OHTs and Long-term care homes

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
Q1	Assessing the extent to which long-term care homes have developed relationships with managed care organizations in Illinois (26)	*Publication date:* 1999 *Jurisdiction studied:* United States *Methods used:* Cross-sectional survey	Examined relationship objectives, obstacles to developing relationships, available services, staffing and networking among long-term care homes in Illinois	Managed care organizations (MCOs)	Long-term care homes with higher strategic goals and more relationships were found to have more risk-sharing relationships with MCOs. Many long-term care home administrators stressed the importance of routine training for administrators on what managed care is, how it is organized, and how its financing works as a necessary first step towards motivating long-term care home administrators to develop partnerships. The study highlights the need to set incentives for population-health management initiatives such as MCOs to develop shared care management strategies with long-term care homes. The financial stake that risk-sharing brings is important to ensure quality partnerships and coordination of administrative systems among providers within population-health management initiatives. The most common barriers to long-term care homes forming partnerships included: 1) difficulties meeting ongoing responsibilities; 2) past history/politics as an obstacle to integration; and 3) worries about costs of integration.(26)	4, 6
	To measure the impact of Medicaid managed long-term services and supports (MLTSS) on long-term care home quality and rebalancing (22)	*Publication date:* 2021 *Jurisdiction studied:* United States *Methods used:* Quasi-experimental	Secondary data from annual nursing home (NH) recertification surveys and the minimum dataset in three states that implemented	Medicaid managed long-term services and supports (MLTSS); a risk-based managed care arrangement for long-term care	Overall, the study found that MLTSS did not lead to any change in long-term care home quality outcomes in Massachusetts or Kansas. MLTSS is often thought of as a way of replacing expensive, undesirable long-term care home services with cheaper, person-centred services. Overall, there was little evidence found that MLTSS had an impact on the percentage of NH	4, 7

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
		(difference-in-difference approach)	MLTSS (Massachusetts (2001-2007), Kansas and Ohio (2011-2017))		patients with low care needs. The authors indicate that this outcome may have been affected by the simultaneous increase in resources in Ohio and Kansas, while MLTSS was being implemented. It may also already be easier for states to divert low-care residents from NH than in the past through another mechanism than MLTSS. Further research is needed to examine the variation in MLTSS program features that may have an impact on their outcomes on NH. The study also found that MLTSS did not result in a decrease in long-term care home utilization, despite two states increasing resources for home and community-based care services while implementing MLTSS. These findings contrast with prior studies on MLTSS programs, which often found a reduction in long-term care home utilization, but whose methods vary substantially. In Ohio MLTSS led to an increase in nursing hours per resident and a decrease in deficiencies. The increase in long-term care home staffing was contrary to the study's hypothesis, and the authors speculate that features of Ohio's MyCare program may account for this finding, including: 1) MCOs may not reduce reimbursement rates below those that would otherwise be in effect under fee-for-service Medicaid; and 2) MyCare provides incentive payments for quality measures, possibly incentivizing higher staffing levels, even in a capitated environment.	
	To understand how long-term care homes are responding to the growth of managed care approaches	*Publication date:* 2000 *Jurisdiction studied:* United States	National sample of 492 skilled nursing facilities that also provide assisted or	Managed care organizations (MCOs)	The findings showed that organizational structure, organizational culture, and environmental characteristics are all correlated with multilevel long-term care facilities interacting with managed care organizations. The strongest indicator of managed-care involvement was being	6, 7

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
	and how external resource pressures, institutional capacity to respond to pressures, and institutional cultural similarity shape their responses (27)	*Methods used:* Survey	independent living services		in a state with high Medicare health maintenance organization (HMO) membership. Secondarily, there was an association with having a large quantity of skilled nursing beds, a distinct Medicare-certified unit, Medicaid patients, and MLFs being part of a chain. The presence of MCOs alone may not be sufficient as an external factor to push long-term care homes into contractual relationships with MCOs. Management of long-term care homes reported increasing levels of acuity in their skilled units and a shift of some care down to unreimbursed levels of care. Number of skilled nursing beds, being part of a chain, and having a Medicare-certified distinct-part unit were associated with long-term care homes being involved with MCOs. In certain cases, a long-term care home's mission and culture were perceived as in conflict with what was perceived as more financially oriented managed-care approaches, with concerns over quality of care that they would be able to supply under the constraints of MCO contracts. Resource constraints posed by managed care organizations was the strongest, independent correlate of MCO contracts by long-term care homes. Model programs to increase primary-care oversight in long-term care homes such as through the use of nurse practitioners and/or physician assistants to reduce hospital days per year, would provide sufficient savings to pay for	

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
					the additional primary-care services. Such innovations require new ways of organizing and financing some services.	
	To understand the concept of Managed Long Term Care (MLTC) from a case manager's perspective, including its uses, defining attributes, cases, antecedents and consequences, and its measurable representations	*Publication date:* 2021 *Jurisdiction studied:* United States *Methods used:* Concept analysis	Academic and grey literature documents describing Managed Long Term Care services	Managed Long Term Care (MLTC) model, as opposed to traditional fee for service	Although MLTC programs vary across states, their core components include treating patients with chronic disease or disability, coordination of care through a care manager, networks of providers, and services provided through Medicaid capitation including long-term care home services, home and community services, and social services. MLTC provided through Medicaid is known as Managed Long-Term Services and Supports (MLTSS). The Centers for Medicare and Medicaid Services (CMS) requires MLTSS plans to have an adequate network of qualified providers to meet the needs of enrolled beneficiaries. These networks most often include long-term care homes, physical or occupational therapists, primary-care physicians, medical suppliers, and pharmacies. (28)	1, 2, 4
	To examine elements of preferred long-term care home networks among ACOs performing well on cost and quality measures (21)	*Publication date:* August 2020 *Jurisdiction studied:* United States *Methods used:* Mixed methods	366 respondents to the National Survey of ACOs (NSACO) and 16 semi-structured interviews with ACOs who performed well on cost and quality measures	This study analyzed quantitative data on levels of engagement, leadership structure, number of facilities and providers, and types of services provided by the ACOs of the NSACO respondents. Qualitative data on ACO	In this study, survey and interview responses were analyzed to determine the approaches that high-performing ACOs used to improve post-acute care. One-fifth of the ACOs in the study formally included skilled nursing facilities (SNFs) within the ACO, while nearly one-quarter of the ACOs had contractual relationships with SNFs. Of the ACOs in the study 56% had no formal relationship with SNFs. The study found that while leaders of high-performing ACOs recognized the importance of efficient post-acute care very early on in their accountable care participation, they shifted their focus to improving this aspect of service delivery at different points in their ACO evolution. Most	1, 2, 6, 8

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
				characteristics, post-acute management strategies, and the regulatory barriers and possible solutions were also analyzed from the included interviews.	ACOs first focused on improving primary-care services before shifting focus to post-acute care service delivery. Some of these ACOs decided to establish a preferred SNF network – a group of high-performing SNFs that would receive preferential referrals and form improvement-focused partnerships. This led to their SNF integration efforts becoming connected to efforts to improve discharge planning in the hospital in order to improve transitions overall across the care continuum. However, none of the ACOs interviewed had integrated their hospital's or physician group's electronic health record with SNF systems. In most cases, SNFs were granted access to patient information through embedded ACO staff or terminals put in place by the ACO. Half of the ACOs had established warm handoff processes to SNF care through collaboration between hospital and SNF staff. To ensure quality care at SNFs, ACOs established performance measures and clinical protocols that were regularly reviewed by an SNF liaison for the ACO. The ACOs' ability to establish effective partnerships with SNFs was influenced by ACO and SNF competition, quality of SNFs, and the geographic spread of SNFs in a region. To offset challenges with coverage, especially for ACOs serving rural communities or patients with complex conditions, a small number of ACOs targeted inclusion of specialized SNFs within their networks. Other challenges identified in the study for ACOs working to improve care coordination with SNFs include the lack of payment frameworks and aligned incentives, unclear regulations around anti-trust and patient	

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
					choice, the lack of integrated health records, and the lack of data on post-acute care to drive performance improvement.	
	To examine whether hospitals participating in Medicare's Shared Saving Program increased the use of highly rated long-term care homes or decreased the use of low-rated long-term care homes after initiation of their ACO contracts compared to non-ACO hospitals (29)	*Publication date:* May 2019 *Jurisdiction studied:* United States *Methods used:* Quantitative study	Discharge-level data from 2010 to 2013 for all fee-for-service Medicare beneficiaries discharged from an acute care hospital to an SNF; 12,736,287 discharges were examined in total	ACO hospitals discharge practices in relation to highly and poorly rated skilled nursing facilities (SNF)	The findings of this study indicate that ACO-participating hospitals were more likely to discharge patients to highly rated SNFs after they began their ACO contract. After joining an ACO, the percentage of hospital discharges going to a five-star SNF increased by 3.4 percentage points on a base of 15.4%. However, the probability of discharge from an ACO-participating hospital to a one-star SNF did not change significantly from its baseline level after joining an ACO when compared with non-ACO participating hospitals. The researchers indicated that compared to contrasting results of previous research that suggested patients attributed to a Medicare ACO were not more likely to use highly rated SNFs, the results of this study suggest that hospitals could be implementing hospital-wide changes in discharge patterns after becoming ACO providers.	7
	Examining the effectiveness of the integrated care model for long-term care facility residents (30)	*Publication date:* June 2009 *Jurisdiction studied:* Northern Taipei City *Methods used:* Randomized Controlled Trial	A total of 74 participants from seven long-term care facilities in Northern Taipei City with bed capacities of 30+	The integrated-care model features an interdisciplinary team (composed of geriatricians, nurses, physical therapists, dietitians, and social workers) that assists in the daily care of residents alongside long-term care facility staff. The integrated-care	The primary objective of this study was to assess the clinical effectiveness of adopting an integrated-care model for long-term care facilities. The primary outcomes measured within the study included: unplanned feed tube replacement; unplanned urinary catheter replacement; emergency-department visit; hospitalizations; urinary infection incidence; pneumonia; and pressure sore. The findings from this study revealed that an integrated-care model in long-term care facilities was minimal in terms of its clinical effectiveness. However, there were statistically significant improvements in serum albumin, hemoglobin,	4

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
				team routinely visits the residents and participates in team meetings on a monthly basis.	and unplanned feeding tube replacement rates in patients receiving care through the integrated model. The authors do note that the lack of clinical effectiveness of this intervention could be attributed to the wide range of participants involved within the study, particularly given that all of the participants were living with severe disability (which has been shown to reduce the likelihood of improvement among residents with or without integrated care).	
	Examining the preliminary data on post-acute care quality experiences of an accountable care organization (31)	*Publication date:* April 2015 *Jurisdiction studied:* United States of America *Methods used:* Not reported	47 skilled nursing facilities	Not reported	The primary focus of this study was to detail the methods that Partners HealthCare System (PHS) utilized to identify skilled nursing facilities in accountable care organizations (ACOs). The findings from this study highlighted that skilled nursing facilities had a greater likelihood of clinical coverage lasting longer than five days and a physician or nurse practitioner viewing the patient within 24-to-48 hours of admission. On average, skilled nursing facilities participating in a partnership with PHS were satisfied with a score of 4.6 on a 5-point Likert scale. Many key themes and lessons also emerged from this study, including the need for ACOs and their physicians to collaborate with skilled nursing facilities and further invest in clinical infrastructure, and the need for validated, risk-adjusted quality measures for ACO management when selecting skilled nursing facilities.	8
	To assess the extent of long-term care home participation in ACOs, and the characteristics of	*Publication date:* December 2019	660,780 nursing-home residents from 14,868 nursing homes in the hospital	Medicare nursing-home residents were identified from 2014 Minimum Data	This study assessed the extent to which nursing homes participated in ACOs in 2014. A quarter of the nursing-home residents were attributed to an ACO and one-fifth of nursing homes cared for a large number of ACO residents. The study	7

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
	residents and their long-term care homes connected to ACOs (19)	*Jurisdiction studied:* United States *Methods used:* Cross-sectional study	services areas with at least 5% ACO participation	Set assessments, and were attributed to ACOs based on Medicare methods	highlighted that short-term post-acute patients are reimbursed primarily through Medicare at higher rates than long-term residents reimbursed primarily through Medicaid, creating conflicting incentives for nursing homes to hospitalize their nursing-home residents. ACO-provider homes were more likely than non-ACO homes to have a five-star rating, be hospital-based, and have Medicare as the primary payer, suggesting that these facilities focus on post-acute, short-term stays.	
	To examine the association between ACO attribution status and utilization and Medicare spending among long-term care home residents (20)	*Publication date:* February 2021 *Jurisdiction studied:* United States *Methods used:* Observational propensity-matched study	522,085 Medicare fee-for-service beneficiaries who were long-term nursing-home residents in areas with at least 5% ACO participation	ACO attribution and covariates were measured in 2013 and outcomes (hospitalization, Medicare spending, outpatient ED visits) were measured in 2014	The aim of this study was to examine the association between ACO attribution, utilization, and Medicare spending among nursing-home residents. At least 23.3% of the nursing-home residents included in the study results were attributed to an ACO in 2013, and these residents had less use of discretionary care (e.g., imaging, testing, ED visits) than non-ACO residents. However, the study did not find that ACO residents had significantly lower Medicare spending. The study's findings suggest that due to the high needs of long-term nursing-home residents who can and often will change their providers at any time, long-term resident populations may receive care from many different providers (ACO or non-ACO) within a year, or largely see nurse practitioners. As a result, the underlying assumption of the ACO model that providers will continuously provide care for their patients over time often will not apply for long-term care residents, and therefore, modifications to the ACO model may be needed when including long-term nursing homes in ACO provider networks.	7
	Examining the impact that hospital	*Publication date:* July 2018	A total of 222 accountable care	Accountable care organization aid	The primary focus of this study was to determine whether hospital and post-acute care participation	4, 6, 7

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
	and post-acute care providers partnering with accountable care organizations can have on patient outcomes (32)	*Jurisdiction studied:* United States of America *Methods used:* Quasi-experimental	organizations, with 89 of them including an acute-care hospital and 60 having one or more post-acute care providers (e.g., 49 skilled nursing facilities, 55 home health agencies, and 103 inpatient rehabilitation facilities)	providers working together to improve the coordination of care	in accountable care organizations (ACOs) can have an impact on patient outcomes and Medicare spending. ACO-participating hospitals with a post-acute care provider were generally larger, more likely to be located in rural settings, and be non-teaching hospitals. The findings from this study highlighted that when hospitals and skilled nursing facilities work together in the same Medicare Shared Savings Program (MSSP) ACO, their patients had lower readmission rates, lengths of stay, and per-discharge Medicare spending. The participation of hospitals and home health agencies yielded a smaller reduction in per-discharge Medicare spending among their patients. The overall findings from this study support the integration of an ACO payment model.	
	To examine the implementation of integrated care in long-term care homes and its effects on the quality of caregiving (33)	*Publication date:* 2008 *Jurisdiction studied:* Netherlands *Methods used:* Before and after	One nursing home in the Netherlands with psycho-geriatric, somatic and rehabilitation wards	Governance of the integrated-care initiative included steering group, advisory group and several working groups. The working groups were appointed to develop the model for integrated care alongside engagement with paramedical staff, residents and their families.	Findings from the study showed an increase in all three characteristics of the initiative in the somatics-care ward. The caregivers were better able to create a home-like environment, use a demand-oriented method, and integrated the provision of care. This same increase was not observed for the psycho-geriatric wards due to increased workload and less ability to place time into the transformation. Similarly on the somatic wards, the introduction of integrated care led to an increase in the supervisor's social support and degree of collaboration between caregivers.	4, 6

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
				The integrated care initiative consisted of three characteristics: 1) a home-like environment on nursing wards that engages residents and their families in daily activities like cooking, cleaning and decorating; 2) demand-oriented working method which recorded residents' care needs and regularly evaluated whether services were meeting this needs, and whether the care plan was still attuned; and 3) integration of services by multidisciplinary team.		
	To examine the extent of integrated working between long-term care homes and primary and community	*Publication date:* 2012 *Jurisdiction studied:* England	Sample of 621 care homes in England	Care homes that provide predominantly residential care due to progressive chronic or	The majority of care homes were located in urban areas and were focused on providing care for people with dementia. Homes reported an average of 39 beds and approximately 0.77 staff FTE for each resident.	4

Question addressed	Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings	Relevant Building Block(s)
	health and social services (34)	*Methods used:* Qualitative survey		cognitive impairment, and rely on local primary-care physicians and a variety of community health and social-care services for access to medical and specialty care	All homes reported receiving services from local physicians, with 78% saying they worked with multiple practices. Many homes reported difficulties in getting physicians to run weekly clinics in the care homes. A small number of homes reported paying retaining fees to physicians, but reported negative comments for having to do so. The majority of care homes reported that while they had decent working relationships with primary care, major communications difficulties arose when working with secondary care, particularly as there was a lack of mechanisms in place for structured exchange of information. Care home workers saw benefits in terms of improving access to services, continuity of care, and speed of response when services were integrated. Many indicated that the NHS did not provide enough support care and as a result had a lack of trust. Comments from care-home staff indicate that some care homes perceived differences in working cultures and priorities, and a lack of understanding of care-home roles, which contributed to poor working relationships.	
	To evaluate the effects of preferred skilled-nursing facility network formation in ACOs on care patterns and outcomes (35)	*Publication date:* 2021 *Jurisdiction studied:* United States *Methods used:* Quasi-experimental – difference in difference	Ten health systems that participated in Medicare ACO programs and established preferred skilled-nursing facility networks	The use of preferred skilled-nursing facilities network formation with Medicare ACOs	By forming networks, hospitals were able to accurately identify higher-quality and lower-cost SNFs. However, no improved outcomes were found. This may be in part a result of hospitals not being permitted to recommend specific skilled-nursing facilities under Medicare regulation,s and so hospital dischargers may not provide patients with full information for fear of contradicting these requirements.	2, 4, 6, 7

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