

Rapid Synthesis

Examining Intersections Between Ontario Health Teams and Home and Community Care

18 April 2022



HEALTH FORUM

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**Rapid Synthesis:
Examining Intersections Between Ontario Health Teams and
Home and Community Care
30-day response**

18 April 2022

McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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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 (<https://www.mcmasterforum.org/find-evidence/rapid-response>).

Funding

The rapid-response program through which this synthesis was prepared is funded by the Government of Ontario through a grant provided to Rapid Improvement Support and Exchange (RISE). The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the rapid synthesis are the views of the authors and should not be taken to represent the views of the Government of Ontario or McMaster University.

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.

Acknowledgements

The authors wish to thank Leighton McDonald for their insightful comments and suggestions.

Citation

Evans C, Waddell K, Lavis JN. Rapid synthesis: Examining intersections between Ontario Health Teams and home and community care. Hamilton: McMaster Health Forum, 18 April 2022.

Product registration numbers

ISSN 2292-7999 (online)

KEY MESSAGES

Questions

- What can be learned from organizations similar to OHTs that have contracted with home and community care providers?
- What is an appropriate scale for home and community care agencies to manage a change in volume? (i.e., what is the optimal size)
- How can home and community care organizations work with OHTs in ways that are responsive to equity considerations?

Why the issue is important

- The home and community care sector in Ontario faces multiple challenges
 - An aging population and growing prevalence of chronic disease and multimorbidity place increasing pressure on the sector
 - Human resource shortfalls and misaligned incentives affect the ability of the sector to meet population needs
- Under new regulations under the *Connecting Care Act 2019*, Ontario Health Teams will contract with home and community care providers for home and community care services

What we found

- We conducted a structured database search, supplemented with targeted database and internet searches
 - These searches identified seven systematic reviews and twenty-eight single studies
- Little empirical evidence was found that addressed the outcomes of different contracting arrangements, the optimal size of provider organizations, the perspective of homecare organizations holding multiple contracts, or the inclusion of virtual care in contracting arrangements
- Further, the literature on contracting included little or no information relevant to pressing concerns in Ontario including the shift to virtual care, the need to address human resource shortfalls, and the capacity of the sector to respond to fluctuations in both individual and population-level need
- We did identify contracts forms using in Australia, U.S. and the U.K. with home care agencies including:
 - alliance contracts, where multiple organizations are equal partners in a contract
 - prime contracts, where a single organization acts as an “integrator” and subcontracts to provide a complete care pathway
 - outcome-based contracts, which include specified outcomes and which may be combined with the above
- Factors affecting implementation of contracts in home and community care may include:
 - provider-level factors including provider engagement, collaboration and trust among providers, and tensions between clinical discretion and contract requirements
 - organization-level factors including collaboration and trust among participating organizations, availability of shared information technology, congruence in population coverage between purchaser and providers, and availability of supports
 - policy-level factors including clarity of goals, feasibility of targets, and stability of policies
- Effective implementation of contracts requires organizations to access: legal supports (to draft contracts), actuarial supports (to assess risk in contracts), technical supports (to understand population needs), business supports (to manage human resources and information technology) and clinical supports (to design clinical pathways)

QUESTIONS

- 1) What can be learned from organizations similar to OHTs that have contracted with home and community care providers?
- 2) What is an appropriate scale for home and community care agencies to manage a change in volume? (i.e., what is the optimal size)
- 3) How can home and community care organizations work with OHTs in ways that are responsive to equity considerations?

WHY THE ISSUE IS IMPORTANT

First introduced in 2019, Ontario Health Teams (OHTs) are networks of healthcare organizations (and in some cases public health and social services) that take a population-health management approach to serving their attributed population. At maturity, OHTs will be clinically and fiscally accountable for population health.

The governance of home and community care in Ontario has undergone shifts both prior to, and concurrent with the development of OHTs. These shifts have had implications for the number and nature of contracting entities:

- In 1996, 43 Community Care Access Centres were created to manage competitive procurement for home and community care providers
- In 2007, the original 43 CCACs were amalgamated into 14 new CCACs, aligned with the 14 new Local Health Integration Networks that assumed responsibility for funding and planning local health services
 - The amalgamated CCACs “inherited” contracts, resulting in differing rates for contracted service providers offering similar services
 - While a standard contract was created for CCACs in 2012, differing rates persisted
 - In 2011, the Ministry of Health directed CCACs to directly employ nurses for specific roles, resulting in a mix of public and private provision of nursing care⁽¹⁾
- In 2017, CCACs were dissolved and their functions were transferred directly to LHINs
- In 2021, health-system planning and funding functions were transferred from LHINs to the newly formed Ontario Health, while LHINs retained their role in home and community care

Most recently, the new Home and Community Care Services Regulation (O. Reg 187/22) under the *Connecting Care Act 2019*, which came into effect May 1, 2022, introduced several important changes to the legislative framework for home and community care in Ontario, including to enable:

Box 1: Background to the rapid synthesis

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

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

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

- Ontario Health to fund OHTs for home and community care services (Ontario Health has had and continues to have the authority to fund not-for-profit health service providers to deliver home and community care);
- OHTs, who are funded to provide home and community care, to provide home and community care services other than care coordination directly (i.e., through their own employees) and/or indirectly (i.e., through contracts with service provider organizations);
- OHTs to provide care coordination services (a defined term in the Regulation) directly and/or indirectly (including through their service provider organizations), subject to requirements in the Regulation and in the terms and conditions of OH's funding; and
- the removal of prescribed service maximums.

While the original vision for OHTs included moving towards an integrated funding envelope that would encompass home care and community care, the details of this arrangement have not yet been articulated.

These regulations will create important new opportunities and responsibilities for OHTs and will be complemented by other instruments (terms and conditions of funding, directives, guidance, and policies) to support their implementation.

Funding OHTs to provide home and community care services through contracts with service provider organizations open new opportunities to address challenges within home and community care. These challenges include an aging population and growing prevalence of multimorbidity and functional decline, which places increasing pressure on the sector.(2; 3)

Fragmentation between home care and community care and other health sectors adversely affects patient experiences.(2; 4) Meanwhile, inequities in access to home and community care exist across income, language, social circumstance, and complexity of needs.(2; 3)

Human resources are a particular challenge in the sector, notably among professional nursing and personal support workers. A briefing note put forward by large home care organizations in Ontario suggests that issues including staffing shortfalls affect the ability of the sector to meet population needs.(5) Human resource concerns are exacerbated by workload intensification, casualization and low job security, and cross-sectoral pay differentials which create challenges for recruiting and retaining home care providers.(6) The COVID-19 pandemic has further strained health human resources across the health system, including in home and community care.

Misaligned financial incentives present a further challenge. For instance, fee-for-service payments for medically complex clients can create resource allocation issues as care (and resulting payments) are interrupted for patient hospitalization. Further, consolidation within the long-term care sector has also resulted in favourable risk-selection by smaller organizations in efforts to remain competitive (personal communication).

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. In Health Systems Evidence we searched for [(contract* OR commissioning) AND [(home care OR community care)]. [(contract* OR commissioning) AND [(home care OR community care)]. We also undertook snowball and targeting sampling to identify other literature.

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.

This synthesis considers how contracts between OHTs and home and community care can be structured to support the equitable achievement of the quadruple aim goals, namely, improved population health and manageable per-capita costs, and improved citizen and provider experiences.

WHAT WE FOUND

We identified seven systematic reviews, addressing either contracting in healthcare generally or in home care specifically. We further identified 27 single studies addressing either contracting in home care, or equity in healthcare contracting.

Important limitations in the literature are described below. Following this, we describe different approaches to contracting, with examples drawn from our targeted search (question 1), examples of the scale of different initiatives (question 2), and evidence from the literature pertaining to equity (question 3).

Limited empirical evidence was found that addressed the outcomes of differing contracting arrangements in home and community care. This evidence primarily related to the process of commissioning (which includes contracting as well as planning and evaluating) and was largely from the United Kingdom. One medium-quality systematic review concluded that limited evidence exists for how commissioning can be used to improve quality and manage costs in health care.⁽⁷⁾ A further medium-quality systematic review noted that limited evidence exists for improved integration, reduced costs, improved quality, or other outcomes of specific contractual models used in the National Health Service in the U.K.⁽⁸⁾ A high-quality systematic review specifically considering joint commissioning between health and social care (which is focused on personal care, social work, and social services) found the quality of evidence of effects was low and prevented making conclusions about effects.⁽⁹⁾ Another medium-quality review notes that most research on links between incentives used in contracts and performance is conceptual rather than empirical.⁽¹⁰⁾

In addition, a substantial proportion of the literature focused on problems rather than solutions, from both empirical and theoretical perspectives. Findings from single studies suggest that organizations similar to OHTs can encounter trade-offs between the transaction costs of contracting (e.g., the investment of time and human resources required for collaboration), and desire to contract with optimal providers for each component of service.^(11; 12) Different stakeholders in a contract also have different motivations and vantage points, introducing additional complexities. For instance, discrepancies in the outcomes valued by different stakeholders including providers, citizens, and governments leading to challenges in formulating incentives.⁽¹³⁾ The different motivations between purchasers (e.g., government or insurers) and provider organizations can also create the potential for favorable risk selection, to advantage certain contractual relationships.⁽¹²⁾ Furthermore, the treatment of low-incidence, high-needs and complex conditions may rely on provider discretion rather than standardized treatment that can be pre-specified in a contract, leading to further difficulties in establishing packages of care and specifying outcomes.⁽¹¹⁾

The literature on contracting did not address other concerns that are pertinent to Ontario Health Teams. This includes important shifts in health care provision and need that have arisen during the COVID-19 pandemic. For instance, reviewed literature did not address implications of contracting for virtual care. Similarly, delays to scheduled surgeries and other procedures can influence demand for community rehabilitation and other services; the contracting literature included minimal information about strategies for dealing with population-level fluctuations in healthcare needs.

Moreover, most literature considered contracts from the perspective of purchasers, who may hold contracts with multiple organizations to provide a complete package of care. In Ontario, while OHTs may contract with multiple home and community care organizations, it is also true that home and community care providers will need to contract with multiple OHTs. Considerations relevant to the latter challenge were not clear from the literature that we reviewed.

1) What can be learned from organizations similar to OHTs that have contracted with home and community care providers?

Researchers describe three types of contracts that can be held between organizations similar to OHTs, and home and community care providers.(8; 14-16) These models are described in Table 1 below. Limited evidence is available pertaining to the effects of these differing contractual arrangements.

Table 1: Types of contractual arrangements with home and community care providers

Contract type	Description	Examples in home and community care
Prime contract	<i>Description</i> - A single contract is granted to an entity that then subcontracts to provide the full intervention. Payment is typically capitated - In some prime contracts, the contractor acts as an integrator - In a prime provider contract, the entity holding the contract provides a part of the intervention and subcontracts for the remaining components <i>Rationale</i> - Prime contracts are intended to reduce fragmentation by including the entire pathway within a single contract, and have the potential to foster innovation(14) <i>Considerations</i> - Prime contracts increase information asymmetry between payers and providers, which can pose a challenge for accountability(8) - In prime provider contracts, a provider organization must also have capacity to manage subcontracts(14)	In the United States, the Program of All-Inclusive Care for the Elderly (PACE) is a capitated program focusing on frail elderly that uses Medicare and Medicaid funding to provide comprehensive care. PACE organizations pool funds to provide a complete package of services including primary care, rehabilitation, personal care, and meals (rather than solely providing services covered under each payer's fee-for-service system). PACE organizations may contract out for some services; contracted providers are accountable to the PACE organization, and take part in a competency evaluation.(17)
Alliance contract	<i>Description</i> - In an alliance contract, multiple organizations enter into a single contract as equal partners - The alliance requires an internal governance structure, including a leadership board that is accountable to the payer <i>Rationale</i> - Alliance contracts are intended to support collaboration, and to incentivize participants to identify efficiencies(14) - Alliance models may discourage gaming(8) <i>Considerations</i> - Alliance contracts require strong trust among participating organizations and may be most effectively built on pre-existing partnerships(14) - The selection of alliance partners may undermine transparency and competition(8)	A survey completed by respondents representing 726 American community-based organizations (predominantly Area Agencies on Aging and Centres for Independent Living) found that 41.3% have one or more contracts with a healthcare organization such as a Medicaid Managed Care Organization (41.6%), hospital system (26.5%), Veterans Administration Medical Center (21.3%), or ACO 12.7%). 30.2% of organizations had entered into a contract as part of a network or alliance in 2018, up 10.5 percentage points from the previous year.(18)
Outcome-based contract	<i>Description:</i> The contract includes incentives for specific outcomes, which may be clinical (e.g., improved health outcomes) or service-oriented (e.g., improved integration)	In the U.K., multispecialty community provider (MCP) 'vanguards' are being developed to provide integrated primary and community services,

Contract type	Description	Examples in home and community care
	• Outcome-based contracting can be combined with the above approaches <i>Rationale</i> • Outcome-based contracting is intended to reduce cream-skimming(14) but can inadvertently encourage gaming(8) • Adequate infrastructure is needed to meet reporting requirements, which may be burdensome for smaller organizations(19) <i>Considerations</i> • Outcome-based contracting attributes outcomes solely to providers, where in fact these outcomes are also produced by users and enabled by macro-level contextual factors; moreover, it is difficult to align incentives across user, provider, citizen and government stakeholders as different outcomes are valued by these different groups(13)	including urgent care (but not hospital services). Three types of contracts have been proposed, including a “fully integrated” contract. The “fully integrated” contract model includes a performance-based element and gain/risk sharing element in addition to a whole-population budget. Under this arrangement the MCP will be a legal entity and will contract with commissioners. “Fully integrated” contracts will have a duration of 10-15 years, longer than typical NHS contracts.(20)

While evidence pertaining to outcomes was scant, more information was available relating to the implementation of contracts in home and community care.

- Provider-level factors affecting implementation of contracts, drawn from single studies, include:
 - engagement of providers in model development (21)
 - communication, collaboration, and trust among providers across participating organizations (22)
 - burden and relevance of measurement requirements for frontline providers (19)
 - perceived support from management (23)
 - need for provider discretion (rather than standardization) to address low-incidence, high-needs and complex conditions (11)
 - alignment or discrepancies between clinical decision-making and service-level objectives (e.g., contractual limits on patient contacts per episode).(24)
- Organizational-level factors affecting implementation of contracts, drawn from single studies and systematic reviews, include:
 - collaboration and trust among participating organizations (9; 10)
 - collaboration between purchasers and providers (7; 22; 25)
 - availability of shared information technology (7; 9; 22)
 - congruence in population coverage between purchaser and providers (9; 24)
 - availability of in-house skills to manage contracts(7; 15)
 - use of decision supports (7)
 - patient and family representation in governance (11; 26) and clearly defined rights for patients and responsibilities for purchaser(26)
 - a “race to the bottom” in fee negotiations between purchasers and organizations, which can lead to pressures to minimize wages or travel coverage for staff or even to the organization exiting the market.(27)
- Policy-level factors affecting implementation of contracts, drawn from single studies and systematic reviews, include:
 - clarity of policy goals (21; 28)
 - feasibility of targets, particularly in the complex context of home care (21)
 - ministerial support (21)
 - policy authority to engage in performance management(21; 29) and a balance of compliance and deterrence-based approaches (26)

- balancing provider autonomy with regulation (26)
- instability of relevant policies (25) and instability of funding cycles (19)
- sensitivity of the home care workforce supply to local labour market conditions.(27)

The supports that organizations may draw on to implement contracts include:

- legal support for drafting contracts(14)
- actuarial support to assess risk(14)
- consultancy support to identify population needs(14)
- business supports including information technology and human resource management(28)
- supports for clinical pathway and service redesign.(28)

2) What is an appropriate scale for home and community care agencies to manage a change in volume? (i.e., what is the optimal size)

The literature included in this synthesis does not identify an optimal scale for home and community care agencies. Home and community care initiatives cover a range of scales, for example:

- Quebec's current approach to care for the elderly originated as the PRISMA research project covers differing populations in three communities: Sherbrooke (urban, population 144,000; 18,500 over 65 years), Coaticook (rural, population 16,500; 2,300 over 65 years), Granit (rural, population 22,000; 3,300 over 65 years)(30)
- in the U.K. (which has a more geographically clustered population than jurisdictions like Quebec and the U.S.), multispecialty community provider 'vanguards' offer primary and community care to a minimum population of 100,000, encompassing multiple 30-50,000 person hubs(20)
- in the U.S., half of Accountable Health Communities (which offer community service navigation and community capacity building) serve communities of over 200,000 beneficiaries(31)

Limited information was found about the number of contracts held by home and community care organizations. A survey of American community-based organizations found that 41.3% of organizations had one or more contracts with a health care entity. Among community-based organizations that held contracts with health entities, the average number of contracts was three, with a range from one to one hundred.(18) In contrast, a UK survey of clinical commissioning groups' community care contracts found that private providers held 1.9 contracts on average, while third sector providers held 2.4 contracts on average. 71% of private community care providers held just one contract.(32)

Organizational scale is recognized as an important consideration for both providers and payers. Providers must be able to manage unpredictability of demand, matched with sufficient workforce supply. It is also a critical consideration to allow for the appropriate level of support to be given to frontline providers by way of education, training and technology that allow them to provide high-quality care. A report on domiciliary (home care) work in England notes that responding to short-notice requests and fluctuations in demand requires providers to have an adequate pool of available labour. The report focuses on the influence of local labour conditions on home care human resources, but it also notes that organizational size plays a role: while some national providers created a pool of reserve staff, smaller providers are often unable to maintain a sufficient and flexible reserve. Providers sometimes turned to subcontracting during periods of high demand, however at these times potential subcontractors may already be operating at full capacity and unable to take on additional work (27) In addition to challenges addressing fluctuating population needs, smaller organizations are also less able to withstand instability and time delays in funding created by contracting processes.(19) On the payer side, contracting is resource- and time-intensive and smaller organizations may lack necessary in-house legal and other resources. Smaller clinical commissioning groups in the UK shared or outsourced some support functions, with a range of opinions on which functions were "core" and needed to remain in-house.(28) Payers must also parcel services into "units of work" that are large enough to justify the costs of commissioning.(12)

3) How can home and community care organizations work with OHTs in ways that are responsive to equity considerations?

Inequities in home and community care are varied and are wide, including in access to services across conditions, populations and geography as well as a lack of standardization of services across the province, to name a few. Identified studies described problems that perpetuate inequities in home and community care. A single study on GP-led commissioning in England found that a tendency to maintain the status quo, prevented equity-focused innovation.(33) The misalignment of incentives, noted above as a common dilemma in healthcare contracting, also has equity implications. Funding arrangements that enable favorable risk selection combined with blunt cost-control practices that disincentivize continuous or high-intensity care, affect the highest-needs clients.(13; 34) A report on home care in England notes higher costs for provider organizations in linguistically diverse areas due to the need for translation or bilingual staff; in areas where two workers may be sent together for safety reasons; and in rural areas due to travel times;. These additional costs are not always accounted for in contracts, and in the case of rural areas sometimes resulted in organizations withdrawing services.(27) With respect to Indigenous self-determination, one study found contracts held by a Maori health organization undermine self-determination through redefining self-determination as ‘empowerment,’ misrepresenting Maori governance structures, prioritizing governmental strategic directions, using a deficit framing and a focus on individual behaviours, and employing ‘feel-good’ language that was not matched with the actual content or implementation of the contract.(35)

Addressing equity in home and community care services requires leadership and expertise. A medium-quality systematic review noted that factors affecting the potential for contracting to address equity concerns include clear responsibility for health equity and related policy directions. Top-down directives need to prioritize equity and make clear who is accountable for increasing health equity at a population level. The review also notes that expertise in health equity concerns within purchasing organization is required.(36)

Specific strategies to address the needs of populations that face inequities in Ontario were not available.

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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.

Appendix 1: Summary of findings from systematic reviews about contracting in home and community care, and/or equity considerations in contracting

Type of review	Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
Systematic review of effects	Impacts of commissioning on utilization, quality, outcomes, and cost-effectiveness in Australian healthcare (where commissioning includes strategic planning, procurement, and monitoring and evaluation); only included articles considering “the primary and acute care interface” or chronic disease(7)	Limited evidence is available regarding outcomes of commissioning. Two of three studies reporting on utilization found that commissioning reduced use, while the third found no effect. One study found practice-based commissioning resulted in user and carer perceptions of better care, and one found reduced smoking rates (in an RCT conducted as part of commissioning). One US study found little change to value while another found improved quality and reduced costs. Factors facilitating implementation include: information sharing and detailed local knowledge. Barriers include: lack of resources including human resources and appropriate skills, limited use of decision supports, and difficulty maintaining relationships with partners. The authors conclude, “There was insufficient evidence to identify any preferred form of commissioning. Although planning, contracting and monitoring are all critical elements in the process of commissioning, the emphasis of studies is on planning, with some attention to contracting but very little on monitoring contracts and performance, or supporting patient choice.”	2015	5/9	0/36
Systematic review addressing other questions (realist review)	Considerations for strategic purchasing in healthcare, informed by economics of organization and inter-organizational relationships theories(26)	Strategic purchasing, as defined by WHO, encompasses identifying optimal interventions, providers, and payment mechanisms and contractual arrangements. Three key objectives for strategic purchasing include patient empowerment, government stewardship, and provider performance. Patient empowerment can be enabled through the purchaser: using data about population needs and patient viewpoints; building trust with patients; and avoiding preferential treatment for powerful lobby groups. Patient representation in governance, and clearly defined rights for patients and responsibilities for purchasers, and regular interaction between purchasers and patients can further support patient empowerment. Patient choice of providers within a market-based structure incentivizes responsiveness and is argued to be appropriate for home care and other “standardized [or] fairly simple” types of care. Two mechanisms are suggested for government stewardship. One is a policy strategy that includes targets which are realistic, culturally relevant, transparent, evidence-based, and incentivized, and which are developed with local input. The other is a regulatory framework that balances compliance and deterrence, and that takes a coordinated approach to responsiveness, equity and efficiency through information provision, financial accountability of purchasers to government, transparency, and assurance of provider competence.	2016	3/9	Unavailable

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Type of review	Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
		Facilitating provider performance involves trade-offs influenced by provider autonomy (which can enable both efficiency and moral hazard), governance arrangements (where contracts may not account for complex situations, requiring extracontractual governance), and the balance of power between providers and purchasers (where balanced power and interdependence can facilitate collaboration).			
Review addressing other questions (qualitative synthesis)	Experiences of social care providers with contracted service provision(37)	Non-profit providers felt that contracting shifted responsibility for austerity policies away from government toward the third sector, required burdensome monitoring of low-relevance quantitative measures, and lead to adoption of a focus on competition that could be at odds with organizational values. Insufficient funding was perceived to lead to poor working conditions. Nonprofits needed to manage strategic relationships with multiple funders. Meanwhile for-profit providers focused on identifying opportunities and optimizing their offerings when bidding for contracts (sometimes through cream skimming). The uncertainty of public contracts poses a challenge for these providers. Commissioners viewed contracts as a way to increase flexibility and to capitalize on greater public trust in nonprofits than in government. Commissioners relied on more easily quantifiable outcomes because quality was perceived as difficult to measure. Authors conclude, “no ownership type can compensate for inadequate funding of social care services.”	2020	4/9	3/26
Systematic review of effects	Joint commissioning across sectors(9)	“The quality of the studies that answered questions relating to the impact of joint commissioning was judged overall to be low. This means that we had little confidence that the impacts claimed for joint commissioning were in fact ‘caused’ by joint commissioning and not by some other factor not investigated or controlled for in the studies.” Participants in included studies perceived potential positive impacts including reduced duplication, cost savings, improved quality and outcomes, improved working relationships. Participants in included studies perceived potential negative impacts including transaction costs, decreased job security, and power struggles among organizations. Quality of evidence on implementation factors was judged to be medium. Factors affecting implementation included inputs (leadership, history of joint working, resources); context (geographical boundary discrepancies, legal issues, policies); issues internal to agencies such as accountability and incentive structure; and relationship among agencies including communication, trust, shared goals, and integration of systems.	2012	8/10	0/25

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Type of review	Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
Review addressing other questions.	Contractual models used in the NHS(8)	Alliance contracting: single contract among commissioner and all organizations delivering the project. Emphasizes relationships and collaborative decision-making; may involve no-dispute clauses. Prime provider contracting: prime contractor provides some services and subcontracts others Outcome-based contracting: contract pays on the basis of outcomes or proxies; may be used in conjunction with other models. Relevant theoretical considerations: principal-agent relations (use incentives for outcomes to discourage opportunistic behaviour); transaction costs; relational elements to balance the inherent incompleteness of contracts which cannot anticipate all possible eventualities. Negotiating and specifying all types of contracts above is costly and relies on relational norms. Identifying outcomes requires ongoing negotiation and investment in data. Outcome-based approaches can encourage gaming, while alliance models may discourage this. Alliance models may include a period of pre-contract joint working to establish relationships and goodwill. Distrust may arise between prime and sub-contractors. It is difficult to determine the effects of contracting models, and strong evidence does not exist for improved integration, reduced costs, improved quality, or other outcomes. Potential governance issues are identified, but not empirically supported, in the literature. For instance prime models create distance between commissioners and providers, increasing information asymmetry and creating challenges for accountability; selection of alliance partners may undermine transparency and competition.	2017	4/9	Unavailable
Systematic review addressing other questions	Public-private partnerships in health care(10)	“Extant literature offers an incoherent picture of PPP outcomes with regards to its benefits and disadvantages.” Lengthy contract negotiation periods reflect a lack of knowledge of which risks are most effectively transferred to the private sector. “[T]here is limited understanding of the interplay between performance-based contracts, incentive mechanisms and subsequent service performance; with much of the specific research on incentives being conceptual.” Aligning stakeholders’ skills and capabilities, and establishing trusting relationships, facilitate partnerships. Contracts are inherently incomplete as not all possibilities can be foreseen. Costs of governance increase along with the number of involved parties. Long-term contracts can foster commitment but also complacency.	2011	4/9	1/11

Type of review	Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
	Equity and other effects of clinical commissioning in the UK(36)	Five of six included articles found that equity was not prioritized in commissioning. Barriers to addressing equity through commissioning included fragmentation of responsibility for health equity, lack of relevant expertise, and lack of engagement with public health. Commissioning was perceived to be beneficial in terms of restructuring services and enabling strategic approaches and engagement of health services and communities.	2020	7/10	0/6

Appendix 2: Summary of findings from primary studies about contracting in home and community care, and/or equity considerations in contracting

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Explains the development of a direct funding policy for older adults in Ontario(38)	<i>Publication date:</i> 2019 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> health reform description	N/A	Development of a Crown Agency for direct funding, whereby home care service users could directly choose and schedule providers without also being responsible for employer duties like payroll	Direct funding for older adults made it onto the policy agenda because of the confluence of factors including supportive research evidence; interest group advocacy from people with disabilities, older people, families, and care providers; and examples from other jurisdictions. A group of provider agencies formed a coalition to oppose the policy. SEIU supported the policy while most other involved unions opposed it. The policy was ultimately scrapped when a new government was elected in 2018.
Describes the development of the <i>Patients First Act</i> (2016), focusing on changes to the <i>Local Health System Integration Act</i> (2006) and the <i>Home Care and Community Services Act</i> (1994)(4)	<i>Publication date:</i> 2019 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> Health reform description	N/A	The <i>Patients First Act</i> (2016) transferred responsibilities for managing and funding home and community care from the former Community Care Access Centres to the Local Health Integration Networks. LHINs were granted authority to issue directives to health service providers excepting hospitals and long-term care homes.	LHINs and CCACs faced criticisms for lacking transparency and adding bureaucracy. CCACs were subject to an auditor-general report which found low spending on direct services, and geographical variation in quality of care. Ongoing negotiations with the OMA, and the influence of hospital boards, limited the ability of LHINs to intervene in primary and hospital care. A 2017 evaluation found that following implementing of the <i>Patients First Act</i> , wait times were shorter and more hours of care were being provided at home, however, this was very early in implementation. Ethnocultural diversity was not addressed in the Act or the evaluation. The Act did not address capacity of home care services.
Describes the targeted transfer for home and community care in the 2017 Canada Health Accord(39)	<i>Publication date:</i> 2021 <i>Jurisdiction studied:</i> Canada <i>Methods used:</i> health reform description	N/A	Canada's 2017 budget included \$6 billion over ten years for home and community care. Shared federal-provincial priorities included infrastructure, spread and scale of evidence-based and integrated models, palliative care, and caregiver support.	Funding for home and community care through the 2003 and 2004 Health Accords was limited to acute care; subsequently, accountability mechanisms in the funding were revoked when a new government was formed. Home and community care made it onto the federal government agenda due to pressing unmet needs and economic challenges for formal and informal caregivers. Home care funding was included in the federal Liberal election platform in 2015. Provinces were opposed to targeted funding and accountability measures; after several rounds of negotiations, bilateral agreements were struck with each province. CIHI worked with provinces to develop common indicators addressing wait times, care settings,

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Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				effectiveness, caregiver experience, and end-of-life care. Disparities continue to exist across provinces including with respect to what services are provided, and baseline data suggests variation in quality of care across provinces. The agreements do not address workforce issues.
Describes Bill 10 in Quebec, which created Centre intégré de santé et des services sociaux/Centre intégré universitaire de santé et des services sociaux (CISSS/CIUSSS)(40)	<i>Publication date:</i> 2018 <i>Jurisdiction studied:</i> Quebec <i>Methods used:</i> Health reform description	N/A	Bill 10 abolished regional health authorities and merged 182 health and social service facilities into 34 CISS/CIUSS. A ministry-appointed board in each CISS/CIUSS reports to the ministry and is responsible for the continuum of health and social services within a geographic area, including community health centres, hospitals, child protection centres, long-term care homes, and rehabilitation facilities. CISS/CIUSS have a single budgetary envelope.	Interest groups largely opposed the reform, including child and youth service groups concerned about the more medical orientation of CISS/CIUSS. However, interests within government pursued the reform in alignment with objectives of increasing accountability and transparency in healthcare, and minimizing bureaucracy. Health and efficiency outcomes of the reform were not available.
Describes Multi-Service Accountability Agreements (MSAAs) in Ontario's community sector services(41)	<i>Publication date:</i> 2014 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> health reform description	N/A	Multi-Service Accountability Agreements (MSAAs) for community agencies include requirements for how funds are managed and used, and for performance focusing largely on access to services (e.g., availability of services in French). Agencies report to their LHIN quarterly on finances and performance.	MSAAs reflect a New Public Management philosophy of the government's role in "steering" rather than "rowing." Agreement templates were created by the MOHLTC, LHINs and groups representing community services; individual LHINs and community agencies completed these templates with details from Community Accountability Planning Submissions. The analysis cites a survey that found 83% of 114 agencies held MSAAs and 26% of those received over 80% of their funding from the LHIN. The authors argue that MSAAs face tension between the heterogeneity of services and contexts, and the need for standard accountability. Reporting requirements are burdensome for small agencies and do not reflect important aspects of service delivery, especially in unique contexts (e.g., rural) or for unique populations.
Describes the development of Ontario's personal support worker registry(42)	<i>Publication date:</i> 2013 <i>Jurisdiction studied:</i> Ontario <i>Methods used:</i> health reform description	N/A	A registry was created for personal support workers. It was initially voluntary with the intention of becoming mandatory for all PSWs employed by publicly-funded providers. The registry was not intended to manage complaints, but would eventually set up a process for removing PSWs	The home care sector increased in terms of per capita costs, number of recipients, and complexity of care. In 2005, the Minister of Health and Long-Term Care instigated a review of the work performed by PSWs and recommendations for regulation. The Health Professions Regulatory Advisory Council concluded that self-regulation was not required, and suggested that costs of a registry would outweigh benefits. In 2011, a registry was nonetheless announced, with support from interest groups representing PSWs, employers, and patients. Labour unions opposed the registry. The registry would provide information about the PSW workforce for the purpose of human resource planning. However it would not address problems including training standards.

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Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
			from the list if they “present a known risk to the public.”	
Comparing patient satisfaction in in-house and contract staffing models for Veterans Affairs community clinics(43)	<i>Publication date:</i> 2012 <i>Jurisdiction studied:</i> USA (Arkansas) <i>Methods used:</i> cross-sectional	Used linked, 2007-2008 Survey of Healthcare Experiences of Patients data from 543 community-based outpatient clinics in Central Arkansas.	VA community-based outpatient clinics provide primary care. Clinics may either be staffed directly by VA employees, or by contracted staff.	VA-staffed clinics scored higher for continuity of care, education and information, emotional support, overall coordination, and preferences. The largest difference was for continuity of care which had 8.60% higher satisfaction, while the second-largest difference was for overall coordination which was 1.68% higher in VA-staffed clinics. No statistically significant differences were found for access, visit coordination, or courtesy,
Describes challenges in commissioning children’s speech and language services(11)	<i>Publication date:</i> 2012 <i>Jurisdiction studied:</i> UK (England) <i>Methods used:</i> case study	23 organizations in one region of England took part. Data sources included an online survey, interviews, workshops, quantitative data, and submission of best practice examples from organizational leaders.	N/A	Challenges for commissioning children’s speech and language services include: treating low-incidence, high-needs and complex conditions relies on provider discretion rather than standardized treatment that can be pre-specified in a contract; unclear boundaries between responsibilities of health and education sector; tension between costs of collaboration (e.g., provider time required), and desire to contract with optimal provider for each component of service; need to engage parents (and include parent interventions in contracts). Organizations addressed these tensions in different ways. One organization took a market approach, switched between providers for short-term savings, and assumed complaints and attendance adequately reflected parent views. In another, providers and commissioners collaborated to develop an integrated strategy: “in the terms of Williamson’s theory of organizations¹³ this model reduces transaction costs by internalizing the relationships between commissioners and providers.” A third devolved part of the budget to schools to manage. Commissioning guidance did not result in similar strategies across organizations.
Home healthcare staff’s views on factors contributing to inequity(34)	<i>Publication date:</i> 2015 <i>Jurisdiction studied:</i> USA (3 Northeastern states) <i>Methods used:</i> qualitative	23 home healthcare staff	N/A	Staff identified multiple factors affecting equity in healthcare based on their experiences in practice. These included differences in insurance coverage and access to resources among patients; cost control practices that disincentivize continuous or high-intensity care; lack of patient-staff cultural concordance; and staff bias and administrative discretion, eg. white staff refusing to work in predominantly racialized neighbourhoods due to perceived safety issues, leading to coverage issues for these neighbourhoods.
Contexts, mechanisms, and outcomes in the implementation of an integrated	<i>Publication date:</i> 2018 <i>Jurisdiction studied:</i> Ontario, Canada	36 months of ethnographic observation, 46 key informant interviews	The intervention was informed by a six-part theory of value, transformed into six “puzzle pieces” of intervention: specialized case management, coordinated assessment, system	At the outset of the project, bundled payment was provided to cover multidisciplinary care and necessary supplies, with a goal of encouraging coordination and innovative cost-saving. Lack of clarity on the intended end state lead to attempts to clarify, which in turn lead away from the originally-intended model. “Key implementation elements” set out in a top-down fashion required massive overhauls to usual ways of doing business;

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
home-based wound care program(21)	<i>Methods used:</i> realist evaluation		navigation, integrated clinical teams, reimbursement that rewards outcomes and innovation, and informed by clinical practice.	this created pushback and lead to a most elements being designated as option with only outcome-based pathways as a required elements. At the same time, fears around the risk involved in bundled payment lead to a decision to separate payment from delivery reforms, with small pilots carried out to estimate a fair bundled payment. These pilots were hampered by managed competition policies which discourage provider organizations from transparently sharing historical data eg. for fear of exposing weaknesses. In addition to lack of a clear end goal, stakeholders perceived a lack of commitment from the Ministry. There was significant turnover in project leadership throughout. The project was lead by OACCAC which commissioned CHQI/HQO to support implementation. HQO helped to map the current state and identify areas for improvement. This work was not perceived as well-aligned with the broader project. After the HQO subproject was completed, leadership for implementation returned to OACCAC. Direct service providers were rarely engaged at this time. The model was further pared down to align with existing work within the CCACs. An audit and feedback strategy was developed which CCAC managers perceived as unhelpful. In year 4 of the project, a larger oversight committee was struck which included broad representation from across the sector and which overhauled the contract negotiation process to move from competitive bidding to performance-based contracts. The project did not have an effect on clinical outcomes. The authors suggest this is attributable to: lack of consistent implementation, autonomy of participant organizations (which were not accountable to OACCAC), lack of power of implementation team, and disregard for the complex context of the home care sector. “The implementation of the changes in care delivery could not be standardized because of the wide variation in patient handling, role definitions and payment structures between the CCACs, the CCACs and their service agencies and between service agencies.”
Experiences of home care managers with commissioning(25)	<i>Publication date:</i> 2020 <i>Jurisdiction studied:</i> UK (England) <i>Methods used:</i> qualitative	20 managers of home care services from 10 local authority areas in England	Commissioners assess needs, and create specifications for contracts. Multiple types of contracts may be used, and contracts also vary across localities.	Relationships between providers and commissioners varied, with a minority reporting collaborative relationships. Providers referred to being motivated by values, and valuing staff. Commissioning is complex, focused on price not quality, and time-consuming. Uncertainty in the commissioning process, including frequent changes and lack of long-term planning, results in uncertainty for both providers and service users.

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Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Relationship between integration and commissioning in the development of an integrated respiratory service(22)	<i>Publication date:</i> 2020 <i>Jurisdiction studied:</i> UK (England) <i>Methods used:</i> qualitative	19 participants: 9 from the community provider, 8 from the hospital, 2 from the clinical commissioning group	An integrated respiratory care program in which the community provider offered oxygen assessment, pulmonary rehabilitation, admission prevention, and supported early discharge.	There was a lack of communication and trust between the hospital and community teams, with hospital staff feeling community staff lacked expertise, and community staff feeling hospital staff were not collaborative. A lack of shared technology also presented a challenge. Informal collaboration, rather than planned team meetings, contributed to improving some relationships. Commissioning created issues up front, as the services commissioned from the community provider were ones the hospital previously provided directly. Moreover as the community organization was commissioned to provide 5 days per week of service, it was unable to follow through on providing early supported discharge which continued to be provided by the hospital. The community organization also lacked clinical supervision and providers were directed to call the hospital for support, although not time was dedicated to this for hospital staff.
Physiotherapist perspectives on influence of commissioning arrangements on a community pain management program(24)	<i>Publication date:</i> 2021 <i>Jurisdiction studied:</i> UK (England) <i>Methods used:</i> qualitative case study	30 physiotherapists in senior roles from 11 NHS providers	ESCAPE-Pain is a pain management group that incorporates education and exercise	Physiotherapists felt that commissioners were more interested in service-level outcomes like wait times and short-term savings, rather than clinical outcomes. Contractual limits on patient contacts per episode of care and key performance indicators focused on reducing follow-up visits resulted in compromising on the 12-session evidence-based program and rationing care. Where different clinical commissioning groups held different contracts, patients within a single NHS provider had differing eligibility for coverage. Some providers chose to absorb costs of providing the intervention when it was not covered.
Implications of contracts with Maori providers for self-determination(35)	<i>Publication date:</i> 2021 <i>Jurisdiction studied:</i> New Zealand <i>Methods used:</i> discourse analysis	Nine contracts held by a single Maori health provider organization	N/A	Discursive strategies maintaining non-Maori power include: redefining self-determination, for instance as “empowerment” or empowerment, or through misrepresentation of Maori governance structures; “feel-good” language that was not matched with the actual content or implementation of the contract; prioritizing governmental strategic directions; a deficit framing and focus on individual behaviours
Commissioning of third sector organizations to provide older persons’ services(19)	<i>Publication date:</i> 2019 <i>Jurisdiction studied:</i> England (UK) <i>Methods used:</i> qualitative	Thirty three interviews with commissioners and third sector stakeholders, and focus groups with 17 older adults		Third sector organizations were seen as having valuable knowledge of communities. The contract and tendering process creates instability in funding, and disadvantaged smaller organizations. Some third sector organization stakeholders felt reporting requirements were burdensome and that data was not used effectively by commissioners. Some standardized assessment tools are used, and participants reported challenges in using standardized tools in practice as these were not felt to inform intervention.
Commissioning support in England(28)	<i>Publication date:</i> 2014 <i>Jurisdiction studied:</i> England (UK)	8 case study sites; 96 interviews with clinical commissioning	Clinical commissioning groups have three broad options for commissioning support: carrying out these functions in-house	Clinical Commissioning Groups face uncertainty about policy directions and struggled with the novel policy context: “CSUs were expecting CCGs to tell them what functions they wanted to commission, while CCGs were expecting the CSUs to tell them what services they offered.” CCGs did not

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
	<i>Methods used:</i> case study	group staff, observation of 146 meetings	(which reduces transaction costs but also reduces economies of scale and access to expertise), purchasing them externally (which introduces choice and competition, but an create misaligned incentives), or through longer-term (e.g., 3 year contracts) that enable building trusting relationships (which align incentives through shared long-term goals, but can lack leadership and flexibility). The government established Commissioning Support Units operating at a regional scale, then in 2014 announced plans to externalize these from the NHS.	receive sufficient funding to keep all commissioning supports in-house. Some CCGs kept some functions in house due to perceived benefits of local knowledge and working relationships. For smaller CCGs outsourcing commissioning was the only feasible option, with a range of opinions on which functions were “core” and needed to remain in-house. Functions could also be divided into “transactional” and “relational,” again with disagreement on how these could be divided (e.g., some felt pathway development was “transactional” while others felt it required local relationships and knowledge). Some small CCGs shared functions with each other. Participants expressed skepticism about the cost-effectiveness of commissioning support units.
Co-production in outcomes-based contracting(13)	<i>Publication date:</i> 2016 <i>Jurisdiction studied:</i> England (UK) <i>Methods used:</i> literature review	Draws on literature relating primarily to homelessness services and welfare-to-work schemes	Outcomes-based contracting includes incentives for achieving particular outcomes.	Co-production occurs at multiple levels: an administrative level where multiple viewpoints are formally solicited; a service management perspective through empowerment of and negotiation with service users at the point of service delivery; and an outcome level where user resources and assets, and broader sociopolitical structures, influence the outcomes achieved. OBC attributes outcomes solely to providers, where in fact these outcomes are also produced by users and enabled by macro-level contextual factors. It is difficult to align incentives across user, provider, citizen and government stakeholders as different outcomes are valued by these different groups. In welfare-to-work schemes, OBC led to “creaming” of clients who can more easily achieve outcomes and “parking” of clients with disabilities, homeless clients, and others with higher-level needs. Attempts to align incentives for service users through sanctioning had adverse effects on user wellbeing. In a social impact bond approach to homelessness, many outcomes were aligned between users and providers; however, broader context affected the feasibility of some goals eg. insecure working conditions affected return to work. In this case, workers did not engage in cream-skimming and parking and instead continued to support users unlikely to achieve desired outcomes, which was attributed to organizational and staff values.
Case study of different	<i>Publication date:</i> 2015	Five local health economies, each encompassing one	Three types of contracts were identified: a prime contract (where the commissioner	Prime contracts were motivated by fragmentation and poor or variable quality. The prime contractor takes on a great deal of risk and sometimes had difficulty negotiating subcontracts.

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Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
contracting models(15)	<i>Jurisdiction studied:</i> England (UK) <i>Methods used:</i> case study	or more clinical commissioning groups and representing a range of contractual arrangements	contracts a single organization that takes responsibility for managing the full scope or pathway), a prime provider contract (where the commissioner contracts a single organization that provides some or all of the scope/pathway, and subcontracts the rest) and an alliance contract (where a set of services enter into a single agreement)	Prime provider contracts were also motivated by fragmentation, as well as intent to focus on outcomes instead of activity. It was hoped that a prime provider would avoid potential problems of adding a third party integrator as in prime contracts, but is unclear of providers have skills to take this role on. Alliance contracts were used where informal collaborations were longstanding, and where there was a desire to build on these and achieve desired outcomes. Because all providers in the contract share risk and reward, it was hoped this would incentivize collaborative innovation. Actual outcomes not reported in this study. Authors recommend engaging patients, nurturing relationships, aligning incentives, and developing appropriate governance models.
Relationships among performance-based contracting, management supportiveness, and professionalism in home care(23)	<i>Publication date:</i> 2015 <i>Jurisdiction studied:</i> Netherlands <i>Methods used:</i> path analysis	156 home care workers, including 43 nurses and 104 “home helps” (personal care workers) from 7 agencies in South Holland	Home care services are contracted by regional purchasing agencies. Contracts include close monitoring of performance and practices.	Strict time registration rules were associated with lower worker autonomy, while cost-efficiency measures did not affect autonomy. These factors were not associated with job satisfaction. Autonomy was not associated with job satisfaction. Higher perceived support from upper management was associated with lower use of time registration and cost efficiency rules. Higher middle management support was associated with greater job satisfaction.
Commissioning for long-term conditions(44)	<i>Publication date:</i> 2013 <i>Jurisdiction studied:</i> UK <i>Methods used:</i> realist evaluation	Case study of three high-performing commissioning communities in England, serving populations of 200,000-525,000.	Commissioning services for long-term conditions, specifically diabetes, dementia, and stroke	Commissioning took place over a number of years, including a minimum of one year spent assessing needs. Success tended to be measured in terms of activity levels and costs, and decommissioning was rare. Commissioning was highly relational rather than transactional; contracting was more transactional and involved small groups of people with specialized skills. Providers were engaged in service planning, but distance between commissioners and providers was viewed as essential for contracting. Commissioning was labour- and time-intensive, did not neatly follow the “commissioning cycle” and was “not always proportionate to impact.” Incremental approaches guided by a long-term vision produced more change than attempts at transformation.
Commissioning for long-term conditions(12)	<i>Publication date:</i> 2013 <i>Jurisdiction studied:</i> UK <i>Methods used:</i> ethnography	Three English primary care trusts, serving populations of 200,000-525,000. The study “gathered data through observing meetings (n=27), semi-structured interviews	Study was conducted while a shift was underway to provider-led commissioning, and while community provider prices were determined locally. Focused on commissioning for dementia, diabetes, and stroke.	Considered five conditions for quasi-markets from the theoretical literature, plus an additional condition of the need to parcel services to enable contracting. 1) Competition: limited competition existed among providers, constrained by limited supply of specialized providers. Purchasers were cautious of disruption to current patterns of service provision. 2) Information on cost and quality: difficulty obtaining information on services, and incompatible information systems, impeded quality monitoring

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
		(n=124), informal update interviews (n=20) and analysis of documents (n=345) .”		3) Transaction costs: substantial costs involved in commissioning. In the absence of cost savings data at the time of the study, it is unknown whether costs of commissioning outweighed cost savings; there will be a need to measure cost savings broadly and not just to services. 4) Motivation: theoretical assumptions suggest that purchasers are motivated by service user concerns while providers are financially motivated. In fact both sides were found to be motivated by service user concerns as well as by national policy. 5) Cream skimming: not observed in this study. 6) Parcelling: services needed to be parcelled into “units of work” that were large enough to justify the costs of commissioning
Perspectives on potential to address inequities through GP-led commissioning(33)	<i>Publication date:</i> 2013 <i>Jurisdiction studied:</i> UK (England) <i>Methods used:</i> qualitative	Key informants including 18 national experts in health inequities and 24 local commissioning experts.	Functions formerly carried out by primary care trusts were divided among a number of new structures. This included clinical commissioning groups, which include physician, nurse, and lay representation and commission services within a local area.	It was seen as easier to adopt a health equity focus when commissioning new services as opposed to redesigning existing ones: participants believed that path dependency of existing large contracts prevented equity-focused innovation. PCTs broadly were not seen as having made progress in reducing health inequities and were perceived to have taken a tokenistic approach; participants also believed that any expertise developed within PCTs with respect to commissioning for equity could be lost during the transition of functions to CCGs. Three threats to future work on health equity were identified: 1) lack of clear central policy direction; 2) lack of population perspective among commissioners; 3) reduced involvement of public health in health service commissioning. The importance of relationships in commissioning was seen as both an opportunity (for GPs to develop new relationships to support health equity) and a threat (given destabilization of existing relationships, and lack of trust between GPs and health equity experts).
Implications of GP-led commissioning(29)	<i>Publication date:</i> 2012 <i>Jurisdiction studied:</i> England (UK) <i>Methods used:</i> qualitative case study	Two cases: implementation of the National Service Framework (NSF) for Long-Term Neurological Conditions, and a study of “health care closer to home” for children (part of a National Service Framework for children’s health). Included a total of 187 interviews with professionals, and 99	National Service Frameworks identified evidence-based standards of care.	Primary care trusts were not able to achieve change in the absence of top-down targets; the NSFs included standards but no performance management systems, incentives, or measurement frameworks. As such the standards were de-prioritized in favour of areas with concrete targets. GPs did not have a population health perspective and were not directly involved in coordinating care for people with specialized care needs.

Examining Intersections Between Ontario Health Teams and Home and Community Care

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
		with patients and families.		
Description of four models of contracting for integrated care(16)	<i>Publication date:</i> 2015 <i>Jurisdiction studied:</i> N/A <i>Methods used:</i> non-systematic literature review	N/A	Focuses on four models of contracting for integrated care: Accountable Care Organisations (ACOs), Alliance Contracting Model, Lead Provider/Prime Contractor Model, and Outcomes-based Commissioning and Contracting.	ACOs: use pay-for-performance to ensure cost savings are not achieved by reducing quality of services; report publicly on a common set of indicators. Evidence of effectiveness not available at the time of this article. Alliance contracting: risk and reward is shared among all parties to the contract. These contracts tend to be longer and to include specific dispute resolution mechanisms. Literature addresses process factors enabling strong alliances (such as knowledge transfer and strong relationships) but not effectiveness. Lead provider/prime contractor: one provider subcontracts and integrates the care pathway. The lead provider holds an outcome-based contract and have both clinical and financial accountability for care delivery. Potential benefits include clear accountability and greater integration, but effectiveness evidence is not available. Lead providers require capacity to take on the integrator role. Outcome-based contracting and commissioning: based on performance rather than activity. Success factors include strong rationales for selected outcomes. Effectiveness evidence is not available.
Contracting for care management for high needs, high cost patients(45)	<i>Publication date:</i> 2018 <i>Jurisdiction studied:</i> US <i>Methods used:</i> interviews	11 “in-depth interviews with organizations who have operated sustainable, effective care management programs for those who are HNHC [high needs, high cost] for at least two years”		When contracting specifically for HNHC patients, interviewees recommended contracting after developing the care model and estimating costs; conducting readiness assessments; contracting for 2-5 years to enable ROI; and focusing on geographical proximity to the relevant population. When contracting for whole-population approaches, interviewees recommended taking a strategic view of the value of investing in HNHC programs, communicating about how contracting decisions affect HNHC programs, and collaborating with clinical providers. Key strategic insights from participants included: segmenting populations, identifying high risk individuals, and geographically targeting programs; operational flexibility to enable staff to provide both clinical and non-clinical support; determining who has access to care management (some programs that work with multiple payers make a strategic choice to provide care management even to individuals not covered by supportive contracts); supporting a range of patient-care manager ratios based on need; sharing real-time and enrollment data; continually refining ROI calculations.
Contracting in the NHS(14)	<i>Publication date:</i> 2016 <i>Jurisdiction studied:</i> England			Two types of contracts were identified: prime contracts (including prime provider contracts) and alliance contracts. Three underpinning principles were identified: contracting for outcomes, contracting for integration, and contracting to shift costs. The report notes that in England, contracting

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
	<i>Methods used:</i> mixed methods			tends to focus on disease or population groups rather than whole populations. Disease-based contracting may struggle to address comorbidities, while population-based contracts can create artificial cut-offs eg. based on age. Defining the population is an important part of negotiating contracts. Creating bespoke contractual models is time-intensive and expensive. CCGs seek support from legal firms, management consultancies, and actuaries. The report makes four recommendations: engaging local providers and communities to identify problems and possible solutions, and build buy-in; consider transactional <i>and</i> relational approaches; use flexibility within capitated budgets to align incentives; and enabling providers to develop appropriate organizational and governance models to meet outcomes, manage risk, and monitor performance.