McMaster University | Health Forum

Evidence Brief Appendices

Enhancing policies and programs to support injured workers with chronic pain in Canada

4 & 5 December 2024

Appendices

Appendix 1: Background to and methods used in preparing the evidence brief

This evidence brief mobilizes global and local research evidence about a problem, three elements for addressing the problem, and key implementation considerations. It also draws on the experiences from a purposive sample of jurisdictions, which were gathered through reviews of government documents and websites (which was completed as part of a contextualized evidence synthesis completed earlier in 2024 by the McMaster Health Forum on the topic of examining the features and impacts of workers' compensation policies for chronic pain on health, social, and economic outcomes), as well as through key informant interviews. Whenever possible, the evidence brief summarizes research evidence drawn from evidence syntheses and occasionally from single research studies. An evidence synthesis 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 evidence brief does not contain recommendations, which would have required the authors of the brief to make judgments based on their personal values and preferences, and which could pre-empt important deliberations about whose values and preferences matter in making such judgments.

The preparation of this evidence brief involved four steps:

1) regularly convening the project Steering Committee composed of representatives from partner organizations, key stakeholder groups, and the McMaster Health Forum to help inform the framing of the evidence brief
2) conducting key informant interviews
3) identifying, selecting, appraising and synthesizing relevant research evidence for each section of the brief
4) drafting the evidence brief in such a way as to present concisely and in accessible language the global and local research evidence, and insights from the panel and the jurisdictional scan.

The three elements for addressing the problem were not designed to be mutually exclusive and could be pursued in a number of ways. The goal of the dialogue is to spark insights and generate action by participants and by those who review the dialogue summary.

Mobilizing research evidence about approach elements for addressing the problem

To identify the best-available research evidence about the approach elements, we primarily searched Health Systems Evidence (www.healthsystemsevidence.org), which is a continuously updated database containing more than 12,600 evidence syntheses and more than 2,900 economic evaluations of delivery, financial, and governance arrangements within health systems. We also searched Social Systems Evidence (www.socialsystemsevidence.org), which is a continuously updated database containing more than 5,900 evidence syntheses and more than 750 economic

evaluations about strengthening 20 government sectors and program areas, and achieving the Sustainable Development Goals. We also complemented this with searches in PubMed, and hand searches of the McMaster Health Forum's recently prepared evidence syntheses if there was overlap in the issues addressed or the elements considered. The authors' conclusions were extracted from the syntheses whenever possible. Some syntheses may have contained no studies despite an exhaustive search (i.e., they were 'empty' syntheses), while others may have concluded that there was substantial uncertainty about the approach elements based on the identified studies. Where relevant, caveats were introduced about these authors' conclusions based on assessments of the syntheses' quality, the local applicability of the syntheses' findings, equity considerations and relevance to the issue.

Being aware of what is not known can be as important as being aware of what is known. When faced with an empty synthesis, substantial uncertainty or concerns about quality and local applicability or lack of attention to equity considerations, primary research could be commissioned, or an element could be pursued and a monitoring and evaluation plan designed as part of its implementation. When faced with a synthesis that was published many years ago, an updating of the synthesis could be commissioned if time allows. No additional research evidence was sought beyond what was included in the evidence syntheses. Those interested in pursuing a particular element may want to search for a more detailed description of the element or for additional research evidence about the element.

Appendices 3, 4, and 5 provide detailed information about the evidence syntheses identified that relate to the three elements. In the first column we list the sub-elements and provide hyperlinks to the search strategies used. In the second column, we provide a hyperlinked 'declarative title' that captures the key findings from each synthesis. Columns 3 to 6 list data related to the criteria that can be used to determine which reviews are 'best' for a single category (i.e., living status, quality, last year literature searched, and availability of a GRADE profile, which provides insights about the strength of the evidence included in a particular synthesis).

As noted above, the fourth column presents a rating of the overall quality of the 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 evidence syntheses 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.)

Appendix 2: Summary of workers' compensation policies for chronic pain in Canadian provinces and territories*

*The content in this table has been adapted from Appendix 3 in a previously completed REP

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
BC	WorkSafeBC	Pain that lasts six months after injury or beyond usual recovery time for an injury	Yes	• 90% of normal take-home pay for 10 weeks • Covers the cost of healthcare services and supplies that are considered reasonably necessary to treat injuries as well as vocational rehabilitation	• Long-term wage rate is determined using a combination of pre-injury net earnings, loss of function percentage, loss of function, and a compensation factor • Chronic pain that is permanent and disproportionate to the associated physical or psychological injuries may be granted permanent disability benefits, equal to 2.5% of total disability	• Assessment is conducted by a Vocational Rehabilitation Consultant	• The timeline for the adjudication process is not clearly stated, but may take longer for complex cases • Workers may be reimbursed for treatments that occurred during this process	• Appeals can be submitted to the Reviews Division process and then the Workers' Compensation Appeal Tribunal
AB	Alberta Workers' Compensation Board	Pain that persists for six months or/and beyond usual healing time for an injury, and impacts earning capacity and life activities	Yes	• Wage replacements are offered for part-time, short-term, and full-time positions • 90% of net income payable up to $98,700 CAD for up to 80 days	• Permanent Clinical Impairment guidelines recommend a percentage of whole-body impairment for injury, which is used to calculate a financial award	• In-person evaluation is provided by an examining physician or physiotherapist • If pain persists past usual healing time, is inconsistent with organic findings, or impairs earning capacity additional	• The timeline for the adjudication process is not stated and it is unclear whether individuals are able to seek treatment in the interim	• A formal review can be requested with the supervisor of the case worker that made the initial adjudication • A supervisor can forward the dispute to the Dispute Resolution and Decision Review Body which is a department of specialists who will determine if the decision is correct

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
						awards may be added		• A final appeal can be made to the Appeals Commission, which is an independent body
SK	Saskatchewan Workers' Compensation Board	Not identified	No	• Up to 90% of average earnings up to a maximum of $68,102 CAD if the injury occurred prior to 2014 or $96,945 if after 2014 • The minimum weekly earning is $753.27 • Workers are entitled to additional compensation for medical treatment and loss of time at work due to medical appointments • Return-to-work and vocational rehabilitation supports	• If symptoms from an injury persist (e.g., chronic pain) individuals are categorized as needing level III care and may be entitled to advanced assessment and treatment	• Assessments dependent on the level of care needed • Level I may be provided by a primary care physician • Level II and III are provided by Workers' Compensation Board multidisciplinary teams	• A claims decision is typically made within days • More complex cases may require additional time and investigation • The board recommends receiving care as soon as needed and asking care providers to bill the board while awaiting a claim decision	• A three-step process is in place and culminates with an appeal to the Workers' Compensation Board Tribunal, which is composed of two or more members of the board and may amend, rescind, or alter any prior decisions
MB	Workers Compensation Board of Manitoba	Not identified	No	• 90% of workers' net pay • Medical treatment and expenses as well as transportation and living expenses if travel is required	• Permanent impairment may be determined one year after an accident, injury, or related surgery • Permanent impairment ratings are established based on	• Initial assessments are provided by a healthcare provider (typically physician) of the claimant's choice	• The timeline for adjudication is not stated and depends on the complexity of the case and information available	• Appeals can be filed with the Appeal Commission, which operates separately and independently from the Workers Compensation Board • The Commission includes a

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				• Return-to-work and vocational rehabilitation supports are also provided	a Rating Schedule as a percentage of the whole body		• It is unclear whether individuals can seek treatment in the interim	commissioner representing public interest, one who is designated by the Chief Appeal Commissioner and one representing the workers and employers
ON	Workplace Safety and Insurance Board (WSIB)	Pain that lasts six months and/or more than usual healing time of injury and impacts earning capacity	Yes	• 85% take-home pay up to an annual maximum • Healthcare benefits including medical treatment, hospitalization, prescription drugs, devices and equipment, and reasonable travel • Return-to-work and vocational rehabilitation	• Non-economic loss benefit is calculated by multiplying the whole person impairment percentage by a base dollar value set out in the Workplace Safety Insurance Act • Entitlements for chronic pain may be provided when it results from a workplace injury, with medical and non-medical evidence of pain that persists for six or more months beyond usual healing, and the pain impacts earning capacity • A chronic pain disability supersedes and replaces any prior award	• Permanent impairment is assessed by a team of nurses according to criteria set out by the American Medical Association • Chronic pain assessments use a holistic approach and account for using a global impairment rating • Assessments may be conducted by a rage of health professionals, which may be chosen by the claimant or by WSIB	• The timeline for adjudication is not stated; it is unclear if workers may be reimbursed for treatment occurring during the claims process	• Appeals Service Division is the first line of appeal • The Workplace Safety and Insurance Appeals Tribunal is the second and final level, which is external to WSIB • Appeals resolution officers are responsible for addressing appeals
QC	Commission des normes, de l'équité, de la santé et de la sécurité du	Not identified	No	• 90% of the workers net-income to a maximum of $94,000	• The product of the percentage of the permanent physical or mental impairment multiplied by a set	• A physician of the claimant's choosing undertakes an	• The adjudication process takes approximately 15 days and benefits are dispersed	• Administrative review is the first step where a supervisor will review the decision

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
	travail (CNESST)			• Medical benefits include services of health professionals, treatment by a public health facility, medicines and pharmaceuticals, prosthetics, and assistive devices • Unpaid interns are eligible for weekly indemnity of $126	amount set out in the Workplace Accident and Professional Injuries Act	initial assessment • It is up to the CNESST, not the doctor, to determine whether the worker is able to do their job, return to work, and subsequently stop income replacement indemnity	within 10 days of approval • Workers may be reimbursed for treatment that occurred during the claim process	• A following appeal can be made to the Tribunal administrative du travail in the following cases: o following an opinion of the medical evaluation office o following an opinion of Special Committee of Chairpersons (which analyzes occupation lung disease) o following opinion of the Committee on Occupational Oncological Diseases o for financing and cost assignment matters
NB	WorkSafeNB	Pain that persists beyond the usual healing time and may continue in the presence or absence of demonstrable pathology	Yes	• 85% of average earnings minus any net estimated capable earnings (labour percentage may vary based on employment) • Healthcare services and supplies that are considered medically necessary to	• Lump sum physical impairment award • Specific guidelines are in place for managing claims that result in chronic pain as a complication of a compensable injury	• Permanent impairment assessments are completed by a WorkSafeNB medical advisor certified by the American Board of Independent Medical Examiners	• The timeline for adjudication is not stated and it is unclear whether individuals are able to seek treatment in the interim	• Decision Review Office can internally review a decision • An appeal can be submitted to the Workers' Compensation Appeals Tribunal, which is an independent body

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
				treat injury and help return to work				
NS	Nova Scotia Workers' Compensation Board (NS WCB)	Pain lasting longer than normal recovery time and is disproportionate to injury	Yes	• 75% of net earnings loss for up to 26 weeks following 85% earnings loss • Healthcare costs related to injury for pre-approved services and personal equipment • Return-to-work and vocational rehabilitation supports	• Permanent impairment is calculated based on a percentage of total body impairment with 100% being the maximum possible rating • Extended earnings replacement is paid monthly for a permanent loss of earnings if the lost earning are greater than the amount paid by the permanent impairment benefit • Where a worker is found to have a pain-related impairment, the Board will pay the worker a permanent benefit based upon a permanent impairment rating of 3% where the worker experiences a slight pain-related impairment or 6% where the worker experiences a substantial pain-related impairment	• Permanent impairment is determined by a NS WCB accredited physician	• The timeline for adjudication depends on the complexity of the case • Low complexity cases can be resolved within a few weeks • Medium complex cases (e.g., sprains) may take four to six weeks • Highly complex cases are variable • Benefits are given only once the claim is accepted • It is unclear whether individuals are able to seek treatment in the interim	• An internal appeal processes is available by a hearing officer • Final decisions can be appealed to the Workers' Compensation Appeals Tribunal, which is an independent body reporting to the Minister of Justice
PE	Workers Compensation Board of PEI	Not identified	No	• 90% of net annual earnings up to a maximum	• Long-term wage loss is calculated based on pre-accident average earnings and current	• Long-term wage loss is based on medical information and	• Once the Workers Compensation Board of PEI registers a claim,	• Requests for internal reconsideration may be submitted to the board

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
				limit of $78,400 CAD • Healthcare coverage for services and treatments are approved based on the policy	net earning capacity, up to 90% of loss net earning capacity	a functional assessment conducted by an approved health professional based on American Medical Association guidelines • Benefits are reviewed after 36 months	the adjudication process typically takes one to two weeks; however, more complex cases can take longer • The injured worker is entitled to benefits once the claim has been accepted but treatments such as physiotherapy and chiropractic services can be approved before a decision is made	• Final appeals may be submitted to the Workers Compensation Appeal Tribunal, which is an independent body
NL	WorkplaceNL	Pain compatible with initial injury, but lasts six months or longer beyond usual healing time and disrupts life	Yes	• 85% of pre-injury earnings, which are re-evaluated after 13 weeks • Healthcare costs including services from allied professionals, medical tests, medications, assistive devices, travel costs, and home modifications	• Lump sum payment based on percentage of injury impairment	• Permanent functional impairment assessment is performed by a physician with special training	• The timeline for the adjudication process is not stated and it is unclear whether individuals are able to seek treatment in the interim	• Internal review is completed by WorkplaceNL • Workers' Compensation Independent Review Board is available for an external independent review
NT/NU	Workers' Safety and Compensation Commission (WSCC)	Pain that persists beyond the usual healing time for the type of injury that	Yes	• 90% of estimated annual earnings up to a maximum insurable amount • Coverage for the cost of	• One-time lump sum based on their permanent medical impairment rating as defined in the	• Permanent medical impairment assessment is conducted by a	• According to the WSCC, the adjudicator has the authority for determining ongoing benefit	• An internal review can be conducted by the Review Committee • A second and final review may be sent to the Appeals Tribunal,

Province/ Territory	Workers' Compensation Board	Definition used for chronic pain	Chronic pain specific policy	Temporary wage loss and medical benefits	Long-term wage loss	Assessment process for long-term wage loss	Adjudication process	Dispute process
		precipitated or triggered the pain, and/or pain that is disproportionate to that expected of the type of injury that precipitated or triggered the pain		healthcare services and treatment • Return-to-work and vocational rehabilitation	American Medical Association guide • Long-term earning loss benefit calculated based on 90% of the difference between the pre-injury and post-injury earnings • Specific guidelines have been set for the coverage of chronic pain	WSCC Medical Advisor	eligibility for workers with time loss claims up to six weeks in duration • However, it is unclear whether individuals can seek treatment and are entitled to reimbursement during the claims process	which is an independent organization
YK	Yukon Workers' Safety and Compensation Board	Pain that lasts longer than the expected normal healing time for the tissue involved; chronic pain may exist in the absence of chronic pain syndrome	Yes	• 75% of estimated worker's loss of earning capacity (with up to 100% for individuals with low average earning) • Coverage of costs for healthcare services and medical treatments, including First Nations healing services • Return-to-work and vocational rehabilitation	• Permanent impairment benefits are calculated by multiplying a percentage of 125% of maximum annual earnings by the permanent impairment rating, which are based on the American Medical Association guide • Specific guidelines are available for chronic pain, which may be compensable once it has been established that it is the result of a work-related disability	• Assessments are provided by Workers' Safety and Compensation Board medical consultants	• According to the Yukon Workers' Safety and Compensation Board, the adjudication process of a claim is completed within an average of 14 days; however, some complex cases may take more time since each claim is considered on an individual basis • It is unclear whether individuals can seek treatment in the interim and become qualified for reimbursement	• Internal reviews are available from the Reconsideration Unit • External and independent reviews may be made by the Appeals Tribunal

Appendix 3: Evidence syntheses relevant to element 1 – Align definitions of chronic pain

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
Identifying an appropriate organization or group to act as secretariat Search 1, Search 2, Search 3 *(one evidence synthesis identified)*	A centre of excellence (CoE) is a team of specialized experts who organize to provide high quality services in a specific field such as healthcare, research, education, information technology, or industrial services (36) • The 12 essential foundations a CoE can be based on are: specialized expertise, infrastructure, innovation, high-impact research, quality service, accreditation/standards, leadership, organizational structure, strategy, collaboration/partnership, sustainable funding/financial mechanism, and/or entrepreneurship	No	5/10	2021	No

Finding a common definition of chronic pain that can be adopted across the country
Search 1, Search 2, Search 3
(*seven evidence syntheses identified)*
	Key concepts that facilitate collaboration in both interprofessional and interorganizational healthcare environments include communication, trust, power, mutual acquaintanceship, shared goals, patient-centredness, task characteristics, and environmental factors (72)
	• Frameworks of interprofessional and interorganizational collaboration both emphasize the following key competencies:
	  ○ formal and informal communication
	  ▪ organizations can facilitate this using protocols and agreements
	  ○ trust, respect, mutual acquaintanceship, and power
	  ▪ the first three are important in balancing power within collaborations
	  ○ shared goals and consensus
	  ▪ goals should be clearly outlined with everyone in agreement
	  ○ patient-centredness and prioritizing active patient participation
	  ○ task characteristics including scope, urgency, and complexity
	  ○ environmental factors including external political, demographic, and social factors
	• Interprofessional collaborations additionally focus on structural and organizational characteristics of a specific facility; this includes:
	  ○ shared vision and goals, and patient-centred orientation
	  ○ evaluation and reflection
	  ○ formalizing collaborations and clarifying roles
	  ○ formal communications channels and space for informal communication
	  ▪ team relationships are facilitated by informal communication in shared spaces
	  ○ adequate resources
	  ○ overall planning of the facility (e.g. workplace safety/culture)
	• Interorganizational collaborations additionally focus on formalization through policies and procedures
		No	6/9	2014	No

	Collaboration between primary care (PC) and public health (PH) is facilitated by systemic, organizational, and interactional factors (74)
	• Systemic factors
	  ○ health reform and government mandates
	  ▪ collaboration is facilitated by common goals
	  ▪ frequent reforms are a barrier to collaboration
	  ○ adequate funding and resources
		No	4/10	2008	No

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	○ power and control ▪ separate of PC and PH bureaucracies is a barrier to collaboration ○ interdisciplinary education & training • Organizational factors ○ A common agenda/shared goals ○ sufficient knowledge and resources ○ leadership in the form of diverse, multiprofessional, community-based advisory committees ○ geographic proximity ▪ network formation can overcome this in geographically dispersed teams ○ shared protocols, tools, and information sharing • Interactional factors ○ shared goals, philosophy, and beliefs ○ clear roles and positive relationships ▪ this can be developed by providing feedback, seeking input, and patiently building relationships • Direct/open communication and decision making that is facilitated by process, appreciation of partner's different skills/expertise, and open communication about issues				
	Positive collaborations between health providers and health consumers are facilitated by factors including mutual respect, two-way dialogue, accountability, shared goals, and taking action to reduce power imbalances (43) • External factors impacting the success of partnerships between health providers and consumers include supportive government policies, clear translation of policy into action, adequate funding, and organizational culture/attitudes of senior management • Recruiting consumers from a broad range of backgrounds including underserved groups can be supported by provident practical aid, flexibility, and reimbursement of expenses • Facilitators of positive interpersonal dynamics between health providers and consumers in collaborations include: ○ mutual respect ○ commitment ○ two-way dialogue and info exchange ○ trust and accountability ○ regular communication ○ strong relationships with decision-makers ○ shared values, powers, and vision ○ skilled moderators ○ clear roles and expectations for all parties ○ informal opportunities for meeting/consumer involvement ○ addressing power imbalances ○ offering consumers opportunities to lead agendas	No	9/9	2018	Yes

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	Low-quality evidence suggests that co-design and co-production are effective approaches in engaging stakeholders in the implementation and development of social prescribing interventions within the community (41) • Utilizing stakeholder knowledge to co-design services can enhance social prescribing initiatives and allow for personalized interventions tailored for each communities' needs, leading to overall improved health outcomes for community members • Patient-centred approaches, such as co-design and co-production, help to encourage buy-in and adoption by providing users with a sense of empowerment and ownership over the intervention • Effective leadership, communication, and an evaluation methodology/framework have been found to be facilitators of co-design and co-production processes	No	8/9	2020	Yes

	Both guideline development and quality assurance schemes, when integrated together under a methodological framework, can help to improve health outcomes; a comprehensive framework is critical in effectively ensuring the integration of these components (40)
	• Key themes for integrating guidelines and quality assurance schemes together include:
	  ○ evidence-based
	  ○ documented in a clear and transparent manner
	  ○ declaration of interests and management of conflicts
	  ○ quality indicator selection
	  ○ retirement of quality indicators
	  ○ potential risks
	• Extension of guideline checklist to incorporate quality assurance considerations
		No	2/9	2019	Yes

	There is "little convincing evidence" to suggest that collaboration between local healthcare and non-healthcare organizations can lead to improved health outcomes (38) • There exists heterogeneity with respect to the evidence base; however, some studies do indicate that collaboration among organizations may improve access to services and satisfaction • In many instances, positive impacts of collaboration are observed in targeted interventions (e.g., health system and community outreach interventions) or narrow measures of impact (e.g., access) • Broad population health interventions often face challenges with implementation, which arise from frequently having measures that are difficult to define, engaging with multiple organizations, the duration of the intervention, and having long-term aims • Factors affecting the success of collaborations include: 1) motivation and purpose; 2) relationships and cultures; 3) resources and capabilities; 4) governance and leadership; and 5) external factors	No	6/10	2019	No
	A scarcity of evidence exists with respect to linking intersectoral collaborations to population health outcomes; the casual loop diagram can serve as a guide to developing a more comprehensive overview of how collaborations may play out in a given context and how they link to health outcomes (37) • Intersectoral collaborations within the health domain are complex, and the interplay of relational and structural governance concepts can help to develop a stronger understanding of governance pathways	No	5/9	2021	No

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• Public health intervention evaluations play a vital role in promoting intersectoral collaborations				
Getting 'buy in' and building consensus among key stakeholders for the definition Search 1, Search 2, Search 3, Search 4, Search 5, Search 6 (*five evidence syntheses identified)*	Participatory approaches were the dominant methods identified among the frameworks, designs, and methods for setting priorities in mental health research (46) • Participatory methods emphasizing the role of the stakeholder in shaping the discussion at hand provides an inclusive method to joint decision-making • Methods for gathering information to inform consensus processes such as research priority setting includes qualitative focus groups, nominal group technique (structured small-group deliberations with voting), modified Delphi processes, surveys, and online consultations • An important consideration for processing insights gathered from stakeholders is preserving their intended meaning • Group consensus approaches used in, for example, finalizing research priority-setting decisions includes metric-based rankings and collaborative workshops using nominal group techniques	N/A	4/9	2021	None

	The selection process for health system performance indicators often involves a known consensus procedure with various stakeholders (47)
	• The process to reach consensus, such as in the selection of health system performance indicators, involves stakeholder engagement in a deliberate manner
	• The well-described consensus methodologies in the literature include the Delphi technique and the RAND Corporation/University of California Los Angeles (RAND/UCLA) Appropriateness Method
	  ○ The Delphi method usually entails two or three rounds of anonymous questionnaires where each round builds toward consensus without face-to-face interactions
	  ○ The RAND/UCLA Appropriateness Method derives from the Delphi method but is more comprehensive in its approach where expert opinions from questionnaires and panel meetings are combined with evidence from the literature
	• Most of the identified consensus procedures were supplemented by field testing, which added utility to the overall process
		N/A	5/9	2020	None

	The use of the Delphi method in reporting guidelines development has long been encouraged though its level remains insufficient (48) • Since 2011, the Delphi method has been advocated for use in consensus processes, including for reporting guidelines development • Problems with not using the Delphi method include issues with the consensus process being dominated by certain participants and the inability for them to bridge gaps or discern divergent views among themselves • In the Delphi method, participants return completed questionnaires to the researcher in each round, who then revises them and returns to each participant an assessment of the group's position and that of each participant's own • While there has been an increasing proportion of reporting guidelines using the Delphi method since 2011, most of the recent reporting guidelines did not	N/A	4/9	2019	None
	The Jandhyala method of reaching consensus involves minimal engagement to engage stakeholders while preserving accurate consensus and transparency in the process (103)	No	5/9	2020	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• There was significant heterogeneity in traditional Delphi methods, suggesting that they vary the methodology to meet their needs • Forced consensus by re-entering items that have reached consensus or face-to-face meetings can impact true consensus on a topic • Jandhyala studies do not experience high attribution, in comparison to traditional Delphi methods • Jandhyala uses minimal engagement and a maximum of two rounds to derive consensus				
	Delphi methods are a systematic and rigour process to derive consensus for social drivers of health, but should include meaningful engagement of lived experience experts (44) • Studies mainly included researchers and healthcare professionals in their process, missing an opportunity to engage lived experience experts • People with lived experiences might not be fully engaged in panel discussions in the Delphi process	No	3/9	2023	Not available
Developing a 'road map' that outlines the ways in which jurisdictions can proceed with adopting and implementing a consistent definition Search 1, Search 2, Search 3 *(one evidence synthesis identified)*	Stakeholders can meaningfully contribute in the planning process but must be explicit and actively engaged (45) • Stakeholder analysis can help understand the context of innovation implementation, knowing who to engage in the planning process, and the wants and needs of the process • Stakeholders must be meaningfully engaged and dedicate time and interest to the process • It is important to explicitly state key characteristics of stakeholders	No	6/10	2011	Not available

Appendix 4: Evidence syntheses relevant to element 2 – Improve chronic pain support programs

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile

Ensuring existing chronic pain programs have in place the right mechanisms for supporting injured workers as they recover from an injury and learn to live and work with chronic pain
 	
Search 1, Search 2, Search 3, Search 4 (*six evidence syntheses identified)*
	Knowledge domains form the foundation for future research into integrated approaches and knowledge utilization aimed at improving work transitions for individuals living with chronic pain who wish to engage in paid or unpaid productive work (16)
	• This knowledge should also address several critical areas:
	  ○ how to maintain a healthy life while managing chronic pain
	  ○ how to understand and apply a human rights-based approach to working with pain
	  ○ how to navigate various systems and benefits to make informed economic decisions
	  ○ how to promote systemic change
	  ○ how to access work transition supports
	  ○ how to advocate for integrated care and services
	  ○ how to push for flexible options in the workplace
		No	4/9	2010	Not available

	There is no conclusive evidence supporting any specific tertiary return-to-work (RTW) intervention for workers with chronic pain (49) • Multidisciplinary approaches should be considered • Efforts should focus on optimizing participant waiting times before interventions begin, tailoring interventions to match participants' risk profiles and needs, and fostering better collaboration among the various stakeholders involved in the RTW process	No	8/10	2018	Not available
	There is limited research exploring prognostic factors for return to work in persons with chronic pain; modifying physical demands and seeking immediate care are important (58) • Workers from lower socio-economic status typically have more physically demanding jobs; thus, accomodations should be made to reduce physical burden • There is insufficient evidence supporting modifing physical demands to support the return-to-work process for people with chronic pain due to limited studies • There is insufficient evidence explaining the relationship between psychosocial factors and return to work for persons with chronic pain • A delay in appropriate pain treatment delays the return-to-work process • Functional capacity and claim related factors have moderate evidence in facilitating the return-to-work process	No	5/10	2012	Not available
	No evidence suggests a relationship between productivity costs and pain management due to poor outcome reporting in existing literature (52) • This review only included pain supports outside of the workplace (e.g., physical therapy, cognitive behavioral therpay, yoga)	No	5/9	2023	Not available
	Return to work for people with chronic health conditions is an individual and multifactorial process that should consider individual, social, and environmental factors (50)	No	4/9	2019	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• Return to work for people with chronic health conditions should be seen as an individual and mutlifactorial process • Return-to-work programs for people with chronic health conditions should highlight symptoms of disease, motivation, social support, and adapting the work environment				
Integrating complementary supports for injured workers that enable them to resume or continue paid work Search 1, Search 2, Search 3 *(14 evidence syntheses and three single studies identified)*	Complementary supports for injured workers with pain should include dynamic work plans, flexible job duties, job coping strategies, assistive devices, self-management, and supportive colleagues (16) • A biopsychosocial support is needed to manage pain; this might include occupational therapists, physical therapists, psychologists, and primary care physicians • Self-management for chronic pain can support goal setting, education, collaboration, communication, etc. • Developing a dynamic work plan is needed to support workers with chronic pain; this includes educating employers and understanding employee needs • Flexibility is needed within the workplace for physical, cognitive, and emotional restraints • Strategies that can support workers include job coping strategies, assistive devices, and adapting job duties • A supportive work environment is important and involves flexibility in job demands, as well as educated and supportive colleagues and employers	No	4/9	2015	Not available
	Supports for managing chronic pain include acupuncture, yoga, physical therapy, cognitive behavioral therapy, and spinal manipulation (52) • This paper does not state how these interventions can be incorporated into the work environment	No	5/9	2023	Not available
	Workplace interventions for pain management including pain education and task modification can support return to work for people with pain, but it is unclear if they provide pain relief (62) • Workplace interventions include pain education consisting of stress management, ergonomics, anatomy, musculoskeletal disorders, pacing, and relaxation • Work environments include modifying work environments and tasks • Work environment modifications did not seem to provide pain relief; however, this was not consistently reported across studies	No	10/11	2010	Not available
	Multidisciplinary interventions can have clinically meaningfully increases in return to work for people with chronic pain (51) • The types of interventions were not specified in this paper	No	5/11	2006	Not available
	Coordinated and tailored work support programs, involving workplace accommodations and interdisciplinary pain management, can reduce productivity loss in workers with chronic pain (53) • This randomized control trial compared the effects of coordinated and tailored work support to conventional case management	No	Not applicable	Not applicable	Not applicable

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• The coordinated and tailored work support program involved an assessment of abilities and barriers, workplace accommodations, and interaction with an interdisciplinary team (occupational therapists, physical therapist, psychologist, chiropractor, case manager, and social worker) • Participants in the coordinated and tailored work support program demonstrated lower workplace absences than the control group and an estimated cost savings of over $10,000 USD per 12 month follow up				
	Integrated care consisting of interdisciplinary care, workplace, and graded activity can reduce costs (54) • This randomized control trail compared the effects of integrated care to care as usual in persons with chronic low back pain • Integrated care consisted of an occupational therapist, physiotherapist, and physician workplace consensus plan, ergonomics, and graded activity • The integrated care group had lower costs (13,600 GBP versus 18,475 GBP)	No	Not applicable	Not applicable	Not applicable
	Multidisciplinary interventions for pain management had worse productivity outcomes (intervention cost and sick leave) than usual care (55) • This study compared usual care to multidisciplinary interventions in persons with chronic low back pain • The multidisciplinary intervention consisted of a case manager, social medicine, rheumatology, physiotherapist, social worker, and occupational therapist • Usual care consisted of a rehabilitation doctor and physiotherapist • The intervention cost and sick leave was higher in the multidisciplinary intervention (13,77 euros) than usual care	No	Not applicable	Not applicable	Not applicable
	Interventions to support pain management in the workplace include flexible hours and breaks, involvement in decision-making, ergonomic changes, assistive devices, and supportive colleagues (59) • Consistent communication and coordination between workers with pain and employers are needed • Women may have additional challenges including balancing health, work, and parental responsibilities	No	4/9	Not stated	Not available
	Multidisciplinary interventions involving the coordination of managers can support workplace retention of people with chronic pain (56) • Common pain management interventions include ergonomics, exercise, relaxation, self-management, and cognitive behavioral therapy • Few studies explored interactions between the workplace, line managers, and pain treatments • Multidisciplinary interventions improved workplace retention compared to other less intensive treatments; however, the level of evidence was low	No	6/11	2017	Not available
	Multidisciplinary interventions can improve return-to-work outcomes in workers with chronic pain (49) • Women have worse outcomes with return-to-work interventions than men • Multidisciplinary interventions are broad but may include cognitive behavioral therapy, graded activity, occupational therapy, physiotherapy, and more	No	8/10	2019	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	Spinal cord stimulation can increase return to work in persons with chronic pain (57)	No	7/11	2017	Not available
	Understanding the significance of different prognostic factors at various stages of the RTW process can guide stakeholders in taking the most effective actions to enhance RTW outcomes (58) • Workplace physical factors play a critical role throughout the entire period of work disability, making it essential to inquire about the nature of the work the injured worker was performing when they were injured, as well as the type of job they will be returning to • In the acute phase, there is strong evidence supporting the importance of treatment-related factors, particularly the content of care • The choice of healthcare provider significantly impacts recovery and RTW outcomes • Offering modified duties or workplace accommodations has been shown to improve RTW success	No	5/10	Not specified	Not available
	For individuals with chronic pain and their employers, overcoming RTW challenges requires balancing the needs of the person with chronic pain, their colleagues, and the organization as a whole (61) • The success of managing pain and negotiating workplace accommodations often depends on the quality of relationships with employers and coworkers, as well as the feasibility of adjustments within the work environment	No	4/9	2017	Not available
	Utilizing health psychology tools to analyze intervention descriptions is a practical approach in a field where the examination of intervention functions, theoretical domains, and behaviour change techniques is notably lacking within employee interventions (60) • This method can provide a more targeted understanding, within a comprehensive systematic review, of the most effective intervention content for future use • It also responds to the call for developing more focused, theory-driven, and replicable employee interventions that clearly identify what works, for whom, and in what context	No	6/9	2020	Not available
	Recovery beliefs, health-related factors, and work capacity play a crucial role in RTW outcomes for individuals with long-term neck or back pain (64) • One reason recovery beliefs are linked to RTW is that, when individuals doubt their ability to recover, they may feel less competent and motivated to return to work • Health is positively associated with RTW, as healthier individuals are more likely to feel capable of working • While self-assessed measures of work capacity, such as pain levels, disability, or work ability, can significantly predict RTW in those with chronic neck or back pain, the accuracy of functional capacity evaluations may depend on how the tests are conducted	No	4/9	2016	Not available
	Several factors can influence the decision to remain in the workforce, including the struggle to affirm oneself as a competent worker, the challenge of balancing life and work amidst unpredictable symptoms, perceptions of disbelief from colleagues, systemic barriers to returning to work, and the fight for legitimacy (63) • Work modifications serve as a strategy that enables workers with chronic musculoskeletal pain to effectively navigate their roles	No	3/9	2012	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• Research shows that collaboratively setting goals for a planned return to work with employers, making workplace accommodations, and maintaining open communication with healthcare professionals can facilitate the RTW process • Evidence also supports the finding that employers' actions, such as questioning the legitimacy of an injury, can hinder the return to work • Individuals often face a battle for legitimacy as they seek to access benefits				
	Expectations held by chronic pain patients before, during, or after treatment may predict their actual return to work following treatment (65) • Pain clinicians focusing on facilitating the return of injured workers to their job functions should incorporate questions about the chronic pain patient expectations for returning to work post-treatment into their evaluations	No	2/10	2017	Not available
Ensuring healthcare and social-care professionals have the knowledge and skills to provide the best chronic pain care for injured workers Search 1, Search 2, Search 3 *(seven evidence syntheses identified)*	Continuing medical education regarding pain management and opioid prescribing for healthcare professionals may improve pain management (66)	No	7/10	2016	Not available
	Professionals should be trained in supporting and educating people with pain to promote self-efficacy and collaborative decision-making (67) • Health professionals should be encouraged to utilize a biopsychosocial approach, facilitate conversations about pain, enable people with pain to be involved in their care, provide pain education, and promote self-efficacy in people with pain	No	4/9	2018	Not available
	The clinical value of computerized decision-support systems is largely unknown due to limited research (104)	No	4/10	2006	Not available
	Graduate medical education can improve healthcare professionals' knowledge of chronic pain by utilizing multimodal training, case-based learning, role playing, and standardized cases (68)	No	4/9	2019	Not available
	Organizational interventions targeting multifaceted components of behaviour may be best suited to impact medication prescription for those with chronic pain (69) • This study found that interventions do not affect medication or prescribing behaviour for people with pain • Of all interventions, organizational interventions targeting multifaceted components may be most effective	No	8/10	2020	Not available
	There is evidence suggesting that Prescription Drug Monitoring Programs can reduce the incidence of adverse opioid-related events, enhance communication between healthcare providers and patients, alter healthcare practitioners' approaches to opioid-prescribed patients, and provide more opportunities for education and counselling for individuals with chronic non-cancer pain (70) • However, only three systematic reviews were included in the analysis	No	5/9	2023	Not available
	There is evidence that educational programs positively influence pediatric nurses' knowledge of pain and help modify their attitudes toward it (105) • There is limited evidence regarding the impact of these programs on nurses' beliefs and perceptions about children's pain reports, their self-efficacy, or the barriers to optimal practice	No	2/10	2016	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
Taking an equity-centred approach to all of the above by identifying priority sub-populations and adapting as needed Search 1, Search 2, Search 3 *(two evidence syntheses identified)*	Multidisciplinary interventions have been shown to reduce pain intensity, enhance functional ability, and alleviate various psychosocial symptoms in chronic pain patients from refugee or immigrant backgrounds (71) • Most effective multidisciplinary interventions highlighted in this review employed a biopsychosocial model that somewhat addresses the cultural differences between patients and healthcare providers • Providers who demonstrate an understanding of their patients' healthcare beliefs and preferences, as well as those who can communicate fluently with their patients, tend to achieve better treatment outcomes	No	4/9	2020	Not available
	The application of virtual reality holds promise for managing chronic pain; however, there are few studies that involve older populations, individuals with limited educational backgrounds, or those from racially or ethnically diverse groups (106)	No	4/9	2021	Not available

Appendix 5: Evidence syntheses relevant to element 3 – Adjust health- and social-system arrangements

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile

Coordinating the delivery of supports for injured workers across settings, sectors, and systems
Search 1, Search 2, Search 3
(23 evidence syntheses identified)
	Interorganizational collaboration in healthcare requires focus on increased coordination and connection between organizations (72)
	• The review defined interprofessional collaboration, the joint effort between healthcare professionals that share a common goal, and interorganizational collaboration, the association of healthcare professionals across different organizations to benefit independent patient care
	  ○ Acknowledged similarities yet distinct differences between the definitions despite conceptual frameworks traditionally using groups interchangeably
	  ○ Team identity, formalization, and professional role clarification are components of collaboration that were found to be more difficult to implement in interorganizational collaboration
	  ○ Building association between different organization's cultures, processes, and modes of communication can benefit interorganizational delivery of care
		No	6/9	2014	Not available

	Strong and equitably resourced cross-sector service provision can benefit care for complex health needs (73) • The review found that cross-sector care for complex health needs requires strong connection, relationships, and collaboration between involved sectors • All cross-sector professionals should be involved in care plans from conceptualization to delivery of care and should have appropriate leadership • Resource and funding allotment should be equitable between all involved sectors with joint funded programs being recommended	No	6/10	2015	Not available
	Systemic and organizational-level factors benefit collaboration between primary care and public health professionals and enable increased access to care and benefit health outcomes in chronic disease management (74) • The review highlighted that government mandates for the development of collaborative teams benefitted collaboration • Collaboration occurred more frequently when mandates involved common goals between primary care and public health professionals • Adequately funded collaborations were successful using capitation and blended funding models • Additional funding not always necessary; pooling or sharing of resources between sectors sufficient • Successful collaboration benefited positive health-related outcomes and access to care for chronic disease management including screening, disease control, and self-management	No	4/10	2008	Not available
	Successful state/non-state health sector partnerships in Nepal require strengthened role understanding and sustainable government systems (75) • State/non-state partnerships improve overall health service delivery in Nepal	No	4/9	Not available	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• The review found that health service delivery partnerships can be strengthened through committed partner leadership and government systems • Program insecurity stemmed from only one year funding commitment from government				
	Partnerships between primary care and mental health services are established and maintained through clinical and organizational alignment (76) • The review highlighted barriers and facilitators to strengthening partnerships between primary mental health care and mental health services • Active communication between partners including regular team meetings, feedback systems, and established protocols benefits patient care • Alignment of care service mandates that address continuity of care are necessary for partner integration	No	1/9	2009	Not available
	Family physicians play a unique role in integrated healthcare teams and can succeed in collaboration through shared patient care goals and reciprocal primary care leadership and decision-making (77) • Structural components found to enable successful family physician collaboration in integrated healthcare teams included clear definition of care goals, leadership participation from all stakeholders, and structured, collaborative decision-making frameworks • Structural components to integrated healthcare success are supported through strong communication, established partner relationships, and shared motivations to improve patient care	No	5/9	2021	Not Available
	Quality improvement initiatives including government leadership support, data monitoring systems, and the engagement of frontline healthcare workers are key for the long-term success of public-private healthcare partnerships in low- and middle-income countries (92) • Collaborating with government and the Ministry of Health is essential for partnership sustainability in terms of infrastructure and responsibility sharing • Introducing shared data systems can benefit both quality improvement initiatives and partnership longevity • Implementing quality improvement initiatives are cost efficient for partnerships • This review highlighted that these quality improvement processes are the same for partnerships in high-income countries	No	4/9	2022	Not Available
	Intersectoral collaborations for health and health equity are primarily found in local scales and rely on governance, credibility, and legitimacy for success (37) • The review highlighted that intersectoral collaboration in healthcare is most found within local or regional scales • Various components relate to success of collaboration including governance, credibility, and legitimacy of involved sectors • Political leadership can impact collaboration success in both a positive and negative way	No	5/9	2021	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• There is limited evidence on the outcomes of intersectoral collaboration related to improving health inequalities				
	Collaboration between local healthcare and non-healthcare organizations show little to mixed evidence on health outcome improvement, health service impact, and resource use (38) • This review highlighted that there is little evidence to support that local healthcare collaboration with non-healthcare organizations benefits health outcomes • Collaboration initiatives focused on minority populations or quality of care showed improved health outcomes • There is mixed evidence on the impact of collaboration on health services and resource use	No	6/10	2019	Not available
	Local health and government agency collaboration show no increased health improvement over standard health services, though evidence is limited by primary study issues (90) • The review found no reliable evidence to suggest collaboration between local health and government agencies leads to increased health improvement over standard services • Environmental intervention collaborations may result in improved health outcomes • Evidence is limited by methodological issues in primary studies and incomplete outcome data	No	11/11	2012	Not available
	Sustainable success of community health collaborations requires organized communication and diversified resources (78) • The review examined facilitators and conditions for community health collaborative sustainability • Utilizing organizational communication systems and diversifying resource generation can aid in long-term program success • Collaboratives are more sustainable when partners have successfully worked together previously and where there is a larger amount of common shared resources	No	4/9	Not available	Not available
	[Protocol – results not yet available] A review examining the facilitators and barriers of intersectoral and multisectoral health policy implementation (79) • Intersectoral and multisectoral collaborative approaches aim to address the social determinants of health and identify issues relating to poverty, housing, and other social factors	No	Not available	2022	Not available
	Person-centred health services with consumers and health providers working in partnership show uncertain effects on health service delivery and performance compared to usual healthcare practice [Synthesis of mainly low-quality studies] (80) • The effects of including consumers to promote person-centred health services is uncertain • There is a possible cost and resource benefit for engaging consumers in healthcare decisions • The review highlights the need for increased research on the effects of partnership interventions on person-centred healthcare	No	11/11	2019	Yes
	Intersectoral action for health equity requires the engagement of sectors outside of healthcare that address both upstream and downstream determinants of health (81) • The review found limited and mixed evidence on intersectional partnerships effects on health outcomes • Downstream interventions including case coordination provided strongest effects	No	7/10	2011	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	Institutional health partnerships are important in strengthening health system delivery between high income and low- and middle-income countries but are limited by scale, monitoring systems, and program sustainability [Synthesis of mainly low-quality studies] (82) • Institutional health partnerships work primarily on small scales, limiting their ability to impact health systems • Monitoring and evaluation systems are important for understanding project outputs and service outcomes • Partnering with regional or national institutions can improve partnership sustainability and impact	No	6/10	2015	Not available
	There is little evidence on the effects of organizational partnerships on direct health outcomes (83) • Low methodological quality of quantitative studies impacts the ability to understand health effects and cost-effectiveness of organizational partnerships	No	6/9	2008	Not available
	Financing systems such as discretionary earmarked funding, recurred delegated funding, and joint budgeting are all positive mechanisms for financing intersectoral actions between health and social sectors (87) • Flexibility in discretionary earmarked funding, which is provided and controlled by the ministry of health, can help maximalize and strengthen government action opportunities • Recurred delegated funding, which is allocated to an independent body, involves the transfer of action power to a non-government agency ○ Can increase action sustainability by relying less on government funding and changes in political leadership • Joint budgeting between sectors can widen action interests, reach, and allow for more diverse funding options • Legislation that allows budget sharing and accountability between agencies can act as a framework for intersectoral action funding	No	3/9	2016	Not available
	Evidence-based practices for collaborative work between professionals include both interdisciplinary and transdisciplinary models (84) • Best interdisciplinary models of collaborative practice included having a key actor who is the contact point between consumer and all collaborating partners • Best transdisciplinary models of practice included having whole team assessments and periodic update meetings during collaborative care initiatives	No	3/9	2019	Not available
	Aligning partner motivations, characteristics, and goals are essential to positive partnership outcomes (85) • Characteristics of a strong collaborative partner include resource profile, previous collaborative experience, power dynamics, and partner reputation • Important for partners to adopt a problem-centric rather than an individual sector-specific model for collaboration	No	4/9	2012	Not available
	Service provision for complex cases requires the collaboration between multiple systems that effectively share vision, collaborative environment, and information (86)	No	6/9	2015	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• The review identified key collaborative enablers for agencies working together on complex health and social cases • Sharing goals, ensuring a culture of teamwork and collaboration, and the structured sharing of information are all essential to the success of collaborative efforts				
	Cross-system child welfare collaborations can lead to positive outcomes with limited resources (88) • Successful collaboration and child welfare outcomes were found with both low and high levels of collaboration efforts ○ Limited resources and collaboration can lead to program success	No	7/11	2018	Not available
	Maintaining successful and sustainable public-private partnerships involves prioritizing trust between public and private parties, prioritizing patient needs, and utilizing medical technologies (89) • Trustworthiness between public and private agencies was the top priority of healthcare professionals involved in partnerships • Utilizing medical technologies readily available in public health settings is essential for public health partnership success	No	8/10	2016	Not available
	There is potential service and policy benefit but limited empirical research on the effectiveness of public-private partnerships in reducing the strain on public healthcare infrastructure (91) • Public-private partnerships may allow the public sector to better focus on core services but may be limiting due to their high costs ○ There is a lack of research on public-private partnerships long-term financial impact on future government • Partnerships in public health may not lead to significant service quality improvement but research is limited	No	4/9	2011	Not available
Updating what (and how much) is covered to reflect advances in chronic pain support for injured workers Search 1, Search 2, Search 3 *(nine evidence syntheses identified)*	Publicly insured individuals in Germany have poorer health, face difficulties accessing new drugs and organ transplatations, experience financial burders, longer waiting times, and face communication challenges with healthcare providers compared to privately insured individuals, emphasizing the need for policy interventions to address these disparities and improve healthcare outcomes (98) • The review highlighted the health disparities that exist between publicly funded and privately funded individuals in Germany ○ Disadvantages of public insurance include longer wait times, financial burden caused by co-payments, and disrupted communciation between patient and provider	No	3/9	2009	Not available
	Government regulations on private health insurance, including cancer screening utilization and other healthcare services, yield inconclusive and varied effects on how healthcare is used, its costs, quality of care, and patient health outcomes [Synthesis of mainly low-quality studies] (99) • Based on available evidence, it is unclear whether governemnt regulation of cost and quality of private health insurance has an effect on healthcare service utilization, costs, or patient care	No	9/9	2019	Yes
	Although private fincancing can supplement services not covered by the national health system, out-of-pocket expenses can futher restrict access to and utilization of dental services among low-income long-term care residents (100)	No	4/9	Not available	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• There is limited public discussion on integrating financial costs of services when services are not publicly financed • Out-of-pocket expenses reduce the access and utilization of dental services, particularly for low-income individuals				

	The expansion of eligibility of Medicaid was associated with increases in healthcare coverage, service use, quality of care, and Medicaid spending (93)
	• The review found that expanding public insurance for lower-income individuals led to increases in service use, quality of care, Medicaid spending, and healthcare coverage
	  ○ There is very little evidence on Medicaid illiciting negative consequences such as increased wait times for care and appointments
	  ○ There is limited evidence due to primary study design on the expansion of Medicaid leading to increased health status
		No	5/11	2018	Not available

	While having health insurance was associated with increased utilization of allied health services for individuals with chronic conditions, no studies examined the effect of provision of health insurance on overall healthcare costs or clinical outcomes (94) • Health insurance was associated with increased utilization of allied health services, including physiotherapy, for individuals with chronic disease ○ The amount of health services that are publicly subsidized also affected allied health service utilization	No	8/10	2011	Not available
	14 studies consistently found that extending health insurance to uninsured people in the U.S. causes increase healthcare utilization and improves health outcomes (95) • The review highlighted a causal relationship between health insurance and healthcare utilization, and health insurance and improved health outcomes ○ Health insurance had effects on the use of physicians, preventative services, health status (self-reported), and a reduction in mortality rates	No	4/10	Not available	Not available
	A cost analysis of 22 studies indicated that a single-payer healthcare financing in the U.S. would result in reduced health expenditures and improve the potential for long-term cost savings to the system; however, costs to the government would likely increase when tax-based financing replace private insurance premiums and out-of-pocket spending (101) • The review highlighted the feasibility of a single-payer approach to healthcare financing in the United States • Single-payer financing would result in reduced health expenditures and improve long-term savings to the healthcare systems ○ Replacing private insurance with public insurance would likely increase costs to the government	No	6/10	2018	Not available
	Based on suggestions from the literature that adopting private financing options to address wait times in the short term would lead to long-term negative implications, there is no immediate or other benefit to Canada to adopt private healthcare insurance (96)	No	3/9	Not available	Not available

Sub-element (and search strategy used)	Available evidence syntheses to inform decision-making about the sub-element	Living status	Quality (AMSTAR rating from McMaster Health Forum)	Last year literature searched	Availability of GRADE profile
	• The review found that private healthcare insurance would have significant negative implications for the healthcare system in Canada and would not reduce wait times in the long term • Adopting private healthcare insurance would induce inequity in healthcare access for low-income individuals				
	Private financing of healthcare can improve access to care and health outcomes; however, it will likely increase overall health system costs and create inequity in accessing healthcare compared to public financing (97) • The rapid evidence profile highlighted that public or private insurance improves health outcomes and private financing benefits its users in terms of access to care and health status outcomes but does not benefit public insurance users • Private financing increases individual and system costs for care because of increased administration and procedure use • Coexistence of public and private financing in healthcare can lead to logistical issues and inequity in care access	No	5/9	2023	Not available
Facilitating the ongoing alignment of chronic pain supports for injured workers across Canada Search 1, Search 2 *(one evidence synthesis identified)*	The politicization and de-politicization of financial and economic governance issues are influenced by the decision-making venue as it can impact the monitoring, evaluation, and outcomes of policy (102) • Financial regulation and economic government issues can phase between politicization and de-politicization • The review emphasizes the importance of venue choice, or decision-making areas, for financial economic governance as it can impact the societal engagement in policy • The politicization or de-politicization and venue choice can impact the monitoring and evaluation of financial regulation and economic governance	No	4/9	2016	Not available

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We are grateful to Steering Committee members and merit reviewers (Martine Bordeleau, Renée Roussel, and Megan Scott) for providing feedback on previous drafts of the brief. The evidence brief and the stakeholder dialogue it was prepared to inform were funded by the Ontario SPOR SUPPORT Unit, which is supported by the Canadian Institutes of Health Research, the Province of Ontario, and partner Ontario hospital foundations and institutes. The McMaster Health Forum receives both financial and in-kind support from McMaster University. This synthesis was prepared in collaboration with Pain Canada, which receives financial support from Health Canada. The views expressed herein are the views of the authors and should not be taken to represent the views of the Ontario SPOR SUPPORT Unit, McMaster University, or Health Canada.