HEALTHCARE

POLICY

Politiques de Santé

Health Services, Management and Policy Research
Services de santé, gestion et recherche de politique

Volume 20 • Number 1

A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings
CARA EVANS, CHRISTOPHER CANNING, MUNAZZAH AMBREEN, BRIAN LO, MARY ROSE VAN KESTEREN, CAROLINE M.E. WALKER AND VICKY STERGIOPOULOS

Whose Accountability Matters in Long-Term Care?
MICHAELLA MILLER AND ELLEN MACEACHEN

How Good Reforms Fail: The Warning Example of Alberta's Borderless EMS System
JANNA NEWTON, TRAVIS CARPENTER AND JENNIFER ZWICKER

Are Small Teams a Viable Strategy to Deliver Early Psychosis Intervention Services in Rural Areas? An Ontario Fidelity Study
AVRA SELICK, GORDON LANGILL, SANDY BROOKS AND JANET DURBIN

Data Matters • Discussion and Debate • Research Papers

A LONGWOODS PUBLICATION Fonds WWW.HEALTHCAREPOLICY.NET

HEALTHCARE QUARTERLY: Best practices, policy and innovations in the administration of healthcare. For administrators, academics, insurers, suppliers and policy leaders. ✦ *Co-Edited by* Anne Wojtak, Lead, East Toronto Health Partners, Adjunct Faculty, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, and Richard Lewanczuk, Senior Medical Director for Health System Integration, Alberta Health Services, Edmonton.

CANADIAN JOURNAL OF NURSING LEADERSHIP: Covering politics, policy, theory and innovations that contribute to leadership in nursing administration, practice, teaching and research. Peer reviewed. ✦ *Edited by* Ruth Martin-Misener, Director and Professor, School of Nursing, Assistant Dean, Research, Faculty of Health, Dalhousie University, Co-Director, Canadian Centre for Advanced Practice Nursing Research, Affiliate Scientist, Nova Scotia Health, Affiliate Scientist, Maritime SPOR Support Unit, Halifax.

HEALTHCARE PAPERS: Review of new models in healthcare. Bridging the gap between the world of academia and the world of healthcare management and policy. Authors explore the potential of new ideas. ✦ *Edited by* Audrey Laporte, Director, Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto, Toronto, and Sara Allin, Associate Professor, Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto, Toronto, and Director, North American Observatory on Health Systems and Policies.

HEALTHCARE POLICY: Healthcare policy research and translation. Peer reviewed. For health system managers, practitioners, politicians and their administrators, and educators and academics. Authors come from a broad range of disciplines including social sciences, humanities, ethics, law, management sciences and knowledge translation. ✦ *Edited by* Dr. Jason Sutherland, Professor, Centre for Health Services and Policy Research, University of British Columbia, Vancouver.

HEALTHCARE
POLICY
Politiques de Santé

Health Services, Management and Policy Research
Services de santé, gestion et recherche de politique

VOLUME 20 NUMBER 1 • AUGUST 2024

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

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

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

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

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

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

CONTENTS

FROM THE EDITOR-IN-CHIEF

6 Does Productivity in Healthcare Matter? An Unfortunate Post-Pandemic Legacy
JASON M. SUTHERLAND

DISCUSSION AND DEBATE

19  A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings
CARA EVANS, CHRISTOPHER CANNING, MUNAZZAH AMBREEN, BRIAN LO, MARY ROSE VAN KESTEREN, CAROLINE M.E. WALKER AND VICKY STERGIOPOULOS

29 Commentary: Reducing the Mortality Gap for the Mentally Ill – Rethinking How and Where We Provide Care
NICK KATES

34  Whose Accountability Matters in Long-Term Care?
MICHAELLA MILLER AND ELLEN MacEACHEN

41 Commentary: Critical to Care – The Problem of Profit in Ontario's Long-Term Care Home Sector
SUSAN BRAEDLEY

47  How Good Reforms Fail: The Warning Example of Alberta's Borderless EMS System
JANNA NEWTON, TRAVIS CARPENTER AND JENNIFER ZWICKER

55 Commentary: The Canadian Healthcare Crisis and the Emerging Role of Paramedicine
MICHAEL FELDMAN AND DONALD L. PIERCE

DATA MATTERS

59  Are Small Teams a Viable Strategy to Deliver Early Psychosis Intervention Services in Rural Areas? An Ontario Fidelity Study
AVRA SELICK, GORDON LANGILL, SANDY BROOKS AND JANET DURBIN

RESEARCH PAPERS

69  Implementing Active Offer of Services in Both Official Languages in a Hospital Setting in Ontario
KATRINE SAUVÉ-SCHENK, JACINTHE SAVARD AND FRANÇOIS DURAND

 Peer Reviewed

TABLE DES MATIÈRES

DU RÉDACTEUR EN CHEF

12 La productivité dans les soins de santé est-elle importante? Un malheureux héritage post-pandémique
JASON M. SUTHERLAND

DISCUSSIONS ET DÉBATS

19  Appel pour la santé physique dans les milieux spécialisés en santé mentale au Canada
CARA EVANS, CHRISTOPHER CANNING, MUNAZZAH AMBREEN, BRIAN LO, MARY ROSE VAN KESTEREN, CAROLINE M.E. WALKER ET VICKY STERGIOPOULOS

29 Commentaire : Réduire l'écart de mortalité chez les personnes atteintes de maladie mentale – repenser la façon et le lieu où nous fournissons des soins
NICK KATES

34  Qui est responsable des soins de longue durée?
MICHAELLA MILLER ET ELLEN MacEACHEN

41 Commentaire : Soins essentiels – le problème du profit dans le secteur des foyers de soins de longue durée en Ontario
SUSAN BRAEDLEY

47  Comment les bonnes réformes échouent : l'avertissement du système des SMU sans frontière de l'Alberta
JANNA NEWTON, TRAVIS CARPENTER ET JENNIFER ZWICKER

55 Commentaire : La crise des soins de santé au Canada et le rôle émergent du personnel paramédical
MICHAEL FELDMAN ET DONALD L. PIERCE

QUESTIONS DE DONNÉES

59  Les petites équipes constituent-elles une stratégie viable pour offrir des services d'intervention précoce contre la psychose dans les régions rurales? Une étude ontarienne sur la fidélité
AVRA SELICK, GORDON LANGILL, SANDY BROOKS ET JANET DURBIN

RAPPORTS DE RECHERCHE

69  Mise en œuvre de l'offre active de services dans les deux langues officielles dans un milieu hospitalier en Ontario
KATRINE SAUVÉ-SCHENK, JACINTHE SAVARD ET FRANÇOIS DURAND

 Examen par les pairs

HEALTHCARE
POLICY
Politiques de Santé

EDITOR-IN-CHIEF
JASON M. SUTHERLAND
Professor, Centre for Health Services and Policy Research, University of British Columbia, Vancouver, BC

SENIOR EDITOR
FRANÇOIS BÉLAND, PhD
Professor, Department of Health Administration, Faculté de médecine, Université de Montréal, Member, Groupe de recherche interdisciplinaire en santé (GRIS), Co-Director, Groupe de recherche Université de Montréal–Université McGill sur les personnes âgées, Montréal, QC

EDITORS
RAISA B. DEBER, PhD
Professor, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, ON

FIONA CLEMENT, PhD
Director, Health Technology Assessment Unit
Associate Professor
O'Brien Institute for Public Health
University of Calgary
Calgary, AB

JOEL LEXCHIN, MSc, MD
Professor and Associate Chair, School of Health Policy and Management, Faculty of Health, York University, Emergency Department, University Health Network, Toronto, ON

SABRINA WONG, RN, PhD, FAAN
Faculty, Centre for Health Services and Policy Research; Professor, UBC School of Nursing, Vancouver, BC

CONTRIBUTING EDITORS
STEVEN LEWIS
President, Access Consulting Ltd., Saskatoon (temporarily in Melbourne, Australia); Adjunct Professor of Health Policy, Simon Fraser University, Burnaby, BC

EDITORIAL DIRECTOR
DIANNE FOSTER-KENT
dkent@longwoods.com

COPY EDITING
KNOWLEDGEWORKS GLOBAL LTD.

TRANSLATOR
ÉRIC BERGERON

PROOFREADER
NATHALIE LEGROS

EDITORIAL ADVISORY BOARD
TONI ASHTON
Associate Professor Health Economics, School of Population Health, The University of Auckland, Auckland, NZ

LUC BOILEAU, MD, MSc, FRCPC
President and Chief Executive Officer, Agence de la santé et des services sociaux de la Montérégie, Montréal, QC

PHILIP DAVIES
Government Social Research Unit, London, UK

MICHAEL DECTER
Founding and Former Chair, Health Council of Canada, Toronto, ON

ROBERT G. EVANS
Professor, Department of Economics, University of British Columbia, Member, Centre for Health Services and Policy Research, University of British Columbia, Vancouver, BC

KENNETH FYKE
Victoria, BC

STEFAN GREß
Department of Health Sciences, University of Applied Sciences Fulda, Germany

CHRIS HAM
Professor of Health Policy and Management, Health Services Management Centre, The University of Birmingham, Birmingham, UK

PAUL LAMARCHE
Professor, Departments of Health Administration & Social and Preventive Medicine, Director, GRIS, Faculté de médecine, Université de Montréal, Montréal, QC

DAVID LEVINE
Président directeur général, Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal-Centre, Montréal, QC

CHRIS LOVELACE
Senior Manager, World Bank, Kyrgyz Republic Country Office, Central Asia Human Development, Bishkek, Kyrgyz Republic

THEODORE R. MARMOR
Professor of Public Policy and Management, Professor of Political Science, Yale School of Management, New Haven, CT

VICENTE ORTÚN
Economics and Business Department and Research Center on Health and Economics (CRES), Pompeu Fabra University, Barcelona, Spain

ROBIN OSBORN
Vice President and Director, International Program in Health Policy and Practice, Commonwealth Fund, New York, NY

DOROTHY PRINGLE
Professor Emeritus and Dean Emeritus, Faculty of Nursing, University of Toronto, Toronto, ON

MARC RENAUD
Lisbon, Portugal (on sabbatical)

JEAN ROCHON
Expert associé, Systèmes de soins et services, Institut national de santé publique du Québec, Sainte-Foy, QC

NORALOU P. ROOS
Manitoba Centre for Health Policy
Professor, Community Health Sciences
University of Manitoba, Winnipeg, MB

RICHARD SALTMAN
Professor of Health Policy and Management, Rollins School of Public Health, Emory University, Atlanta, GA

HON. HUGH D. SEGAL, CM
Senator, Kingston-Frontenac-Leeds, Ottawa, ON

ALAN WOLFSON
South Africa

LONGWOODS PUBLISHING CORPORATION

PUBLISHER & CEO
MATTHEW HART
mhart@longwoods.com

PUBLISHER & COO
REBECCA HART
rhart@longwoods.com

EDITORIAL DIRECTOR
DIANNE FOSTER-KENT
dkent@longwoods.com

ASSOCIATE PUBLISHER, CAREERS & WEB
SUSAN HALE
shale@longwoods.com

ASSOCIATE PUBLISHER, CUSTOMER SERVICE & ADMINISTRATION
BARBARA MARSHALL
bmarshall@longwoods.com

PRODUCTION MANAGER & SOCIAL MEDIA COORDINATOR
SUSMITA DEY
sdey@longwoods.com

DESIGN
BEN HARRIS

CREATIVE
ERIC HART

HOW TO REACH THE EDITORS AND PUBLISHER
Telephone: 416-864-9667; fax: 416-368-4443

ADDRESSES
All mail should go to: Longwoods Publishing Corporation, 260 Adelaide Street East, No. 8, Toronto, Ontario M5A 1N1, Canada.

For deliveries to our studio: 54 Berkeley St., Suite 305, Toronto, Ontario M5A 2W4, Canada.

SUBSCRIPTIONS
Individual subscription rates for one year are [C] $127 for online only and [C] $225 for print + online. Institutional subscription rates are [C] $550 for online only and [C] $753 for print + online. For subscriptions contact Barbara Marshall at telephone 416-864-9667, ext. 100 or by e-mail at bmarshall@longwoods.com.

Subscriptions must be paid in advance. An additional tax (GST/HST) is payable on all Canadian transactions. Rates outside of Canada are in US dollars. Our GST/HST number is R138513668.

SUBSCRIBE ONLINE
Go to www.healthcarepolicy.net and click on "Subscribe."

REPRINTS
Reprints can be ordered in lots of 100 or more. For reprint information call Barbara Marshall at 416-864-9667 or fax 416-368-4443 or e-mail to bmarshall@longwoods.com.

Return undeliverable Canadian addresses to: Circulation Department, Longwoods Publishing Corporation, 260 Adelaide Street East, No. 8, Toronto, Ontario M5A 1N1, Canada.

EDITORIAL
To submit material or talk to our editors please contact Dianne Foster Kent by e-mail at dkent@longwoods.com. Author guidelines are available online at longwoods.com/pages/hpl-for-authors.

ADVERTISING
For advertising rates and inquiries, please contact Matthew Hart at 416-864-9667, ext. 113 or by e-mail at mhart@longwoods.com.

PUBLISHING
To discuss supplements or other publishing issues contact Rebecca Hart at 416-864-9667, ext. 114 or by e-mail at rhart@longwoods.com.

Healthcare Policy/Politiques de Santé is published four times per year by Longwoods Publishing Corp., 260 Adelaide St. East, No. 8, Toronto, ON M5A 1N1, Canada. Manuscripts are reviewed by the editors and a panel of peers appointed by the editors. Information contained in this publication has been compiled from sources believed to be reliable. While every effort has been made to ensure accuracy and completeness, these are not guaranteed. The views and opinions expressed are those of the individual contributors and do not necessarily represent an official opinion of *Healthcare Policy* or Longwoods Publishing Corporation. Readers are urged to consult their professional advisors prior to acting on the basis of material in this journal.

Longwoods Publishing was founded by Publisher Anton Hart (1946–2022).

Healthcare Policy/Politiques de Santé is indexed in the following: PubMed/Medline, CINAHL, CSA (Cambridge), Ulrich's, Embase, IndexCopernicus, Scopus, ProQuest, EBSCO Discovery Service, is archived in PubMed Central, and is a partner of HINARI.

No liability for this journal's content shall be incurred by Longwoods Publishing Corporation, the editors, the editorial advisory board or any contributors.

ISSN No. 1715-6572
eISSN No. 1715-6580

Publications Mail Agreement No. 40069375
© August 2024

EDITORIAL

Does Productivity in Healthcare Matter? An Unfortunate Post-Pandemic Legacy

In speeches this year, a Bank of Canada official announced that our country experienced no growth in productivity over the past two years (Rogers 2024a, 2024b). To improve this predicament, the bank says businesses should focus on adding value and being more efficient. These recommendations should be heeded by healthcare – the industry exceeds 12% of Canada's gross domestic product and is growing (CIHI 2024b).

There is good reason to focus on hospitals' productivity for the simple reason that hospitals are the government's single greatest source of spending. Improving productivity would take the form of reducing costs for generating the same amount of health, improving health outcomes for the same amount of money, or improving health outcomes at less cost than what is current.

Hospital spending is closing in on $100 billion per year according to the Canadian Institute for Health Information's (CIHI) 2024 forecast (CIHI 2024a). This is a lot of money no matter how one looks at it. Provinces and territories have much work to do to slow spending and improve productivity, especially since hospital spending is growing at a rate of 6.1% in 2024 (CIHI 2024b).

There have been policy responses by provincial and territorial governments over the years to slow hospital spending growth and improve productivity. During the 2000s, provincial governments exerted great pressure on hospital executives to slow spending growth, using global budgets to restrain growth and ration services and technologies. Hospital executives carried out their mission by implementing policies to be more cost efficient, including reorganizing care processes to make greater use of less-expensive nurse practitioners, physician assistants and registered practical nurses (OHA 2024) or implementing shared procurement strategies (Provincial Health Services Authority n.d.).

Improving productivity and efficiency is not a one-time event. Taxpayers should expect that hospital productivity will increase over time through the adoption of new technologies, redesigned processes of care, more efficient workflows, elimination of ineffective care or duplicate testing and minimizing the burden of unnecessary documentation.

If hospitals are not improving productivity, taxpayers will be left to pay more for the same thing.

Cost Efficiency

Cost efficiency is an important aspect of productivity. Being cost efficient means that hospital executives have been judicious about spending their monies on healthcare services, technologies and products used to provide healthcare services. Cost-efficient hospitals are good for taxpayers.

This is not a theoretical concept. In Canada's healthcare landscape, cost efficiency is a number that is calculated and comparable between hospitals, regions or provinces. The "number" is generated as the ratio of hospitals' spending relative to the volume of care they provide. The volume of care hospitals provide reflects the different types of patients that hospitals treat, referred to as case mix (University of Manitoba 2023).

Cost efficiency is a popular and important measure since it is calculated from hospital's data collected for other purposes. Provincial and territorial cost efficiency numbers are comparable and are published periodically by the CIHI (2024c). The most recently published findings revealed that Ontario's hospitals were the most cost efficient. Quebec, Alberta and British Columbia meaningfully spent more per standardized patient (CIHI 2024d). This means that Quebec, Alberta and British Columbia spent billions more on hospital care than Ontario for the same type of care.

It should not be lost on the reader that Ontario was the only province to have enshrined the desirability of cost-efficient hospitals within their funding policies. The province used a series of hospital funding policies to create incentives for hospitals to be cost efficient. The innovative Health-Based Allocation Model (Howlett 2012; OHA n.d.) was the first initiative, and through the enabling legislation of the *Excellent Care for All Act*, 2010, a second initiative followed, known as Quality-Based Procedures (Ontario Ministry of Health 2023) and bundled care (Province of Ontario 2015). While Ontario's hospitals experienced enviably lower hospital costs compared with other provinces, the measure of cost efficiency is not perfect; cost efficiency does not measure the effectiveness of the hospital's treatments nor the amount of health their hospitals generate, and more research is needed to determine whether some portion of Ontario's cost efficiency can be attributed to economies of scale.

The COVID-19 pandemic ushered in a different era of government spending on hospitals to reflect different priorities. Billions of additional dollars were poured into provinces' and territories' hospitals (CIHI 2024b). Rightly or wrongly, cost efficiency took a back seat.

Time for Focusing on Productivity and Cost Efficiency

The pandemic's effect of increasing governments' spending on hospitals is in the rear-view mirror for the most part. The legacy is that the price of hospital care went up, without a commensurate increase in the volume of care provided, including in Ontario (CIHI 2024a, 2024b).

It is becoming urgent for the federal, provincial and territorial governments to pursue policies to improve cost efficiency of hospitals. For the next 10 years, demand for hospital-based care will not abate and the provinces' hospitals are at risk of being overrun by more seniors living longer with more medical complexity, population growth due to high immigration and lack of access to primary care.

Given the astronomic sums involved, the growth rate and low productivity, the public should demand all levels of government enact policies that cause hospitals to act differently and seek cost efficiencies.

For the federal, provincial and territorial governments, there are different paths forward. The federal government funds a portion of provinces' and territories' healthcare systems through transfer payments and has a vested, though indirect, interest in hospitals being cost efficient. To date, Health Canada has not articulated targets for hospitals' cost efficiency or spending growth rates even though it has the data to do so. Health Canada taking the initiative could provide provinces cover for implementing policies focused on hospitals' cost efficiency.

Provinces and territories have the most to gain by improving cost efficiency and slowing spending growth. They also are the most at risk due to not meeting the expected growth in demand for hospital-based care. There is a need for provincial and territorial policies that incentivize their hospitals' executives to take action and pick winners or losers that result in cost-efficient care and root out ineffective care.

Local communities also have a strong interest in their hospitals' cost efficiency. Hospitals that are financially efficient are more likely to attract new public investments and less likely to experience tumult in the managerial ranks.

Beginning Now

Hospitals are a critical element of communities across the country. They are the first stop in emergencies and protect families from financial ruin due to health reasons. Canadians need their public hospitals to be vibrant and sustainable. Improving cost efficiency needs to begin now to help them face the coming wave of demand. New policies that drive cost efficiency should come back into vogue.

This Issue

This issue of *Healthcare Policy* leads with a Discussion and Debate article written by Evans et al. (2024) who call for action by provinces to improve the physical health of Canadians with serious mental illnesses. Applying for policies of "reverse integration," the article focuses on principles of prioritizing health equity, leveraging current delivery system strengths and embedding people with lived experience into building processes to improve the physical health of Canadians with serious mental illnesses (Evans et al. 2024: 19).

A rejoinder to the article was written by Kates (2024) of McMaster University. The rejoinder provides a number of insightful options for extending the policy recommendations

by Evans and colleagues (Evans et al. 2024). Kates' (2024) rejoinder offers a number of policy options for reducing health inequities among people with serious mental illness, including reducing barriers to care, increasing prevention and early detection efforts, guaranteeing minimum incomes and providing annual physical exams.

A second Discussion and Debate written by Miller and MacEachen (2024) focuses on the implications of Ontario's *Fixing Long Term Care Act*, 2021. The article discussed the consequences of increased compliance with the Act in resource-constrained environments and concludes that accountability should focus on the entire long-term care system and not individual homes. The article offers a number of policy options, including staffing ratios, resource need assessments and strategies for safeguarding care in for-profit long-term care homes.

A rejoinder by Braedley (2024) focuses on the relationships between accountabilities and profit in the long-term care sector. The rejoinder notes that given the myriad of different ownership structures, it is difficult or impossible to determine how much public funding in long-term care represents profit along with challenges in identifying who is responsible for quality or where the power lies. The rejoinder offers a number of strategies for improving accountability among for-profit long-term care homes, such as government retaining land or ownership of long-term care homes, requiring transparency regarding ownership and paying taxes in jurisdictions where owners operate long-term care homes.

This issue's third Discussion and Debate article describes the limits of Alberta's borderless emergency medical services (EMS) policies (Newton et al. 2024). The article describes borderless EMS policies that led to rural communities having poorer EMS coverage and increased burnout among EMS staff due to prolonged diversions. The article offers a number of policy options for addressing the current policies' limitations, including minimum coverage levels for specific rural regions, reducing emergency department congestion and reducing low-acuity EMS calls.

A rejoinder by Feldman and Pierce (2024) reiterates that EMS is experiencing significant strains across the country as Canadians struggle to access their province's healthcare systems. The authors offer a number of options for policy makers to reduce the strain on EMS, including online consultations with emergency medicine specialists, expanding the scope of community paramedicine education and improving access to community-based healthcare providers.

The Data Matters section features an article examining whether smaller care teams might be effective in delivering early psychosis intervention services in rural communities (Selick et al. 2024). The article evaluated data from 24 of Ontario's early psychosis intervention programs and found that while smaller care teams were viable, large as well as small teams were unable to deliver key aspects of psychosis
intervention services.

This issue includes a research article assessing the practices of active offer of French-language services in acute care settings in a region of Ontario with a low density of

francophones. Using a qualitative design of interviewing managers and site coordinators, the study found that the active offer of French-language services' success was linked to support from upper management and site coordinators (Sauvé-Schenk et al. 2024). The research paper concludes with a list of recommendations for maximizing the success of French-language service implementations.

JASON M. SUTHERLAND, PhD
Editor-in-Chief

References

Braedley, S. 2024. Commentary: Critical to Care – The Problem of Profit in Ontario's Long-Term Care Home Sector. *Healthcare Policy* 20(1): 41–46. doi:10.12927/hcpol.2024.27483.

Canadian Institute for Health Information (CIHI). 2024a, November. *Health Expenditure Data in Brief*. Retrieved December 20, 2024. <https://www.cihi.ca/sites/default/files/document/health-expenditure-data-in-brief-2024-en.pdf>.

Canadian Institute for Health Information (CIHI). 2024b. National Health Expenditure Trends, 2024 – Snapshot. Retrieved December 4, 2024. <https://www.cihi.ca/en/national-health-expenditure-trends-2024-snapshot>.

Canadian Institute for Health Information (CIHI). 2024c, October. Cost of a Standard Hospital Stay: Methodology Notes. Retrieved December 4, 2024. <https://www.cihi.ca/sites/default/files/document/cost-standard-hospital-stay-methodology-notes-en.pdf>.

Canadian Institute for Health Information (CIHI). 2024d. Cost of a Standard Hospital Stay. Retrieved December 4, 2024. <https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/015/cost-of-a-standard-hospital-stay/;mapC1;mapLevel2;/>.

Evans, C., C. Canning, M. Ambreen, B. Lo, M.R. Van Kesteren, C.M.E. Walker et al. 2024. A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings. *Healthcare Policy* 20(1): 19–28. doi:10.12927/hcpol.2024.27475.

Excellent Care for All Act, 2010, S.O. 2010, c. 14. 2010. Government of Ontario. Retrieved December 4, 2024. <https://www.ontario.ca/laws/statute/10e14>.

Feldman, M. and D.L. Pierce. 2024. Commentary: The Canadian Healthcare Crisis and the Emerging Role of Paramedicine. *Healthcare Policy* 20(1): 55–58. doi:10.12927/hcpol.2024.27484.

Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1. 2021. Government of Ontario. Retrieved December 20, 2024. <https://www.ontario.ca/laws/statute/21f39>.

Howlett, K. 2012, March 18. Ontario Hospital-Funding Changes to Favor Growing Communities. *The Globe and Mail*. Retrieved December 5, 2024. <https://www.theglobeandmail.com/news/politics/ontario-hospital-funding-changes-to-favour-growing-communities/article534676/>.

Kates, N. 2024. Commentary: Reducing the Mortality Gap for the Mentally Ill – Rethinking How and Where We Provide Care. *Healthcare Policy* 20(1): 29–33. doi:10.12927/hcpol.2024.27482.

Miller, M. and E. MacEachen. 2024. Whose Accountability Matters in Long-Term Care? *Healthcare Policy* 20(1): 34–40. doi:10.12927/hcpol.2024.27420.

Newton, J., T. Carpenter and J. Zwicker. 2024. How Good Reforms Fail: The Warning Example of Alberta's Borderless EMS System. *Healthcare Policy* 20(1): 47–54. doi:10.12927/hcpol.2024.27476.

Ontario Hospital Association (OHA). n.d. *Health-Based Allocation Model: What You Need to Know*. Retrieved December 4, 2024. <https://www.oha.com/Documents/HBAM-What%20You%20Need%20To%20Know.pdf>.

Ontario Hospital Association (OHA). 2024, August. *Ontario Hospitals – Leaders in Efficiency (Second Edition)*. Retrieved December 5, 2024. <https://www.oha.com/Bulletins/OHA-Hospital%20Efficiency%20Paper_August2024_FINAL.pdf>.

Ontario Ministry of Health. 2023, December 14. Quality-Based Procedures. Retrieved December 4, 2024. <https://www.ontario.ca/page/quality-based-procedures>.

Province of Ontario. 2015, September 2. Ontario Funds Bundled Care Teams to Improve Patient Experience: Province Expands Coordinated Team Approach to Provide Seamless Service to Patients [News release]. Retrieved December 5, 2024. <https://news.ontario.ca/en/release/34097/ontario-funds-bundled-care-teams-to-improve-patient-experience>.

Provincial Health Services Authority. n.d. Supply Chain & Procurement. Retrieved December 5, 2024. <http://www.phsa.ca/our-services/support-services/supply-chain>.

Rogers, C. 2024a, March 26. The Productivity Problem [Speech summary]. Bank of Canada. Retrieved December 10, 2024. <https://www.bankofcanada.ca/2024/03/productivity-problem/>.

Rogers, C. 2024b, March 26. Time to Break the Glass: Fixing Canada's Productivity Problem [Remarks]. Bank of Canada. Retrieved December 11, 2024. <https://www.bankofcanada.ca/2024/03/time-to-break-the-glass-fixing-canadas-productivity-problem/>.

Sauvé-Schenk, K., J. Savard and F. Durand. 2024. Implementing Active Offer of Services in Both Official Languages in a Hospital Setting in Ontario. *Healthcare Policy* 20(1): 69–81. doi:10.12927/hcpol.2024.27485.

Selick, A., G. Langill, S. Brooks and J. Durbin. 2024. Are Small Teams a Viable Strategy to Deliver Early Psychosis Intervention Services in Rural Areas? An Ontario Fidelity Study. *Healthcare Policy* 20(1): 59–68. doi:10.12927/hcpol.2024.27421.

University of Manitoba. 2023, October 23. Concept: Calculating Hospital Costs Using Cost Per Weighted Case (CPWC) / Cost of a Standard Hospital Stay (CSHS) Values. Retrieved December 4, 2024. <http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?conceptID=1100>.

ÉDITORIAL

La productivité dans les soins de santé est-elle importante? Un malheureux héritage post-pandémique

Dans des discours cette année, un représentant de la Banque du Canada a annoncé que notre pays n'avait connu aucune croissance de la productivité au cours des deux dernières années (Rogers 2024a, 2024b). Pour améliorer cette situation, la Banque estime que les entreprises devraient se concentrer sur l'ajout de valeur et sur une plus grande efficacité. Ces recommandations devraient être suivies par les soins de santé – l'industrie représente plus de 12 % du produit intérieur brut du Canada et elle est en croissance (ICIS 2024b).

Il y a de bonnes raisons de se concentrer sur la productivité des hôpitaux, pour la simple raison qu'ils représentent la principale source de dépenses du gouvernement. L'amélioration de la productivité consisterait à réduire les coûts pour produire le même volume de soins, améliorer les résultats en matière de santé pour le même montant d'argent ou améliorer ces résultats à un coût inférieur à celui des services actuels.

Les dépenses hospitalières s'approchent des 100 milliards de dollars par année, selon les prévisions de l'Institut canadien d'information sur la santé (ICIS) pour 2024 (ICIS 2024a). C'est beaucoup d'argent, peu importe comment on le regarde. Les provinces et les territoires ont beaucoup de travail à faire pour ralentir les dépenses et améliorer la productivité, d'autant plus que l'ICIS estime que les dépenses hospitalières ont augmenté à un taux de 6,1 % en 2024 (ICIS 2024b).

Au fil des ans, les gouvernements provinciaux et territoriaux ont réagi afin de ralentir la croissance des dépenses hospitalières et d'améliorer la productivité. Pendant les années 2000, les gouvernements provinciaux ont exercé de fortes pressions sur les administrateurs d'hôpitaux pour qu'ils ralentissent la croissance des dépenses, en utilisant les budgets globaux pour limiter la croissance et pour rationner les services et les technologies. Les administrateurs d'hôpitaux ont également accompli cette mission en mettant en œuvre des politiques visant une meilleure rentabilité, notamment par une réorganisation des processus de soins afin d'utiliser davantage les infirmières praticiennes, les adjoints aux médecins et les

infirmières auxiliaires autorisées, qui sont tous trois moins coûteux (OHA 2024), ou encore par la mise en œuvre de stratégies d'approvisionnement partagées (Provincial Health Services Authority s.d.).

Améliorer la productivité et l'efficacité n'est pas un accomplissement ponctuel. Les contribuables devraient s'attendre à ce que la productivité des hôpitaux augmente avec le temps grâce à l'adoption de nouvelles technologies, à la refonte des processus de soins, à des flux de travail plus efficaces, à l'élimination des soins inefficaces ou de la répétition des tests et à la réduction du fardeau de la documentation.

Si les hôpitaux n'améliorent pas leur productivité, les contribuables devront payer plus pour obtenir les mêmes choses.

La rentabilité

La rentabilité est un aspect important de la productivité. Être rentable veut dire que les administrateurs d'hôpitaux font preuve de discernement quand ils dépensent l'argent pour les services, les technologies et les produits de santé. Les hôpitaux rentables sont salutaires pour les contribuables.

Il ne s'agit pas là d'un concept théorique. Dans le contexte des soins de santé au Canada, la rentabilité est un chiffre calculé et comparable entre les hôpitaux, les régions ou les provinces. Le « nombre » est généré par le ratio des dépenses des hôpitaux par rapport au volume de soins qu'ils fournissent. Le volume des soins fournis par les hôpitaux reflète les différents types de patients que les hôpitaux traitent, ce qu'on appelle les groupes de maladies analogues (Université du Manitoba 2023).

La rentabilité est une mesure populaire et importante, car elle peut être calculée à partir des données de l'hôpital recueillies à d'autres fins. Les chiffres sur la rentabilité des hôpitaux des provinces et des territoires sont comparables entre eux et régulièrement publiés par l'ICIS (2024c). Les résultats les plus récents révèlent que les hôpitaux de l'Ontario sont les plus rentables. Le Québec, l'Alberta et la Colombie-Britannique ont dépensé significativement plus d'argent par patient standard (ICIS 2024d). Cela veut dire que le Québec, l'Alberta et la Colombie-Britannique ont dépensé des milliards de dollars de plus en soins hospitaliers que l'Ontario pour les mêmes types de soins.

Il ne faut pas oublier que l'Ontario est la seule province à avoir enchassé dans ses politiques de financement la question de la rentabilité des hôpitaux. La province emploie une série de politiques de financement pour créer des incitatifs afin que les hôpitaux soient rentables. Le modèle d'allocation fondée sur la santé (Howlett 2012; OHA s.d.) était la première initiative en ce sens puis, par l'entremise de la *Loi de 2010 sur l'excellence des soins pour tous*, une deuxième initiative a suivi, connue comme les procédures fondées sur la qualité (ministère de la Santé de l'Ontario 2023) et les soins regroupés (province de l'Ontario 2015). Bien que les hôpitaux de l'Ontario aient connu des coûts hospitaliers plus faibles par rapport à d'autres provinces, la mesure du rendement n'est pas parfaite, car le rendement ne mesure pas l'efficacité des traitements ni la quantité de soins de santé qu'ils génèrent. Davantage

de recherches seront nécessaires pour déterminer si une partie du rendement de l'Ontario s'explique par des économies d'échelle.

La pandémie de COVID-19 a marqué le début d'une nouvelle ère où les dépenses gouvernementales pour les hôpitaux reflètent de nouvelles priorités. Des milliards de dollars supplémentaires ont été versés aux hôpitaux des provinces et des territoires (ICIS 2024b). La rentabilité a dû céder le pas, à tort ou à raison.

Il est temps de se concentrer sur la productivité et la rentabilité

Les effets, pendant la pandémie, d'une augmentation des dépenses gouvernementales pour les hôpitaux, sont pour la plupart dans le rétroviseur. Le prix des soins hospitaliers a augmenté, y compris en Ontario (ICIS 2024a, 2024b).

Il devient urgent, pour les gouvernements fédéral, provinciaux et territoriaux, de mettre en œuvre des politiques visant à améliorer la rentabilité des hôpitaux. Au cours des 10 prochaines années, la demande de soins hospitaliers ne diminuera pas et les hôpitaux provinciaux risquent d'être envahis par un nombre plus élevé que jamais d'aînés qui vivent plus longtemps avec une complexité médicale accrue, une croissance démographique due à l'immigration élevée et à un manque d'accès aux soins primaires.

Compte tenu des sommes astronomiques en jeu, du taux de croissance et de la faible productivité, le public devrait exiger que tous les niveaux de gouvernement adoptent des politiques qui incitent les hôpitaux à agir différemment et à rechercher des économies.

Diverses voies en ce sens s'offrent aux gouvernements fédéral, provinciaux et territoriaux. Le gouvernement fédéral, qui finance par paiements de transfert une partie des systèmes de santé des provinces et des territoires, s'intéresse fondamentalement, bien qu'indirectement, à la rentabilité des hôpitaux. À ce jour, Santé Canada n'a pas défini d'objectifs pour la rentabilité des hôpitaux ou pour le taux de croissance des dépenses, même s'il dispose des données nécessaires. Santé Canada pourrait prendre l'initiative de fournir aux provinces une *couverture* pour la mise en œuvre de politiques axées sur la rentabilité des hôpitaux.

Les provinces et les territoires ont le plus à gagner en améliorant l'efficacité des coûts et en ralentissant la croissance des dépenses. Ils sont également les plus à risque s'ils ne réagissent pas face à la croissance prévue de la demande de soins hospitaliers. Il faut des politiques provinciales et territoriales qui incitent les administrateurs d'hôpitaux à agir et à déterminer les atout gagnants et perdants, ce qui se traduirait par des soins rentables et une élimination des soins inefficaces.

Les communautés sont également très intéressées par la rentabilité des hôpitaux. Des hôpitaux rentables financièrement sont plus susceptibles d'attirer de nouveaux investissements publics et moins susceptibles de connaître des bouleversements dans les rangs des gestionnaires.

Il faut commencer maintenant

Les hôpitaux sont un élément essentiel des collectivités partout au pays. Ils sont le premier arrêt en cas d'urgence et protègent les familles de la ruine financière pour des raisons de santé. Les Canadiens ont besoin d'hôpitaux publics dynamiques et durables. Il faut commencer dès maintenant à améliorer la rentabilité pour les aider à faire face à la vague de demande qui s'annonce. Les nouvelles politiques qui favorisent la rentabilité devraient revenir à l'ordre du jour.

Dans ce numéro

La section Discussions et débats du présent numéro de *Politiques de Santé* s'ouvre par un article rédigé par Evans et al. (2024). Les auteurs demandent aux provinces d'agir pour améliorer la santé physique des Canadiens atteints de maladies mentales graves. Préconisant des politiques d'« intégration inverse », l'article met l'accent sur les principes de priorisation de l'équité en santé, sur le fait de tirer parti des points forts actuels du système et sur l'intégration de personnes ayant une expérience vécue dans la mise en œuvre de processus visant à améliorer la santé physique des Canadiens atteints de maladies mentales graves (Evans et al. 2024: 19).

Une réplique à cet article est signée par Kates (2024) de l'Université McMaster. La réplique présente un certain nombre de pistes intéressantes pour les recommandations formulées par Evans et ses collègues (Evans et al. 2024). La réplique de Kates (2024) propose des stratégies pour réduire les inégalités en matière de santé chez les personnes atteintes de maladies mentales graves, notamment la réduction des obstacles aux soins, l'augmentation des efforts de prévention et de détection précoce, la garantie de revenus minimums et la planification d'examens physiques annuels.

Un deuxième article de la section Discussions et débats, rédigé par Miller et MacEachen (2024), porte sur les répercussions en Ontario de la *Loi de 2021 sur le redressement des soins de longue durée*. L'article examine les conséquences d'une plus grande conformité à la *Loi* dans des milieux où les ressources sont limitées et conclut que la responsabilisation devrait porter sur l'ensemble du système de soins de longue durée et non sur les foyers individuels. L'article présente un certain nombre d'options stratégiques, notamment les ratios de dotation en personnel, les évaluations des besoins en ressources et les stratégies pour protéger les soins dans les foyers de soins de longue durée à but lucratif.

Une réplique de Braedley (2024) porte sur les relations entre la responsabilité et le profit dans le secteur des soins de longue durée. La réplique indique qu'étant donné la myriade de structures de propriétés, il est difficile ou impossible de déterminer combien le financement public des soins de longue durée représente un profit. Pas plus qu'il est possible de savoir quels sont les défis à relever pour déterminer qui est responsable de la qualité et où se trouve

le pouvoir. La réplique propose un certain nombre de stratégies pour améliorer la responsabilisation des foyers de soins de longue durée à but lucratif, telles que la propriété des terres ou des foyers qui serait du ressort du gouvernement, l'exigence de transparence quant à la propriété, ou encore, le paiement de l'impôt dans les administrations où sont exploités les foyers.

Le troisième article de la section Discussions et débats décrit les limites des politiques concernant les services médicaux d'urgence (SMU) sans frontière en Alberta (Newton et al. 2024). L'article décrit comment, dans les communautés rurales, les politiques de SMU sans frontière ont appauvri la couverture des SMU et aggravé l'épuisement du personnel en raison de longues déviations. L'article propose un certain nombre d'options stratégiques pour remédier aux limites des politiques actuelles, notamment des niveaux de couverture minimum dans certaines régions rurales, la réduction de la congestion des services d'urgence et la réduction des appels au SMU pour des soins moins urgents.

Feldman et Pierce (2024) réitèrent dans leur réplique que les SMU sont soumis à des contraintes importantes partout au pays, alors que les Canadiens ont du mal à accéder aux systèmes de santé de leur provinces respectives. Les auteurs proposent aux décideurs un certain nombre d'options pour réduire la pression sur les SMU, notamment des consultations en ligne avec des spécialistes de médecine d'urgence, l'élargissement du champ d'action de la formation paramédicale communautaire et l'amélioration de l'accès aux prestataires de soins de santé communautaires.

La section Questions de données présente un article qui examine si les petites équipes de soins sont efficaces pour offrir des services d'intervention précoce en cas de psychose dans les collectivités rurales (Selick et al. 2024). L'article évalue les données de 24 programmes d'intervention précoce en Ontario et constate que, même si les petites équipes de soins sont viables, les grandes comme les petites équipes ne sont pas toujours en mesure d'offrir certains services clés d'intervention en cas de psychose.

Ce numéro comprend un article de recherche qui évalue les pratiques d'offre active de services en français dans des établissements de soins de courte durée d'une région de l'Ontario à faible densité de francophones. Au moyen d'une conception qualitative d'entrevues auprès de gestionnaires et de coordonnateurs locaux, l'étude révèle que la réussite des services en français est liée au soutien de la haute direction et des coordonnateurs locaux (Sauvé-Schenk et al. 2024). L'article se termine par une liste de recommandations visant à maximiser la réussite de la mise en œuvre de services en français.

JASON M. SUTHERLAND, PhD
Rédacteur en chef

Références

Braedley, S. 2024. Commentaire : Soins essentiels – le problème du profit dans le secteur des foyers de soins de longue durée en Ontario. *Politiques de Santé* 20(1): 41–46. doi:10.12927/hcpol.2024.27483.

Evans, C., C. Canning, M. Ambreen, B. Lo, M.R. Van Kesteren, C.M.E. Walker et al. 2024. Appel pour la santé physique dans les milieux spécialisés en santé mentale au Canada. *Politiques de Santé* 20(1): 19–28. doi:10.12927/hcpol.2024.27475.

Feldman, M. et D.L. Pierce. 2024. Commentaire : La crise des soins de santé au Canada et le rôle émergent du personnel paramédical. *Politiques de Santé* 20(1): 55–58. doi:10.12927/hcpol.2024.27484.

Howlett, K. 2012, 18 mars. Ontario Hospital-Funding Changes to Favor Growing Communities. *The Globe and Mail*. Consulté le 5 décembre 2024. <https://www.theglobeandmail.com/news/politics/ontario-hospital-funding-changes-to-favour-growing-communities/article534676/>.

Institut canadien d'information sur la santé (ICIS). 2024a, novembre. *Données sur les dépenses de santé en bref*. Consulté le 20 décembre 2024. <https://www.cihi.ca/sites/default/files/document/health-expenditure-data-in-brief-2024-fr.pdf>.

Institut canadien d'information sur la santé (ICIS). 2024b. Tendances des dépenses nationales de santé, 2024 – analyse éclair. Consulté le 4 décembre 2024. <https://www.cihi.ca/fr/tendances-des-depenses-nationales-de-sante-2024-analyse-eclair>.

Institut canadien d'information sur la santé (ICIS). 2024c, octobre. Coût d'un séjour standard à l'hôpital : notes méthodologiques. Consulté le 4 décembre 2024. <https://www.cihi.ca/sites/default/files/document/cost-standard-hospital-stay-methodology-notes-fr.pdf>.

Institut canadien d'information sur la santé (ICIS). 2024d. Coût d'un séjour standard à l'hôpital. Consulté le 4 décembre 2024. <https://votresystemedesante.icis.ca/hsp/inbrief?lang=fr#!/indicateurs/015/cost-of-a-standard-hospital-stay/;mapC1;mapLevel2;/>.

Kates, N. 2024. Commentaire : Réduire l'écart de mortalité chez les personnes atteintes de maladie mentale – repenser la façon et le lieu où nous fournissons des soins. *Politiques de Santé* 20(1): 29–33. doi:10.12927/hcpol.2024.27482.

Loi de 2010 sur l'excellence des soins pour tous, L.O. 2010, chap. 14. 2010. Gouvernement de l'Ontario. Consulté le 4 décembre 2024. <https://www.ontario.ca/lois/loi/10e14>.

Loi de 2021 sur le redressement des soins de longue durée, L.O. 2021, chap. 39, annexe 1. 2021. Gouvernement de l'Ontario. Consulté le 20 décembre 2024. <https://www.ontario.ca/lois/loi/21f39>.

Miller, M. et E. MacEachen. 2024. Qui est responsable des soins de longue durée? *Politiques de Santé* 20(1): 34–40. doi:10.12927/hcpol.2024.27420.

Ministère de la Santé de l'Ontario. 14 décembre 2023. Procédures fondées sur la qualité. Consulté le 4 décembre 2024. <https://www.ontario.ca/fr/page/procedures-fondees-sur-la-qualite-0>.

Newton, J., T. Carpenter et J. Zwicker. 2024. Comment les bonnes réformes échouent : l'avertissement du système des SMU sans frontière de l'Alberta. *Politiques de Santé* 20(1): 47–54. doi:10.12927/hcpol.2024.27476.

Ontario Hospital Association (OHA). s.d. *Health-Based Allocation Model: What You Need to Know*. Consulté le 4 décembre 2024. <https://www.oha.com/Documents/HBAM-What%20You%20Need%20To%20Know.pdf>.

Ontario Hospital Association (OHA). 2024, août. *Ontario Hospitals – Leaders in Efficiency (Second Edition)*. Consulté le 5 décembre 2024. <https://www.oha.com/Bulletins/OHA-Hospital%20Efficiency%20Paper_August2024_FINAL.pdf>.

Province de l'Ontario. 2 septembre 2015. L'Ontario finance des équipes de soins regroupés en vue d'améliorer l'expérience des patients : La province élargit l'approche coordonnée par équipe afin d'offrir un service unifié aux patients [communiqué de presse]. Consulté le 5 décembre 2024. <https://news.ontario.ca/fr/release/34097/lontario-finance-des-equipes-de-soins-regroupes-en-vue-dameliorer-lexperience-des-patients>.

Provincial Health Services Authority. s.d. Supply Chain & Procurement. Consulté le 5 décembre 2024. <http://www.phsa.ca/our-services/support-services/supply-chain>.

Rogers, C. 2024a, 26 mars. Le problème de productivité [Sommaire du discours]. Banque du Canada. Consulté le 10 décembre 2024. <https://www.banqueducanada.ca/2024/03/probleme-productivite/>.

Rogers, C. 2024b, 26 mars. L'heure a sonné : réglons le problème de productivité du Canada [Discours]. Banque du Canada. Consulté le 11 décembre 2024. <https://www.banqueducanada.ca/2024/03/heure-sonne-reglons-probleme-productivite-canada/>.

Sauvé-Schenk, K., J. Savard et F. Durand. 2024. Mise en œuvre de l'offre active de services dans les deux langues officielles dans un milieu hospitalier en Ontario. *Politiques de Santé* 20(1): 69–81. doi:10.12927/hcpol.2024.27485.

Selick, A., G. Langill, S. Brooks et J. Durbin. 2024. Les petites équipes constituent-elles une stratégie viable pour offrir des services d'intervention précoce contre la psychose dans les régions rurales? Une étude ontarienne sur la fidélité. *Politiques de Santé* 20(1): 59–67. doi:10.12927/hcpol.2024.27421.

Université du Manitoba. 23 octobre 2023. Concept: Calculating Hospital Costs Using Cost Per Weighted Case (CPWC) / Cost of a Standard Hospital Stay (CSHS) Values. Consulté le 4 décembre 2024. <http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?conceptID=1100>.

DISCUSSION AND DEBATE

A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings

Appel pour la santé physique dans les milieux spécialisés en santé mentale au Canada

CARA EVANS, PhD
CIHR Health System Impact Postdoctoral Fellow
Waypoint Centre for Mental Health Care
Penetanguishene, ON
CIHR Health System Impact Postdoctoral Fellow
University of Toronto
Toronto, ON

CHRISTOPHER CANNING, PhD
Director of Research and Academics
Waypoint Centre for Mental Health Care
Penetanguishene, ON

MUNAZZAH AMBREEN, MBBS, MSc
Research Coordinator
The Centre for Addiction and Mental Health
Toronto, ON

BRIAN LO, MHI, PhD(c)
CIHR Health System Impact Fellow
The Centre for Addiction and Mental Health
Doctoral Candidate
University of Toronto
Toronto, ON

MARY ROSE VAN KESTEREN, BA (HONS)
Peer Partner Advisor
The Centre for Addiction and Mental Health
Toronto, ON

CAROLINE M.E. WALKER, MI
Community Health and Education Assistant
The Centre for Addiction and Mental Health
Toronto, ON

VICKY STERGIOPOULOS, MD FRCPC, MHSc
Senior Scientist
The Centre for Addiction and Mental Health
Professor
University of Toronto
Toronto, ON

Abstract

People with serious mental illness experience poorer physical health and higher mortality rates than the general population. One option for responding to this disparity is *reverse integration*, which promotes physical health monitoring in secondary and tertiary mental health

settings. Health leaders in Canada can learn from reverse integration approaches that have been adopted or proposed in other jurisdictions. We conducted a jurisdictional scan and applied the 3I framework for policy analysis to suggest that Canadian adaptations of existing approaches should foreground equity, build on existing infrastructure and human resources and prioritize leadership of people with lived experience.

Résumé

Les personnes atteintes de maladies mentales graves ont une moins bonne santé physique et présentent des taux de mortalité plus élevés que la population générale. Une des réponses à cette disparité est « l'intégration inverse », qui favorise la surveillance de la santé physique dans les établissements de santé mentale secondaires et tertiaires. Les dirigeants de la santé au Canada peuvent tirer des leçons des initiatives d'intégration inverse qui ont été adoptées ou proposées dans d'autres administrations. L'analyse que nous avons effectuée auprès des administrations et le cadre des « 3I » que nous avons employé pour l'analyse des politiques nous portent à proposer que l'adaptation de ces initiatives au Canada devrait privilégier l'équité, s'appuyer sur les infrastructures et les ressources humaines en place et donner la priorité au leadership de personnes ayant une expérience vécue.

Introduction

People with serious mental illness (SMI) experience poorer physical health and higher mortality rates and die on average 10–20 years earlier than the general population (de Mooij et al. 2019; Olfson et al. 2015). Health inequities for people with SMI have many contributing factors, including poverty and unstable housing (Topor et al. 2016), poor access to primary care, pervasive stigma and other systematic barriers to engagement, leading to poor quality and experiences of care (Ronaldson et al. 2020). While a full review of literature is beyond the scope of this commentary, these inequities are long-standing and well-documented.

Current population and policy trends in Canada may contribute to a policy window to address this health inequity. As health policy makers are acutely aware, increasing numbers of people are living with multiple chronic illnesses, posing a challenge to siloed, biomedical models of care that focus on a single disease (Nicholson et al. 2019). Concurrently, health inequities are an area of increasing (and overdue) policy focus. The poor health and early deaths of people with SMI are deeply interwoven with other injustices, including anti-Black and anti-Indigenous racism (Asonye et al. 2020; Bingham et al. 2019). This inequity also manifests in the disproportionate involuntary hospitalization of racialized people with SMI, in particular Black people with SMI (Walker et al. 2019). The COVID-19 pandemic further sharpened the policy focus on these health inequities: both racialized people and people with SMI experienced higher mortality rates due to COVID-19 (Blair et al. 2022; Pardamean et al. 2022).

This equity-focused policy window is influenced by attention to possible solutions. Healthcare integration, including integration across physical health, mental health and social services, is a policy priority in many Canadian provinces (MHCC 2021). Policy makers' attunement to the challenges of multi-morbidity and social inequity, along with the potential of health and social care integration as a response, creates possibilities for tackling health inequities among people with SMI.

Integration and reverse integration

Broadly, healthcare integration refers to linking health services across sectors and/or across the continuum of healthcare (Valentijn et al. 2013). In mental health, integration research and practice has focused on co-locating mental health specialists in primary care settings or offering consultative specialist support to promote timely access and treatment of common mental disorders (Reilly et al. 2013). However, people with SMI may be in more regular contact with specialized mental health services than with primary care or any other element of the healthcare system. In this commentary, we focus on individuals with SMI who are receiving longitudinal care through community-based mental health services, such as intensive case management or assertive community treatment teams. These individuals typically have complex, ongoing needs that cannot be successfully addressed in primary care (Ontario Association for ACT and FACT n.d.). For these individuals, mental health services represent their *health home*, where their holistic needs may be best understood and addressed.

Reverse integration leverages this health home by promoting physical health monitoring in secondary and tertiary mental health settings, advancing a no-wrong-door approach to comprehensive healthcare (Ward and Druss 2017). The emerging evidence for reverse integration approaches is promising. Integrating physical healthcare into community-based secondary mental health settings has been found to improve rates of access to primary care (Johnson et al. 2022) and uptake of screening (Tse et al. 2021) and has been positively received by consumers (Talley et al. 2019). However, it is important to note that reverse integration does not refer to a single model of care. Rather, the academic literature describes an array of approaches, involving different providers and interventions embedded within mental health services at different scales. For instance, examples include outreach-based nurse practitioner care provided through an assertive community treatment (ACT) team (Henwood et al. 2018) and care planning and care coordination provided through a statewide adoption of a health home model in outpatient mental health clinics (McGinty et al. 2020).

Reverse integration is, therefore, a promising concept, and although the evidence base is still preliminary, there is growing momentum internationally. Canada can learn from and build on this momentum as part of a multi-faceted response to health inequities faced by SMI. The 3I policy analysis framework is one tool for analyzing approaches to policy development and implementation. It draws on a wide range of political science theories to suggest three categories of factors that influence these policy processes: *ideas*, including evidence and values; *institutions*, including the administrative capacities and prior policies that create

resources for future policy making; and *interests*, such as interest groups and policy entrepreneurs (i.e., individuals who push forward particular policy solutions) (Lavis et al. 2002). We use this framework to explore international approaches to reverse integration and assess their feasibility in the Canadian context. We considered approaches at the level of a health system (e.g., an integrated delivery system) or a national or subnational scale. We excluded initiatives based within a single organization or small number of organizations. We did not limit our scope to governmental policy and, instead, also included large-scale initiatives or broad frameworks developed by any health system stakeholders. Finally, as noted earlier, reverse integration is not a single model of care but rather a conceptual approach to service design in which physical healthcare is addressed in mental health settings. The breadth of this definition is reflected in the range of approaches we identified.

Ideas, interests and institutions: Considering international approaches and the Canadian context

Our team conducted a jurisdictional scan of international approaches to reverse integration. These approaches – summarized in Table 1 – include collaborative efforts led by networks of health service organizations, governmental policies and frameworks intended to inform system design. In the following sections, we briefly explore how ideas, institutions and interests shaped international approaches to reverse integration, and what this means for policy learning here in Canada.

IDEATIONAL FACTORS

International approaches to reverse integration respond to the well-documented evidence of health inequities and premature mortality for people with SMI. For instance, in the US, grants were established to integrate primary care into community-based mental health services (Primary and Behavioral Health Care Integration [PBHCI]). An evaluation of the grant program notes that people with SMI are twice as likely to die prematurely from chronic disease when compared with the general population (Scharf et al. 2013). Meanwhile an Australian roadmap document, produced by a collective of governmental and non-governmental stakeholders called Equally Well Australia, cites evidence that people with SMI are six times as likely to die from cardiovascular illness and four times as likely to die from respiratory illness (Morgan et al. 2021).

The problem reflected in these statistics has been framed in varying ways. A group of health service organizations in New Zealand formed the first of several international Equally Well collectives. Their consensus position paper endorses "the rights of all New Zealanders to reach their full health potential" and the right of people with SMI to access appropriate healthcare (Te Pou 2014). Organizations in the UK were inspired by their New Zealand counterparts to form a similar collective. The charter of Equally Well UK similarly states that "we all, regardless of where we live, have an equal right to good health

TABLE 1. International approaches to reverse integration

Approach	Type	Jurisdiction	Description
Equally Well New Zealand	Inter-organizational network	New Zealand	Equally Well New Zealand adopts a collective impact approach in which a "backbone team" facilitates the voluntary engagement of relevant partner organizations. The backbone team supports "partner-driven actions" to promote physical health among people with SMI, i.e., initiatives developed by signatory organizations that contribute to Equally Well's objectives such as adapting screening tools or creating indicators at a district level. It has over 100 signatory organizations (Equally Well n.d.).
Equally Well Australia	Inter-organizational network (with governmental support)	Australia	Equally Well Australia was inspired by Equally Well New Zealand and adopts a collective impact approach, supported by endorsement from regional health authorities and the Mental Health Commission of Australia. Initiatives organized under Equally Well Australia primarily have a clinical focus, such as the development of guidelines or integrated care programs. It has over 90 signatory organizations (Morgan et al. 2021).
Equally Well UK	Inter-organizational network	The UK	Equally Well UK adopts a collective impact approach and encourages organizations to develop their own initiatives as well as promote shared learning. It has over 60 signatory organizations (Equally Well UK n.d.).
Comprehensive Healthcare Integration (CHI) Framework	System design framework	The US	The CHI Framework describes key elements of bidirectional integration across a number of domains related to care and coordination, quality improvement and sustainability at three different levels of integration. It can be taken up on a voluntary basis by provider organizations and can be supported by funding agreements with payers (National Council for Mental Wellbeing 2022).
Primary and Behavioral Health Care Integration (PBHCI)	Governmental policy	The US	Through PBHCI grants, funding was made available to embed primary care services in community mental health organizations (Scharf et al. 2013).
Commissioning for Quality and Innovation (CQUIN)	Governmental policy	The UK (England)	CQUIN is a financial incentive program incentivizing performance for specific indicators, including those relating to physical health of people with SMI. These indicators have been primarily related to process measures, such as assessment or creation of a care plan (NHS England 2018).

SMI = serious mental illness.

and effective health care" (Equally Well UK n.d.: 1). Meanwhile, both the Comprehensive Healthcare Integration (CHI) Framework, produced in the US by the National Council for Mental Wellbeing, and NHS England's policy framework, Commissioning for Quality and Innovation (CQUIN), frame the problem in terms of quality. The CHI Framework document argues that integration enables higher-quality and higher-value care (National Council for Mental Wellbeing 2022). CQUIN similarly "aim[s] to improve quality and outcomes for patients including reducing health inequalities [and] encourag[es] collaboration across different providers" (NHS England 2018: 3).

Problem framing shapes the choice of solution; however, there is limited evidence related to the various *solutions* adopted. Some initiatives are yet to be implemented at scale, such as the CHI Framework. In other cases, preliminary evaluation has been conducted. A process evaluation of Equally Well New Zealand noted strengths of its governance structure and found facilitators of collaboration but noted that – seven years into the collaborative's existence – it is too early to measure health equity outcomes (Te Pou 2021). Health indicators such as blood pressure and cholesterol were measured in an evaluation of PBHCI, with varying results (Scharf et al. 2013). None of the initiatives included in the jurisdictional scan have been evaluated for their impact on outcomes such as mortality or quality of life. Meanwhile, a further factor that could underpin the lack of a cumulative evidence base across initiatives is heterogeneity. The wide range of approaches to reverse integration may pose a challenge for comparison and learning.

Given the above-mentioned considerations, a Canadian reverse integration approach will require framing the problem in terms that resonate with stakeholders. It will also require drawing on evidence about *what works* – to the extent that such evidence is available. Given the current emergent nature of the evidence base for reverse integration, Canadian efforts will require a robust evaluation plan and may benefit from adopting learning health system principles to enable rigorous and ongoing monitoring and improvement. Healthcare providers will also need to be equipped with the new knowledge needed to implement the selected approach.

INSTITUTIONAL FACTORS

The inter-jurisdictional approaches described above are each embedded in a unique institutional context. For instance, Equally Well Australia is an inter-organizational network inspired by its New Zealand counterpart but differs from the other Equally Well initiatives in the extent of government involvement – a differentiation made possible by Australia's unique mental health policymaking infrastructure. The collective is spearheaded by the National Mental Health Commission, a governmental agency that provides independent advice and reporting (Morgan et al. 2021). Meanwhile, CQUIN and the CHI Framework build on the unique value-based payment infrastructures of the UK and the US respectively, where the former includes commissioners under the National Health Service and the latter encompasses a complex array of payors and delivery systems.

The Canadian policy context will similarly influence the design of reverse integration initiatives. Canada does not have a single health system, but rather a patchwork of provincial, territorial and federal systems. This poses a challenge to the collaboration that underpins the various Equally Well initiatives, as most relevant health and social service organizations are local or provincial in scope and are not embedded in national networks or collaborations. Some efforts at national collaboration in the mental health sector in Canada have focused on the creation of non-binding standards and frameworks, as seen in the National Mental Health and Substance Use Standardization Collaborative; however, widespread implementation of standards will still require a coordinated effort and dedicated funding. Nonetheless, coordination is possible, as demonstrated by the success of integrated youth services (IYSs). IYSs were first championed in Canada through a governmental and philanthropic funding initiative that resulted in a national research and evaluation platform, Access Open Minds (Halsall et al. 2019). While Access Open Minds supported several early IYSs in Canada, other IYSs developed separately. Today, a knowledge translation platform called Frayme supports the generation and dissemination of knowledge about key principles and elements of IYSs, provides implementation support and fosters advocacy (Halsall et al. 2019). Efforts to promote reverse integration across Canada can learn from the IYS experience, including the mobilization of core principles, international evidence, intermediary supports and diverse funding sources.

INTEREST FACTORS

Different interest groups – inside and outside of government – also played a role in the development of the approaches mentioned above. Equally Well New Zealand was driven by an organization representing the mental health and disability workforce and was initially launched by eight organizations, including organizations that represent mental health consumers. This origin informed its bottom-up, collective impact approach, which focuses on how organizations can achieve change through collaboration. The leadership of Māori community members is reflected in Ngā Waka o Matariki, the Equally Well Māori Health Strategy 2020–2025 (Equally Well n.d.). The CHI Framework was developed by an expert panel of individuals holding leadership positions in mental health services, policy and payor organizations across the US (National Council for Mental Wellbeing 2022). The emphasis on quality and scalable and flexible approaches reflects the breadth of the council's members.

A number of interest groups in Canada will be essential to the development of reverse integration approaches and initiatives. The knowledge of people with lived experience of SMI, family members and medical and non-medical healthcare providers can be brought forward by national interest groups such as the Canadian Alliance on Mental Illness and Mental Health, the Canadian Mental Health Association, the Mental Health Commission of Canada, the National Network on Mental Health and the Schizophrenia Society of Canada. Groups such as the Black Health Alliance, the Hong Fook Mental Health Association, the South Asian Health Network and the Thunderbird Partnership

Foundation can deepen the conversation with knowledge of specific communities. Moreover, while a pan-Canadian approach may be appropriate, Canada does not have a single health system, and local champions and experts will be needed to translate approaches into action on the ground in each region.

A Canadian call to action

There are preliminary actions underway in Canada that align with the aims of reverse integration. For instance, the Mental Health Commission of Canada is collaborating with Ontario Shores Centre for Mental Health Sciences to implement Ontario Health's Schizophrenia Quality Standards at demonstration sites in four different provinces. The standards address physical health assessment, physical health promotion and smoking cessation. This is an exciting development that can be understood within ideas, institutions and interests in the Canadian context. Framed around quality, the initiative leverages existing intermediaries and evidence supports and relies on voluntary demonstration sites that are rather aspiring for broad collaboration across a decentralized context. However, while standards offer one lever for prompting action, there continues to be scope for broader policies and multi-sectoral and multi-faceted interventions that can leverage and build on the momentum for reverse integration. Although more specific recommendations will need to leverage input from patients, families, health providers and organizational and policy leaders, we suggest the following considerations for a made-in-Canada reverse integration approach.

First, taking the role of ideas seriously means foregrounding both values and evidence. A Canadian approach should prioritize health equity: Indigenous, racialized, immigrant and other communities have distinct values, needs and worldviews that should be front and centre. Meanwhile, a learning health system approach can ensure that evidence is generated and fed into practice in real time.

Second, institutional capacities will need to be leveraged and expanded. Reverse integration can build on existing infrastructure and human resources, but it will need to contend with the current health human resource crisis. Moreover, reverse integration will also require new knowledge, practices and attitudes, making training and new dedicated roles essential. A Canadian approach will further need to balance an overarching framework with local solutions. Communities have unique needs and unique knowledge, which should be reflected at a local level.

Third, reverse integration is relevant to a range of interest groups. People with lived experience of SMI and family carers must hold positions of leadership in the design, implementation and evaluation of reverse integration approaches. It will also be critical to engage broadly with health and social care workers, including nurse practitioners, allied healthcare providers and peer workers. Pan-Canadian organizations also have an important role in mobilizing knowledge to build momentum and support policy development and implementation.

Finally, a key recommendation is a call to action. Health and mortality inequities for people with SMI are well-documented; concerted policy action will be needed to move toward healthier and longer lives for people with SMI in Canada.

Correspondence may be directed to Cara Evans by e-mail at cevans@waypointcentre.ca.

References

Asonye, U., N. Apping, L.V. Lopez and D.M. Popeo. 2020. Health Disparities in Black Patients With Severe Mental Illness and the Role of Structural Racism. *Psychiatric Annals* 50(11): 483–88. doi:10.3928/00485713-20201007-01.

Bingham, B., A. Moniruzzaman, M. Patterson, J. Distasio, J. Sareen, J. O'Neil et al. 2019. Indigenous and Non-Indigenous People Experiencing Homelessness and Mental Illness in Two Canadian Cities: A Retrospective Analysis and Implications for Culturally Informed Action. *BMJ Open* 9(4): e024748. doi:10.1136/bmjopen-2018-024748.

Blair, A., S.Y. Pan, R. Subedi, F.-J. Yang, N. Aitken and C. Steensma. 2022. Social Inequalities in COVID-19 Mortality by Area and Individual-Level Characteristics in Canada, January to July/August 2020: Results From Two National Data Integrations. *Canada Communicable Disease Report* 48(1): 27–38. doi:10.14745/ccdr.v48i01a05.

de Mooij, L.D., M. Kikkert, J. Theunissen, A.T.F. Beekman, L. de Haan, P.W.R.A. Duurkoop et al. 2019. Dying Too Soon: Excess Mortality in Severe Mental Illness. *Frontiers in Psychiatry* 10: 855. doi:10.3389/fpsyt.2019.00855.

Equally Well. n.d. Everyone Should Have the Same Opportunities to Be Physically Well. Wisegroup. Retrieved January 7, 2025. <https://www.equallywell.co.nz/>.

Equally Well UK. n.d. Equally Well UK Charter for Equal Health. Retrieved December 29, 2023. <https://equallywell.co.uk/wp-content/uploads/2020/09/Equally-Well-Charter-for-Equal-Health.pdf>.

Halsall, T., I. Manion, S.N. Iyer, S. Mathias, R. Purcell and J. Henderson. 2019. Trends in Mental Health System Transformation: Integrating Youth Services Within the Canadian Context. *Healthcare Management Forum* 32(2): 51–55. doi:10.1177/0840470418808815.

Henwood, B.F., E. Siantz, D.R. Hrouda, D. Innes-Gomberg and T.P. Gilmer. 2018. Integrated Primary Care in Assertive Community Treatment. *Psychiatric Services* 69(2): 133–35. doi:10.1176/appi.ps.201700009.

Johnson, K., M. Tepper, H.S. Leff, B.O. Mullin, B.L. Cook and A.M. Progovac. 2022. Assessing the Long-Term Effectiveness of a Behavioral Health Home for Adults With Bipolar and Psychotic Disorders. *Psychiatric Services* 73(2): 172–79. doi:10.1176/appi.ps.202000589.

Lavis, J.N., S.E. Ross and J.E. Hurley. 2002. Examining the Role of Health Services Research in Public Policymaking. *The Milbank Quarterly* 80(1): 125–54. doi:10.1111/1468-0009.00005.

McGinty, E.E., E.M. Stone, A. Kennedy-Hendricks, S. Bandara, K.A. Murphy, E.A. Stuart et al. 2020. Effects of Maryland's Affordable Care Act Medicaid Health Home Waiver on Quality of Cardiovascular Care Among People With Serious Mental Illness. *Journal of General Internal Medicine* 35(11): 3148–58. doi:10.1007/s11606-020-05690-9.

Mental Health Commission of Canada (MHCC). 2021. *Towards Better Mental and Physical Health: Preventing and Managing Concurrent Mental and Physical Conditions: A Scoping and Rapid Realist Review*. Retrieved December 29, 2020. <https://mentalhealthcommission.ca/wp-content/uploads/2021/11/MHCC-CPAC-Chronic-Disease-Report-EN-Final-1.pdf>.

Morgan, M., D. Peters, M. Hopwood, D. Castle, C. Moy, C. Fehily et al. 2021, August. *Being Equally Well: A National Policy Roadmap to Better Physical Health Care and Longer Lives for People Living With Serious Mental Illness.* Mitchell Institute, Victoria University. Retrieved December 29, 2023. <https://www.vu.edu.au/sites/default/files/being-equally-well-policy-roadmap-mitchell-institute.pdf>.

National Council for Mental Wellbeing. 2022, April 22. The Comprehensive Healthcare Integration (CHI) Framework. Retrieved December 29, 2023. <https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/>.

NHS England. 2018, March. *Commissioning for Quality and Innovation (CQUIN): Guidance for 2017-2019.* Retrieved December 29, 2023. <https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf>.

Nicholson, K., A.L. Terry, M. Fortin, T. Williamson, M. Bauer and A. Thind. 2019. Prevalence, Characteristics, and Patterns of Patients With Multimorbidity in Primary Care: A Retrospective Cohort Analysis in Canada. *British Journal of General Practice* 69(686): e647–56. doi:10.3399/bjgp19X704657.

Olfson, M., T. Gerhard, C. Huang, S. Crystal and T.S. Stroup. 2015. Premature Mortality Among Adults With Schizophrenia in the United States. *JAMA Psychiatry* 72(12): 1172–81. doi:10.1001/jamapsychiatry.2015.1737.

Ontario Association for ACT and FACT. n.d. The ACT Model. Retrieved July 10, 2021. <https://ontarioactassociation.com/act-model/>.

Pardamean, E., W. Roan, K.T.A. Iskandar, R. Prayangga and T.I. Hariyanto. 2022. Mortality From Coronavirus Disease 2019 (COVID-19) in Patients With Schizophrenia: A Systematic Review, Meta-Analysis and Meta-Regression. *General Hospital Psychiatry* 75: 61–67. doi:10.1016/j.genhosppsych.2022.01.010.

Reilly, S., C. Planner, L. Gask, M. Hann, S. Knowles, B. Druss et al. 2013. Collaborative Care Approaches for People With Severe Mental Illness. *Cochrane Database of Systematic Reviews* 11: CD009531. doi:10.1002/14651858.CD009531.pub2.

Ronaldson, A., L. Elton, S. Jayakumar, A. Jieman, K. Halvorsrud and K. Bhui. 2020. Severe Mental Illness and Health Service Utilisation for Nonpsychiatric Medical Disorders: A Systematic Review and Meta-Analysis. *PLoS Medicine* 17(9): e1003284. doi:10.1371/journal.pmed.1003284.

Scharf, D.M., N.K. Eberhart, N.S. Hackbarth, M. Horvitz-Lennon, R. Beckman, B. Han et al. 2013. *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report*. RAND Corporation. Retrieved December 29, 2023. <https://aspe.hhs.gov/reports/evaluation-samhsa-primary-behavioral-health-care-integration-pbhci-grant-program-final-report>.

Talley, R.M., S.A. Rolin, B.N. Trejo, M.L. Goldman, J.-M.E. Alves-Bradford and L.B. Dixon. 2019. Perspectives of Individuals With Serious Mental Illness on a Reverse-Colocated Care Model: A Qualitative Study. *Psychiatric Services* 70(9): 793–800. doi:10.1176/appi.ps.201800480.

Te Pou. 2014, September 11. *Equally Well: Take Action to Improve Physical Health Outcomes for New Zealanders Who Experience Mental Illness and/or Addiction: A Consensus Position Paper*. Retrieved December 29, 2023. <https://www.equallywell.co.nz/wp-content/uploads/2022/10/EQW-A-consensus-position-paper.pdf>.

Te Pou. 2021, August. *Equally Well Evaluation Report*. Retrieved December 29, 2023. <https://www.equallywell.co.nz/wp-content/uploads/2022/10/Equally-Well-evaluation-report-August-2021.pdf>.

Topor, A., I. Ljungqvist and E.L. Strandberg. 2016. Living in Poverty With Severe Mental Illness Coping With Double Trouble. *Nordic Social Work Research* 6(3): 201–10. doi:10.1080/2156857X.2015.1134629.

Tse, J., J.E. Cheng, E. Tabasky, E. Kingman, D. LaStella, G. Quitangon et al. 2021. Integrating Primary Care Into Assertive Community Treatment. *Psychiatric Services* 73(5): 565–69. doi:10.1176/appi.ps.202100069.

Valentijn, P.P., S.M. Schepman, W. Opheij and M.A. Bruijnzeels, 2013. Understanding Integrated Care: A Comprehensive Conceptual Framework Based on the Integrative Functions of Primary Care. *International Journal of Integrated Care* 13: e010. doi:10.5334/ijic.886.

Walker, S., E. Mackay, P. Barnett, L. Sheridan Rains, M. Leverton, C. Dalton-Locke et al. 2019. Clinical and Social Factors Associated With Increased Risk for Involuntary Psychiatric Hospitalisation: A Systematic Review, Meta-Analysis, and Narrative Synthesis. *Lancet Psychiatry* 6(12): 1039–53. doi:10.1016/S2215-0366(19)30406-7.

Ward, M.C. and B.G. Druss. 2017. Reverse Integration Initiatives for Individuals With Serious Mental Illness. *Focus* 15(3): 271–78. doi:10.1176/appi.focus.20170011.

Commentary: Reducing the Mortality Gap for the Mentally Ill – Rethinking How and Where We Provide Care

Commentaire : Réduire l'écart de mortalité chez les personnes atteintes de maladie mentale – repenser la façon et le lieu où nous fournissons des soins

NICK KATES, MBBS, FRCPC, MCFP (HON)
Professor
Department of Psychiatry and Behavioural Neurosciences
McMaster University
Hamilton, ON

Abstract

The mortality gap faced by Canadians living with a severe and persistent mental illness is a national scandal. If we are to change this and take advantage of the possibilities that *reverse integration* presents, we need to rethink the ways our systems of care function and remove barriers to accessing care while tapping the full potential of collaborative partnerships, moving to earlier interventions with this population and integrating poverty reduction into all our work. Above all, we need to be much more effective in bringing these issues into the public discourse.

Abstract

L'écart de mortalité auquel font face les Canadiens atteints d'une maladie mentale grave et persistante est un scandale d'ordre national. Si nous voulons changer cela et tirer parti des possibilités que présente « l'intégration inverse », il faut repenser la façon dont les systèmes de soins fonctionnent et éliminer les obstacles à l'accès aux soins, tout en tirant pleinement profit du potentiel des partenariats collaboratifs. Il faut aussi commencer à intervenir plus tôt auprès de cette population et à intégrer la réduction de la pauvreté dans tous les aspects de notre travail. Nous devons surtout être beaucoup plus efficaces pour faire entrer ces enjeux dans le débat public.

Introduction

Evans et al. (2024) issue a timely call to action about the shameful situation of the premature mortality of individuals living with a severe and persistent mental illness (SPMI) (Fiorillo and Sartorius 2021; Thornicroft 2011). While we have long been aware of this, we have been unable to correct the situation despite many previous windows of opportunity, and if we are to have more success this time, we need to better understand why that has been the case.

Evans et al.'s (2024) proposals – reverse integration (Ward and Druss 2017) and the buildings of collaboratives to advocate for this approach (Scharf et al. 2013) – are laudable and achievable, as is the emphasis on building programs based on key underlying principles, within a common framework.

But if we are to achieve this, however, we have to recognize that many of these problems arise from system failures and take a deeper dive into their root causes. That will allow us to identify the specific factors that need to be addressed and the ways in which our systems of care need to be redesigned (Kates 2017) so that we can take full advantage of the possibilities that these approaches offer and introduce new standards for care.

These system issues can be divided into two broad groups: barriers to accessing care and the ways our systems of care are organized and connected.

Barriers to Accessing Care

Obvious issues include lengthy waiting lists, restrictive intake processes, decreased availability of family physicians, limited outreach activity and costs associated with accessing treatment or getting to appointment (Mental Health Commission of Canada 2021).

But many of the SPMIs, especially those with concurrent substance use problems, have also been abandoned by services because their behaviours may not always conform to expected norms – such as not always showing up for appointments – or because of stigma or bias on the part of providers (Ronaldson et al. 2020). Service delivery models need to be more inclusive, flexible and user friendly, tailoring services around the needs of individuals who face multiple challenges and who may already feel traumatized by contacts with the mental healthcare system (WHO 2018).

The Ways Our Systems of Care Are Organized and Connected

Fragmentation of services and over-specialization create problems with communication between providers and with transitions between services while reducing the likelihood of a single service or provider taking primary responsibility for an individual's ongoing care (Ayerbe et al. 2018) or people being *lost to care* when moving between services or sectors. We also need to rethink our approaches to health teaching and support for self-management and lifestyle interventions (De Rosa et al. 2017; Fiorillo et al. 2019), as we may be failing to provide individuals with the tools to better manage their own conditions, especially at times when they have no contact with any (mental) health service. Inadequate monitoring of medications and their metabolic side effects is also a contributing factor.

There are, however, two additional and potentially significant factors that the authors have not included in their analysis. These are: (1) a need to focus on prevention and earlier identification rather than just treating more advanced conditions and (2) a broader view of the potential of collaborative partnerships.

A focus on prevention and early detection

Simply focusing on treating well-established and possibly already life-threatening conditions is not enough. To make a lasting difference to the trajectory of these problems, we must find ways to intervene sooner. These problems usually develop over a lengthy period of time, with many opportunities to identify and treat emerging medical issues, often before other factors complicate the picture (Firth et al. 2020). In addition to promoting lifestyle changes, reversed integration teams can assist by regularly reviewing the medical histories of everyone with a SPMI being seen in a mental health service and adding a periodic health check-up. Services must also monitor people proactively rather than waiting for individuals to come to them when a problem becomes more severe.

The potential of collaborative partnerships

Co-location is an important step in the right direction, but that should be the start, not the endpoint of collaborative partnerships. Once working side by side, primary care and mental health personnel can interact in new ways to fully realize its benefits (Kates et al. 2023). Regular two-way communication facilitates the integration of care and the coordination of plans as well as the sharing of information on community resources. Co-location can also help to increase the skills and comfort of mental health providers in identifying and monitoring physical health problems – it is probably the most effective and lasting way of doing so – and to build integrated teams to assist with care that goes beyond just medical treatment, including effective health teaching.

And while the authors excluded socio-economic factors from their analysis, it is impossible to overstate the impact of poverty and its contribution to the development or worsening of physical health problems (Topor et al. 2016), whether through inadequate diet and food insecurity, climate inequity, inadequate or unhealthy housing and living environments or an inability to purchase healthcare aids or medication that are not covered (Luciano et al. 2021). Poverty reduction needs to be part of every individual care plan, and one critical policy change may be a minimum guaranteed income (Rizvi et al. 2024).

How to move forward

As the authors point out, building "Collaborations" between various stakeholders – based on the Equally Well approach (Te Pou 2014) – requires careful consideration. Who is best positioned to take the lead, can different groups come together around a single issue or will differing agendas fracture these coalitions, is there an optimum size and what can facilitate these arrangements, bearing in mind that every community's solution will likely differ from every other?

But to make real headway, there are three other steps we can take, in addition to a guaranteed minimum income:

1. We must increase the awareness of this crisis, and its possible solutions, among both the medical and the wider community. This issue needs to be front and centre in our public discourse until we reach a *tipping point*, where decision makers and funders can no longer ignore this national disgrace.
2. All mental health services should include an annual screening and physical exam of everyone living with a SPMI as an expected standard of care, as is now the case in the UK (NHS England n.d.) with Core20PLUS5.
3. As Ontario moves to guarantee access to a primary care provider for every citizen, could this guarantee extend beyond traditional clinics and practice to include individuals who will only receive the medical care they need if primary care services come to where they are living or receiving mental healthcare (Government of Ontario 2024)?

In raising this issue and linking it to a specific and potentially effective solution, Evans et al. (2024) have taken a helpful step in that direction.

Correspondence may be directed to Nick Kates by e-mail at nkates@mcmaster.ca.

References

Ayerbe, L., I. Forgnone, Q. Foguet-Boreu, E. González, J. Addo and S. Ayis. 2018. Disparities in the Management of Cardiovascular Risk Factors in Patients With Psychiatric Disorders: A Systematic Review and Meta-Analysis. *Psychological Medicine* 48(16): 2693–701. doi:10.1017/S0033291718000302.

De Rosa, C., G. Sampogna, M. Luciano, V. Del Vecchio, B. Pocai, G. Borriello et al. 2017. Improving Physical Health of Patients With Severe Mental Disorders: A Critical Review of Lifestyle Psychosocial Interventions. *Expert Review of Neurotherapeutics* 17: 667–81. doi:10.1080/14737175.2017.1325321.

Evans, C., C. Canning, M. Ambreen, B. Lo, M.R. Van Kesteren, C.M.E. Walker et al. 2024. A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings. *Healthcare Policy* 20(1): 19–28. doi:10.12927/hcpol.2024.27475.

Fiorillo, A., M. Luciano, M. Pompili and N. Sartorius. 2019. Editorial: Reducing the Mortality Gap in People With Severe Mental Disorders: The Role of Lifestyle Psychosocial Interventions. *Frontiers in Psychiatry* 20: 434. doi:10.3389/fpsyt.2019.00434.

Fiorillo, A. and N. Sartorius. 2021. Mortality Gap and Physical Comorbidity of People With Severe Mental Disorders: The Public Health Scandal. *Annals of General Psychiatry* 20(1): 52. doi:10.1186/s12991-021-00374-y.

Firth, J., M. Solmi, R.E. Wootton, D. Vancampfort, F.B. Schuch, E. Hoare et al. 2020. A Meta-Review of "Lifestyle Psychiatry": The Role of Exercise, Smoking, Diet and Sleep in the Prevention and Treatment of Mental Disorders. *World Psychiatry* 19: 360–80. doi:10.1002/wps.20773.

Government of Ontario. 2024, October 21. Province Appoints Dr. Jane Philpott as Chair of New Primary Care Action Team [News release]. Retrieved November 16, 2024. <https://news.ontario.ca/en/release/1005209/province-appoints-dr-jane-philpott-as-chair-of-new-primary-care-action-team>.

Kates, N. 2017. Mental Health and Primary Care: Contributing to Mental Health System Transformation in Canada. *Canadian Journal of Community Mental Health* 36(4): 33–67. doi:10.7870/cjcmh-2017-033.

Kates, N., N. Sunderji, V. Ng, M.J. Patriquin, J. Alloo, P. Mirwaldt et al. 2023. Collaborative Mental Health Care in Canada: Challenges, Opportunities and New Directions. *The Canadian Journal of Psychiatry* 68(5): 372–98. doi:10.1177/07067437221102201.

Luciano, M., G. Sampogna, V. Del Vecchio, V. Giallonardo, C. Palummo, I. Andriola et al. 2021. The Impact of Clinical and Social Factors on the Physical Health of People With Severe Mental Illness: Results From an Italian Multicentre Study. *Psychiatry Research* 303: 114073. doi:10.1016/j.psychres.2021.114073.

Mental Health Commission of Canada. 2021. *Towards Better Mental and Physical Health: Preventing and Managing Concurrent Mental and Physical Conditions: A Scoping and Rapid Realist Review*. Retrieved October 31, 2024. <https://mentalhealthcommission.ca/wp-content/uploads/2021/11/MHCC-CPAC-Chronic-Disease-Report-EN-Final-1.pdf>.

NHS England. n.d. Core20PLUS5 (Adults) – An Approach to Reducing Healthcare Inequalities. Retrieved November 16, 2024. <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>.

Rizvi, A., M. Kearns, M. Dignam, A. Coates, M.K. Sharp, O. Magwood et al. 2024. Effects of Guaranteed Basic Income Interventions on Poverty-Related Outcomes in High-Income Countries: A Systematic Review and Meta-Analysis. *Campbell Systematic Reviews* 20(2): e1414. doi:10.1002/cl2.1414.

Ronaldson, A., L. Elton, S. Jayakumar, A. Jieman, K. Halvorsrud and K. Bhui. 2020. Severe Mental Illness and Health Service Utilisation for Nonpsychiatric Medical Disorders: A Systematic Review and Meta-Analysis. *PLoS Medicine* 17(9): e1003284. doi:10.1371/journal.pmed.1003284.

Scharf, D.M., N.K. Eberhart, N.S. Hackbarth, M. Horvitz-Lennon, R. Beckman, B. Han et al. 2013, November 13. *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report*. RAND Corporation. Retrieved November 5, 2024. <https://aspe.hhs.gov/reports/evaluation-samhsa-primary-behavioral-health-care-integration-pbhci-grant-program-final-report>.

Te Pou. 2014. *Equally Well: Take Action to Improve Physical Health Outcomes for New Zealanders Who Experience Mental Illness and/or Addiction: A Consensus Position Paper*. Retrieved November 8, 2024. <https://www.equallywell.co.nz/wp-content/uploads/2022/10/EQW-A-consensus-position-paper.pdf>.

Thornicroft, G. 2011. Physical Health Disparities and Mental Illness: The Scandal of Premature Mortality. *The British Journal of Psychiatry* 199: 441–42. doi:10.1192/bjp.bp.111.092718.

Topor, A., I. Ljungqvist and E.L. Strandberg. 2016. Living in Poverty With Severe Mental Illness Coping With Double Trouble. *Nordic Social Work Research* 6(3): 201–10. doi:10.1080/2156857X.2015.1134629.

Ward, M.C. and B.G. Druss. 2017. Reverse Integration Initiatives for Individuals With Serious Mental Illness. *Focus* 15(3): 271–78. doi:10.1176/appi.focus.20170011.

World Health Organization (WHO). 2018, January 1. *Management of Physical Health Conditions in Adults With Severe Mental Disorders: WHO Guidelines*. Retrieved November 7, 2024. <https://www.who.int/publications/i/item/978-92-4-155038-3>.

Whose Accountability Matters in Long-Term Care?

Qui est responsable des soins de longue durée?

MICHAELLA MILLER, MSc
PhD Candidate
School of Public Health Sciences
University of Waterloo
Waterloo, ON

ELLEN MACEACHEN, PHD
Professor and Director
School of Public Health Sciences
University of Waterloo
Waterloo, ON

Abstract

In response to quality issues within the long-term care (LTC) sector, the Government of Ontario implemented the *Fixing Long-Term Care Act*, 2021, and updated accountability and compliance measures, including doubling fines for non-compliance and investing in 193 new inspectors. However, enforcement tactics and inspection regimes may contribute to harm and neglect the root issues within the sector. Fines for non-compliance may create catch-22 situations in which homes lack the funds to fix the root issues. Governments also dictate and determine much of the resource allocation within the LTC sector. Accountability and quality improvement should involve addressing performance problems as a system.

Résumé

En réponse aux problèmes de qualité dans le secteur des soins de longue durée (SLD), le gouvernement de l'Ontario a mis en œuvre la Loi de 2001 sur le redressement des soins de longue durée tout en mettant à jour les mesures de responsabilisation et de conformité, y

compris le doublement des amendes pour non-conformité et l'investissement dans la formation de 193 nouveaux inspecteurs. Cependant, les tactiques d'application de la loi et les régimes d'inspection peuvent contribuer à nuire aux problèmes fondamentaux du secteur. Les amendes pour non-conformité peuvent mener à de véritables dilemmes où les foyers de soins ne disposent pas des fonds nécessaires pour régler les problèmes à la racine. Les gouvernements dictent et déterminent également une grande partie de l'allocation des ressources dans le secteur des SLD. La responsabilisation et l'amélioration de la qualité devraient comprendre le traitement des problèmes de rendement en tant que système.

Introduction

In April 2022, the Government of Ontario legislated a new *Act* to regulate the long-term care (LTC) sector, the *Fixing Long-Term Care Act*, 2021. This legislation, as stated by the Ontario Government, is transformative and impacts the care work that is provided in LTC homes in Ontario to residents and the structure and organization of how care is provided (*Fixing Long-Term Care Act*, 2021). However, the impact of this regulation and its related accountability measures could backfire based on its approach to focus on individual LTC homes. This paper examines the implications of the *Fixing Long Term Care Act*, 2021, and the consequences of increased compliance measures when supports and resources for LTC are under-addressed. We examine policy implications at the federal, provincial and institutional levels and make recommendations to address current needs in the LTC sector.

Compliance and Accountability at the Institutional Level

The *Fixing Long Term Care Act*, 2021, updated regulations to include emergency preparedness; defined "caregiver" to ensure access during outbreaks; updated palliative care, infection prevention and control information; defined mandatory increase targets for direct care hours; included protections for whistleblowers; increased monetary penalties for non-compliance; and increased transparency of the licensing process (*Fixing Long Term Care Act*, 2021). However, the impact of these changes is yet to be seen.

Accountability measures within LTC are often focused on a strict assessment of whether the home was able to follow specific regulatory requirements set out by the Ministry of Long-Term Care and are accompanied by stiff fines. However, these fines may have the effect of compounding rather than fixing problems within LTC homes, especially when regulatory requirements do not account for context and circumstances. A lack of consideration of context is evident in the blunt way that the Act uses disciplinary measures and compliance protocols. The Act stipulates in regulation 162 (1) that:

> The authority to make an order or issue a notice under sections 155 to 161 [and 169/170] against a licensee who has not complied with a requirement under this Act applied regardless of the following, and they shall not be considered in deciding whether to exercise authority:
>
> 1. Whether the licensee took all reasonable steps to prevent the non-compliance.
> 2. Whether, at the time of the non-compliance, the licensee had an honest and reasonable belief in a set of facts that, if true, would have resulted in there not being any non-compliance. (*Fixing Long-Term Care Act*, 2021: 74).

Financial penalties for the Act's non-compliance have doubled as part of the implementation of the new *Act* (Government of Ontario 2023), and the Ontario Government has invested in 193 new inspectors for LTC homes, doubling the number of inspectors in the province to enforce accountability measures. As stated on the Ontario Government's website, they intend to drive quality through "enforcing this accountability through a strong inspections regime coupled with new and updated enforcement tools" (Government of Ontario 2023). The Ontario Government states that they have one inspector per every two LTC homes and that they are a leading province in inspector-to-home ratios (Government of Ontario 2023). However, these increases in enforcement and inspection tactics may not be supportive in driving improvement in LTC homes in the sectors' current context and may unintentionally contribute to harm. There are consequences of increased compliance measures when supports and resources for LTC are under-addressed.

Advocates and professionals in the sector have raised concerns about the punishment-oriented practice of fines to individual homes. As far back as 2018, the *Canadian Medical Association Journal* (Vogel 2018) released an article highlighting that LTC sectors' fines posed a catch-22 situation for homes that lack resources to correct the issues. The article suggested that the LTC root problems with staffing are not addressed with fines and are often due to factors beyond the homes' control, which may require additional funds to improve (Vogel 2018).

Removing funding from homes can adversely affect the quality of the care provided to residents, remove needed resources from homes, create moral distress among workers and prompt structural violence in the homes. For example, Daly et al. (2011) revealed how a cost-saving practice in Canadian LTC homes led to harmful care practices regarding diaper allocation for residents. Cost-cutting policies prevented staff from changing diapers until a blue line appeared when it was three-quarters wet, and staff were told to put wet diapers back on until they were full (Daly et al. 2011). While fines are meant to stop these kinds of practices, it may instead prompt them as a cost-saving tactic. Where the funds come from to pay financial penalties is determined by the home. In some cases, it may be from profits, while in others, wages, employee benefits, services and operational funds may be used at the expense of the staff and residents.

Are funding models to blame?

Questions remain about whose accountability is required for ensuring quality of care in LTC. Funding models in the LTC sector complicate issues of accountability. LTC homes consist of different ownership types, including homes that are non-profit, for-profit and public (municipal). Significant research suggests that for-profit models create negative consequences to residents (Armstrong et al. 2021) and consistently have care quality problems. Public models may have more funding to provide higher levels of care, hire needed staff and offer more support and recreation options than not-for-profit homes (Wohlgemut 2022). An examination of organizational practices of different LTC model types could illuminate what causes care discrepancies between and within different profit models. For example, different types of for-profit configurations have not been explored in depth to discern the defining aspects of profit that specifically contribute to harm. Ethically managed for-profit homes, such as those that use profit to support research initiatives, may have better outcomes than homes focused on profit generation and optimization of shareholder wealth. Ontario's Long-Term Care COVID-19 Commission also makes a distinction between mission-driven and commercial-driven ownership models, indicating that for-profit homes that are mission driven can and do provide good care (Marrocco et al. 2021). While provincial governments determine and control the ownership mix within the province (how many for-profit homes, number of beds, etc.), it is also likely that we will continue to rely on for-profit homes because of lack of government funding to provide for the growing need for LTC homes. Policies restricting private equity firms from treating LTC as an asset class may be necessary to address harm when financialized ownership prioritizes increasing revenue over quality of care or work (August 2022).

Government protections and resource provision

Our governments must also be held accountable for determining much of the resource availability and regulatory requirements placed on LTC organizations, such as mandates for staffing levels, staff-to-resident ratios and protections within the health system. At the federal level, access to appropriate care is hindered by a lack of clear or explicit legal information regarding a right for health under the *Canadian Charter of Rights and Freedoms* (Government of Canada 2024). Previous interpretation of the *Charter* has precluded the enactment of the *Charter's* protection of life, liberty and security of the person under Section 7 for healthcare as a fundamental right. Interpretation of the *Charter* deemed that adequate care was not a focus and would only protect individual rights in situations of "active deprivation" (Windwick 1994: 4). When evidence of inadequate resources preventing appropriate care provision for individuals in LTC was presented to the Supreme Court, legislation outlining the minimum standards of care were used to deny legal action. As such, the current interpretation of the *Charter* enables degradation of healthcare delivery when public funding is reduced or through "de-legislating" services (Windwick 1994: 4). Consequentially, our right to adequate healthcare is not actively protected.

As a provincially held jurisdiction, LTC is funded and regulated in Ontario by the Ministry of Long-Term Care. On December 6, 2023, the Auditor General of Ontario released their *Value-for-Money Audit: Long-Term Care Homes: Delivery of Resident-Centred Care*, reviewing LTC's delivery of care (Office of the Auditor General of Ontario 2023). They found several quality issues stemming from the ministry and a failure to support LTC organizations. Their report highlights that a core problem impeding ability to care for residents is a lack of resources and supports (Office of the Auditor General of Ontario 2023). Despite the ministry reporting that they had achieved their direct hours of care mandate, this audit found that a quarter of Ontario LTC homes failed to provide this level of care hours due to systemic staffing shortages and that their reliance on agency staff to fill staffing vacancies was nearly double the cost of a full-time employee (Office of the Auditor General of Ontario 2023). The Long-Term Care COVID-19 Commission also directly indicated misleading data use from the province in their reported *direct hours of care* mandate:

> During its investigation, the Commission reviewed various calculations of the daily care rate. It was apparent that the data being used were inconsistent and differed depending on the source. The Commission was advised that the data collected by the province did not reflect actual hours of care provided but, instead, the scheduled hours of care. Staffing shortages, holidays and sick days were not factored into the calculation, which led to an over-counting of actual care hours. In addition, care-hour data are consistently presented as an average. This does not mean that all residents in all homes receive the same amount of care. The presentation of staffing data as an average is misleading; the danger lies in the extremes, where insufficient care is being provided. (Marrocco et al. 2021: 57).

Calls for increased funding within LTC are not new and are often met with arguments about the financial constraints of the provincial budget. Arguments about the lack of available funds to raise wages or increase care support have impacted adequate financial provisions to LTC organizations. However, it is important to remember that budget constraints are determined by the provincial government and are based on political interests and priorities.

What Can Be Addressed?

The focus of accountability on single institutions neglects the system-level barriers to care quality that exist at both the provincial and the federal levels. While accountability measures are necessary for individual homes, much of the power to address the root problems in the LTC sector require government-level interventions through adequate protections and resource distribution.

In the *Fixing Long-Term Care Act*, 2021, financial penalties for not meeting care requirements that are placed on the individual homes, both in for-profit and not-for-profit homes, would primarily affect the workers' ability to provide care and resident outcomes.

System-level support to improve the ability of organizations to comply with the *Fixing Long-Term Care Act*, 2021, need to be in place before enforcement measures, such as fines, can be effective in driving improvement.

Policy makers can improve regulations by using updated evidence bases or developing legal frameworks that address organizations' *ability* to provide good and sufficient care rather than punishment-oriented enforcement measures. Governments can:

- Develop standards and clear regulation for the operation of homes, such as registered nurse-to-resident ratios appropriate for care. Provinces can implement evidence-based staffing standards that address working conditions for staff, including conditions creating burnout. Such standards would then be included in funding calculations for provincial funding envelopes for LTC homes. Provincial regulation would make the staffing skill mix and ratios a provincial decision rather than an organizational one and could help dismantle some of the tension between wealth generation and quality of care.
- Conduct an assessment of resource needs to adequately support the care of residents *and* the needs of the workers. The current mandate for direct hours of care was recommended by research conducted over 22 years ago when resident needs were not as high as they are today (CMS 2001).
- Add definitions of "adequate care" to legal frameworks on minimum care standards to ensure that care needs are appropriately met and to protect the right to health in Canada. Establishing an appropriate level of care would prevent denial of resources to support the needs of those in the sector.
- Develop a legal framework to address exploitive practices for profit maximization in for-profit homes beyond financial penalties and pursue legal inquiry into malpractice in operation of homes at the ownership and "C-suite" level. While arguably part of institutional accountability, shifting the consequence to the owners reduces the burden on those who live and work in the individual homes and their ability to provide care. This shift would need to be part of the provincial-level regulatory schema. Legal frameworks could extend beyond the LTC sector given the Ontario government's current push for for-profit healthcare. Legal sanctions that limit profit generation may require significant leadership buy-in. Investors and organizations that benefit from a current lack of legal frameworks may create political upset and impact stakeholder investments. However, the priority of providing high-quality care and an ethical workplace are arguably morally more important than wealth generation.

Barriers to implementing these recommendations include adequate funding, organizational disruption and legal burden. Provinces would be required to fund appropriate staffing infrastructure. Current budgets would require adjustment to properly address funding needs. In the short term, this may require additional funds; however, having a safe and sufficient healthcare workforce might reduce injury and illness, minimize use of costly contracted

agency staff and ultimately reduce the economic costs associated with staffing. However, this requires political buy-in for long-term system-level solutions that go beyond the four-year government cycles.

Conclusion

Accountability and quality improvement for LTC sectors should involve addressing performance problems *as a system* rather than as independent entities. If we are to genuinely improve conditions within this sector, accountability needs to be assessed and monitored at all levels, including how funding is allocated and spent, what rights to care exist, how adequate provision of care is protected, how information is gatekept and how these conditions interact to create the current state of LTC. Developing staffing standards that address care needs and workplace quality are essential to address the quality of care within the sector.

Correspondence may be directed to Michaella Miller by e-mail at m29mille@uwaterloo.ca.

References

Armstrong, P., H. Armstrong, D. Buchanan, T. Dean, G. Donner, A. Donner et al. 2021. *Investing in Care, Not Profit: Recommendations to Transform Long-Term Care in Ontario*. Retrieved December 20, 2023. <https://policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2021/05/Investing%20in%20care%20not%20profit%20report.pdf>.

August, M. 2022. Securitising Seniors Housing: The Financialisation of Real Estate and Social Reproduction in Retirement and Long-Term Care Homes. *Antipode* 54(3): 653–80. doi:10.1111/anti.12795.

Centers for Medicare and Medicaid Services. (CMS) 2001. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*. Retrieved October 5, 2023. <https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf>.

Daly, T., A. Banerjee, P. Armstrong, H. Armstrong and M. Szebehely. 2011. Lifting the "Violence Veil": Examining Working Conditions in Long-Term Care Facilities Using Iterative Mixed Methods. *Canadian Journal on Aging / La Revue canadienne du vieillissement* 30(2): 271–84. doi:10.1017/S071498081100016X.

Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1. Government of Ontario. Retrieved January 17, 2025. <https://www.ontario.ca/laws/statute/21f39>.

Government of Ontario. 2023, February 15. Published Plans and Annual Reports 2022–2023: Ministry of Long-Term Care. Retrieved December 20, 2023. <https://www.ontario.ca/page/published-plans-and-annual-reports-2022-2023-ministry-long-term-care>.

Government of Canada. 2024, April 16. The Canadian Charter of Rights and Freedoms. Retrieved January 17, 2025. <https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/>.

Marrocco, F.N., A. Coke and J. Kitts. 2021. *Ontario's Long-Term Care COVID-19 Commission: Final Report*. Retrevied September 3, 2024. <https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf>.

Office of the Auditor General of Ontario. 2023, December. *Value-for-Money Audit: Long-Term Care Homes: Delivery of Resident-Centred Care*. Retrieved December 17, 2023. <https://auditor.on.ca/en/content/annualreports/arreports/en23/AR_LTCresidential_en23.pdf>.

Vogel, L. 2018. New Fines Pose Financial Catch-22 for Ontario Long-Term Care. *CMAJ* 190(20): E630–31. doi:10.1503/cmaj.109-5600.

Windwick, B.F. 1994. Health-Care and Section 7 of the Canadian Charter of Rights and Freedoms. *Health Law Review* 3(1): 1–5.

Wohlgemut, J. 2022. Leveling the Playing Field in Long-Term Care. *CMAJ* 194(13): E501. doi:10.1503/cmaj.81199.

Commentary: Critical to Care – The Problem of Profit in Ontario's Long-Term Care Home Sector

Commentaire : Soins essentiels – le problème du profit dans le secteur des foyers de soins de longue durée en Ontario

SUSAN BRAEDLEY, MSW, PHD
Professor
School of Social Work
Carleton University
Ottawa, ON

Abstract

The search for profit in the Ontario long-term care (LTC) home sector means that inspections and fines are unlikely to drive quality improvement. For-profit ownership, operations and contracts thwart accountability for quality and financial stewardship while blocking full public reporting, thus preventing public oversight. Laying out the problems presented by the for-profit LTC homes' financial and operations infrastructure with examples, this commentary presents policy paths forward to address the problem of profit and improve accountability.

Résumé

La recherche du profit dans le secteur des foyers de soins de longue durée (SLD) en Ontario implique que les inspections et les amendes sont peu susceptibles d'améliorer la qualité. La propriété, les opérations et les contrats à but lucratif empêchent la reddition de comptes en matière de qualité et de gérance financière tout en bloquant l'établissement de rapports publics complets, ce qui nuit à la surveillance publique. En présentant les problèmes posés par l'infrastructure financière et opérationnelle des établissements à but lucratif, ce commentaire présente des pistes stratégiques pour résoudre le problème du profit et pour améliorer la responsabilisation.

Accounting for Care

Accountability for care quality and financial stewardship are intertwined problems in Ontario's long-term care (LTC) home system. Miller and MacEachen (2024) take up these issues in their analysis of the Ontario LTC home inspection regulations instituted in 2021 to argue for quality improvement at a system level. They warn that the legislation's deterrence-oriented accountability regime – that punishes individual LTC homes for non-compliance – will not drive quality improvement in a context that simply does not have sufficient staffing and other needed resources to care safely and well. For decades, Ontario has relied on deterrence-oriented audits and inspections (Choiniere et al. 2016). The recent legislation adds more inspectors and fines to the already available mechanisms, including compliance orders, withholding funds, appointing a temporary manager or revoking a license. The authors are correct that the additional measures are unlikely to drive quality improvement, given staffing and other resource issues (Miller and MacEachen 2024).

In their discussion, Miller and MacEachen (2024) note the higher incidence of quality problems in for-profit homes, a relatively consistent finding across many studies over more than a decade (a few examples are Akhtar-Danesh et al. 2022; Ronald et al. 2016; Tanuseputro et al. 2015). However, they fail to address the accountability challenge presented by the 57% of all Ontario LTC homes that have for-profit ownership, the largest percentage of any Canadian jurisdiction. Ascribing to a quality distinction between *good* mission-driven for-profit owners and *bad* commercial-driven for-profit owners (that includes private equity firms), Miller and MacEachen (2024) completely miss the structural inverse relationship between profit and accountability.

This issue is important. Ontarians have a huge stake in LTC homes' quality, first, because this service is mandated to offer care security to Ontario's most vulnerable, frail citizens and their families; second, because the sector should provide decent work to the thousands of Ontarians it employs; and third, because of the public investment and costs this sector represents. To drive quality improvement together with fiscal responsibility in the LTC home sector, accounting scholars have articulated three key types of accountability necessary to quality improvement (Graham et al. 2024). The first type, healthcare accountability, relies on the government LTC home inspection system and is Miller and MacEachen's (2024) focus. The second type is financial accountability for the use of public funds. The third type is ensuring accessible public information on these other types of accountability that can inform the media and advocates, who, in turn, inform the public (Graham et al. 2024: 6).

For-profit provision prevents or obscures all these types of accountability. First, it is difficult to impossible to know *how public funds are spent by for-profit providers, including how much public funding ends up as profit*. Second, it is increasingly difficult to know *who is responsible for care quality and has the power to address quality deficits*.

The Profit Problem

Similar to all municipal services and charities, municipal and non-profit charitable LTC homes are subject to regulations that require them to provide regular, publicly available financial information. Municipal LTC home funding allocations can be assessed by accessing municipal-audited financial statements and LTC committee minutes and reports. Non-profit charitable LTC homes' spending can be assessed through accessing annual reports, audited financial statements and information published by the Canada Revenue Agency. For-profit companies, however, operate under different legislative requirements, making these assessments difficult to impossible to access or decode.

Among for-profit corporations, differences in structure produce an assortment of barriers to financial and healthcare quality accountability. First, some for-profit LTC homes and chains are entirely privately owned and thus have no regulatory requirement to publicly disclose their financial information. For example, Schlegel, the fifth largest for-profit chain in Canada, is a fully privately owned business owned by one family. All its homes are in Ontario. Revera is a privately owned international chain that has a Canadian public sector pension plan as its principal shareholder and operates many Ontario LTC homes. It is impossible to determine how these owners and operators spend public monies or what funds end up as profit.

A second group of for-profits are publicly traded. These company financial statements are publicly available, but in many cases, their financial and operational infrastructure is so complex that determining how they spend public funds, and with what rate of profit, is obscured and disguised. Extendicare is one relatively straightforward Canadian example. It owns LTC homes in Ontario, Alberta and Manitoba and two companies that provide management (Extendicare Assist) and procurement services (SGP) to LTC homes and related services in the aforementioned provinces, plus British Columbia and Quebec. It also has a homecare division. An Extendicare presentation to investors in August 2024 refers to recent LTC home joint ventures with Revera and Axium, a limited-partnership LTC home investor. This infrastructure complexity obscures clear information about where public monies go and the rate of profit in any facility or province. However, the presentation notes that recent increases in Ontario LTC funding have more than offset cost increases due to inflation, producing more net revenue and profit (Extendicare 2024). Furthermore, management services reported a 50–55% net operating income margin – an incredible rate of profit that, in LTC homes, comes primarily out of public monies. It is worth noting that LTC homes managed by Extendicare Assist had COVID-19 death rates of 81%, well above the industry average, with reports that residents were not cleaned or fed. Yet, by 2023, Extendicare Assist had won contracts to manage 134 Revera and other Ontario LTC homes, or about 20% of all LTC homes in the province (Roy 2023).

Both privately owned and publicly traded LTC home ownership types intertwine in complex corporate forms, including private equity firms, real estate investment trusts

(REITs) and institutional investors interested in cashing in on senior's housing. These interests have made substantial investments in both retirement homes and LTC homes, a sector ranked as Canada's third *hottest* real estate investment in 2019. In 2020, financial firms had acquired 22% of all Canadian LTC homes outside Quebec (August 2022: 654). Both REITs and private equity firm investors expect a high return from these financial instruments. Executive compensation is tied to profit maximization and asset value increases over short timeframes, with penalties for failures to achieve targets (August 2022; Harrington et al. 2014). Chartwell is one such company. During the pandemic, Chartwell refused "staff personal protective equipment … voted against living wages for employees but paid out stable investor distributions during the pandemic and issued record-high executive bonuses" (August 2022: 656).

A third group is the many LTC homes of all ownership types, including for-profit, municipal and non-profit homes, that contract out one or more of the food services, laundry services, housekeeping, human resources and payroll, management and/or even some of their clinical nursing and other care staffing to for-profit companies. Often, residents and families are unaware of these sub-contractors, and they are not often mentioned on LTC home websites either. However, Schlegel Homes and Revera have contracted with Extendicare Assist to manage some of their LTC homes.

This discussion only skims the surface of the sector's financial complexity. For example, some LTC home ownership configurations mean that land and/or buildings are owned by one company and operations owned by another that, in turn, sub-contracts to one or more companies for some service delivery. Furthermore, LTC homes, or pieces of them, are being bought, sold, closed and opened in a flurry of market activity (Armstrong 2023; Roy 2023). The accountability consequences are obvious. Not only is it difficult to know where public monies go, but also it is incredibly difficult to sort out which entity is responsible for non-compliance or making necessary quality improvements.

The results of failed accountability mechanisms are starkly illustrated in the case of Orchard Villa, with a government failure to hold for-profit providers accountable amid a murky, layered financial and operational infrastructure. Orchard Villa was one of five Ontario LTC homes taken over by the military at the height of the COVID-19 pandemic, with 78 of its 233 residents dying from the virus. The military report describes finding cockroaches, flies, rotten food, inappropriate infection control, residents left in soiled undergarments, residents left without proper hydration or mouth care, serious resident health concerns left unattended, residents sleeping on bare mattresses due to lack of linens and many more quality problems (4th Canadian Division Joint Task Force 2020). Orchard Villa is owned by CVH (No. 6), a division of Southbridge Care Homes Inc, a property development company. Now, Southbridge Health Care LP is managed by Southbridge Health Care GP Inc, which is a wholly owned subsidiary of Southbridge Capital Inc. This is a limited partnership, with no requirement to publish financial information (Armstrong 2024).

Furthermore, Extendicare Assist, the management firm with tremendous profit that managed homes with high mortality rates during the pandemic, was managing Orchard Villa.

When the military report was released, Ontario premier Doug Ford said, "Nothing drives me more crazy than these big corporations saying, 'No, we're watching dollars and cents.' There's a lot more we can do. Number one, we can pull their license" (Bochove 2020). Yet, Orchard Villa's license was not pulled. Confounding logic, in 2023, the Ministry of Long-Term Care awarded Orchard Villa a 30-year license that includes an initial expansion of 87 new beds and a promise for more, a decision that is now the subject of a court challenge.

This result was not due to regulatory loopholes, the lack of compliance mechanisms or an absence of policy alternatives. It is, however, a problem of accountability by both owners and government, shaped by the problem of profit.

Policy Solutions

In agreement with Miller and MacEachen (2024), my assessment is that system-level measures can improve the three kinds of accountability laid out earlier in this commentary, but they must directly address the problem of profit. In a recent international forum on profit in LTC, Armstrong (2024) laid out strategies to address this issue, and they are worth repeating. First, governments can acquire and retain land and buildings, so that licenses can be revoked from for-profit license holders that fail to provide adequate care without losing facilities. Second, regulations can require full transparency of both the ownership and operation of every individual LTC home and of the financial flows among *related parties* involved in LTC home ownership and operations. Third, contracting out could be eliminated completely, whether to *related parties* or to independent providers. Furthermore, given that many LTC homes are owned by international companies that transfer money to tax havens, Armstrong (2024) recommends that owners should be required to pay taxes in the jurisdiction(s) in which they own or operate a facility. Finally, LTC homes should be required to fully and regularly report on their direct care staffing numbers and skill mix, with rules that prevent institutional *gaming*, such as LTC home staffing reports of direct staffing hours that fail to exclude staff who are absent while on sick leave and vacation.

To be successful, these measures require political will and a wise long-term public investment strategy to acquire and maintain land and buildings. Furthermore, they require regulations that will likely deter LTC home sector for-profit investment. To date, no Ontario government has shown interest in this path, although in other countries, many of these measures are implemented or being considered. Without them, the problem of profit continues and so does the problem with quality.

Correspondence may be directed to Susan Braedley by e-mail at susan.braedley@carleton.ca.

References

4th Canadian Division Joint Task Force (Central). 2020. OP Laser - JTFC Observations in Long-term Care Facilities in Ontario. Retrieved February 4, 2025. <https://eapon.ca/wp-content/uploads/2021/09/JTFC-Observations-in-LTCF-in-ON.pdf>.

Akhtar-Danesh, N., A. Baumann, M. Crea-Arsenio and V. Antonipillai. 2022. COVID-19 Excess Mortality Among Long-Term Care Residents in Ontario, Canada. *PLoS ONE* 17(1): e0262807. doi:10.1371/journal.pone.0262807.

Armstrong, H. 2023. Piercing the Corporate Veil: Nursing Home Ownership in Turbulent Times. P. Armstrong and S. Braedley, eds., *Care Homes in a Turbulent Era: Do They Have a Future?* (pp. 19–33). Edward Elgar Publishing.

Armstrong, H. 2024, March 13. *What Does Profitization Look Like in Canada's Long-Term Care Sector? Presentation to "Risky Business: Profitizing Long Term Care."* The Care Economy Forum. Retrieved January 20, 2025. <https://thecareeconomy.ca/wp-content/uploads/2024/04/Armstrong-LTC-profitization-talk-13mar24.pdf>.

August, M. 2022. Securitising Seniors Housing: The Financialisation of Real Estate and Social Reproduction in Retirement and Long-Term Care Homes. *Antipode* 54(3): 653–80. doi:10.1111/anti.12795.

Bochove, D. 2020, May 28. Ontario Threatens to Pull Licenses of Care Homes if Unsafe. *Bloomberg News*. Retrieved January 20, 2025. <https://news.bloomberglaw.com/health-law-and-business/ontario-threatens-to-pull-licenses-of-care-homes-if-unsafe>.

Choiniere, J.A., M. Doupe, M. Goldmann, C. Harrington, F.F. Jacobsen, L. Lloyd et al. 2016. Mapping Nursing Home Inspections & Audits in Six Countries. *Ageing International* 41(1): 40–61. doi:10.1007/s12126-015-9230-6.

Extendicare. 2024, December. *Extendicare Growing Together. Investor Presentation*. Retrieved January 20, 2025. <https://www.extendicare.com/investors/overview/>.

Graham, C., D. Himick and P.-L. Nappert. 2024. The Dissipation of Corporate Accountability: Deaths of the Elderly in For-Profit Care Homes During the Coronavirus Pandemic. *Critical Perspectives on Accounting* 99: 102595. doi:10.1016/j.cpa.2023.102595.

Harrington, C., J. Stockton and S. Hooper. 2014. The Effects of Regulation and Litigation on a Large For-Profit Nursing Home Chain. *Journal of Health Politics, Policy and Law* 39(4): 781–809. doi:10.1215/03616878-2743039.

Miller, M. and E. MacEachen. 2024. Whose Accountability Matters in Long-Term Care? *Healthcare Policy* 20(1): 34–40. doi:10.12927/hcpol.2024.27420.

Ronald, L.A., M.J. McGregor, C. Harrington, A. Pollock and J. Lexchin. 2016. Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change? *PLoS Medicine* 13(4): e1001995. doi:10.1371/journal.pmed.1001995.

Roy, I. 2023, March 13. The Private Deals Remaking Long-Term Care. *The Local*. Retrieved January 20, 2025. <https://thelocal.to/long-term-care-extendicare-revera-private-care/>.

Tanuseputro, P., M. Chalifoux, C. Bennett, A. Gruneir, S.E. Bronskill, P. Walker et al. 2015. Hospitalization and Mortality Rates in Long-Term Care Facilities: Does For-Profit Status Matter? *Journal of the American Medical Directors Association* 16(10): 874–83. doi:10.1016/j.jamda.2015.06.004.

How Good Reforms Fail: The Warning Example of Alberta's Borderless EMS System

Comment les bonnes réformes échouent : l'avertissement du système des SMU sans frontière de l'Alberta

JANNA NEWTON, MPP
Student
School of Public Policy
University of Calgary
Calgary, AB

TRAVIS CARPENTER, MD, MPH
Assistant Professor
Temerty Faculty of Medicine
University of Toronto
Staff Physician
St. Joseph's Health Centre and Unity Health Toronto
Toronto, ON

JENNIFER ZWICKER, PHD, MPP
Associate Professor
School of Public Policy
University of Calgary
Calgary, AB

Abstract

When ill, many Albertans' first interaction with their healthcare system is Alberta's centralized emergency medical services (EMS) system operated by Alberta Health Services (AHS). The media has become saturated with articles articulating concerns about lagging response time, limited ambulance availability and poor work conditions. As Alberta undergoes restructuring of the EMS system by Alberta Health and AHS, there are lessons to be learned from prior EMS restructuring. It is crucial that front-line paramedics are heard and

their concerns addressed regarding implemented policies. Several policy recommendations focus on optimizing operations and improving the working environment for paramedics in the long term.

Résumé

Lorsque les Albertains sont malades, leur première interaction avec le système de santé est le système centralisé des services médicaux d'urgence (SMU) de l'Alberta, géré par les Services de santé de l'Alberta (SAA). Les médias sont saturés d'articles faisant état de préoccupations au sujet du retard dans le temps de réponse, de la disponibilité limitée des ambulances et des mauvaises conditions de travail. Alors que les SAA et Santé Alberta procèdent à une restructuration du système des SMU, il y a des leçons à tirer des restructurations antérieures. Il est crucial que les ambulanciers paramédicaux de première ligne soient entendus et que leurs préoccupations concernant les politiques mises en œuvre soient prises en compte. Plusieurs recommandations de politiques sont axées sur l'optimisation des opérations et l'amélioration à long terme de l'environnement de travail pour les ambulanciers paramédicaux.

Introduction

Across Canada, long emergency medical services (EMS) response times continue to make headlines. The reality beyond the headlines is the implications of not getting emergency care when you need it most. With the current restructuring of Alberta Health Services (AHS) and Alberta Health, there are important lessons to be learned from prior EMS restructuring. Red alerts (Raymond 2024) and long EMS response times are visible and concerning indicators of increasing workloads and inadequate capacity but also of broader governance failures in the health system overall (Kreindler et al. 2022). A fundamental lack of staffed ambulances is a predominant driver of deterioration in these indicators, but this challenge also reflects broader inefficiencies that compromise staffing or appropriate use of available resources. The challenges within EMS have a longer-standing history (particularly with increasing call volumes and staffing shortages), and provincial health systems have for some time been adjusting and adapting practices in an effort to reduce wait times and maintain quality of care. In this commentary, we discuss Alberta's implementation of a borderless EMS system as a case study. First, we focus on how policy decisions targeting restructuring can fail to generate expected improvements when broader issues remain unaddressed. Based on analysis of interviews with paramedics in Alberta (Newton et al. 2024), we then discuss how this current crisis in EMS service delivery can be addressed with more comprehensive operational enhancements, measures to empower paramedics to deliver more efficient and effective care, as well as supports to create a more sustainable and resilient staffing model.

The Shift to a Borderless EMS System in Alberta

In 2009, Alberta implemented a borderless, provincially funded EMS system. This restructuring was aimed at significantly enhancing service delivery by optimizing resource availability and use across the province, formally integrating EMS into the healthcare system and assuming management of services from disparate municipalities. Instead of geography determining which municipal ambulance would respond to an emergency, a borderless EMS system meant that the closest ambulance would respond to an emergency regardless of the municipality it originated from. This reform also standardized treatment practices across Alberta, an important step to ensuring that patients across the province received consistent and appropriate care. Under AHS, resource management became more efficient and responsive, with one unified system sharing scarce healthcare resources. Finally, this policy also brought the benefit of online medical consultation, improving data management and eliminating the need to compile disparate data from different regions, enabling performance to be better tracked (Rusjan and Kiauta 2019) and audited by AHS.

Unfortunately, even seemingly sound health system reforms can fail to achieve the intended impact when broader issues remain unaddressed. These common-sense reforms were designed to enhance integration, standardization and efficiency by eliminating regional resource disputes and response time discrepancies with improved province-wide service delivery (AHS 2009). The borderless system explicitly aimed to efficiently optimize use and distribution of ambulances across the province: ambulances would now *flex* or move to cover other communities when their ambulances are out on calls or unavailable due to staffing shortages.

These best-laid plans resulted in negative impacts on rural communities. Larger communities are structurally inclined to poach resources of smaller ones: larger centres such as Calgary and Edmonton had higher overall call volumes and were a natural magnet for units in the surrounding communities. This meant small communities did not have emergency units positioned to respond. Data from 2023 show that rural emergency ambulances surrounding Calgary were called into Calgary 1,178 times in a year, or 98 times a month, just for non-urgent inter-facility transfers alone (Offin 2024). Considering paramedics can generally respond and transport up to four emergency calls in a 12-hour shift, this number represents considerable non-urgent EMS utilization. With only one or two ambulances, rural communities were left vulnerable, with potential response times getting dangerously long once their home units were diverted elsewhere.

With respect to the borderless system resulting in frequent and prolonged diversions of units away from their home communities, this continues to have outsized counterproductive effects on costs, efficiency and staff burnout. The reforms were also a strong contributor to worsening staffing issues and burnout, as being drawn far from home for the majority of their 12-hour shifts is needlessly and frequently pushing paramedics into overtime, because after providing care to those in urban centres, these crews need to restock and return to their home communities. As a result, economic efficiency is reduced because of increased

staff costs (Ryan 2021). The strain on paramedics has led to more than 80,000 vacant hours according to data from January 1, 2023, to October 27, 2023, and full-time staff leaving positions to work part-time or casual, which reduces the reliability of the workforce (Villani 2024). For paramedics, increasing call volumes, staffing shortages and emergency department (ED) waits have all contributed to a more difficult work environment and increased expectations that EMS serves as a catchall backfilling other healthcare gaps across the province (Bellefontaine 2023; Rumbolt 2018). The specific challenges that paramedics in Alberta face highlight the nature of most other pressing multifactorial health system challenges in Canada. Health professionals consistently report being overworked (Jones 2022), unable to adequately fill their intended roles and struggling to provide quality care because of broader system factors.

As a paramedic working in this system, JN (the lead author) experienced first-hand the challenges and consequences of system dysfunction and ever-longer response times. This led the lead author to ask why conditions seemed to worsen after this reform was implemented. Our 60- to 90-minute virtual interviews with front-line providers (Newton et al. 2024) suggest that today's perceived failures (Ryan 2021) of the borderless system mostly do not reflect fundamental flaws in the policy itself but rather an ongoing lack of resources and support for EMS providers overall, which is not just limited to Alberta. Worsening metrics include evidence from December 2021 showing that in Calgary and Edmonton, there were 695 red alerts – meaning no available ambulances in either city for a portion of time (Easton 2022). Such critical shortages likely reflect inadequate accommodations for increases in call volumes – up by 39% since 2017, with a disproportionate increase in rural Alberta (PWC 2022). Research suggests that the predominant drivers of these increases in call volumes are (presumably predictable variables of) population growth and an aging population (Toloo et al. 2011).

Addressing Core EMS Policy Issues

Addressing the long EMS response times is a critical issue that requires action. While a reversion to fractured service and inefficient local municipal fiefdoms is clearly undesirable, re-institution of some guardrails (at least temporarily) to address these identified shortcomings of the borderless system is likely necessary before long-term solutions can be formally put into place. Participants in our qualitative research referenced First Nations communities (with independent EMS services) responding outside their geographic area only for higher acuity calls, as well as considering more thoughtful minimums for safe coverage of specific geographic areas before dispatching the remaining available units to other areas (Newton et al. 2024). This specific policy at least helps ensure that First Nations communities have an available ambulance. For EMS, thoughtfully deploying new resources to directly increase staffing and unit availability across all areas of the province is a crucial first step to ensuring efficient service delivery and patient safety, but special attention needs to be directed at

the deeper compounding problems that nullify or undermine any benefit of new or redeployed resources.

Broader solutions, expected to be more durable and impactful, again need to concurrently address a multitude of interconnected factors (Government of Alberta 2022; Newton et al. 2024). Often, these measures will be part of broader health reforms to address issues like ED overcrowding with knock-on effects that put timely and effective EMS service in peril. One recent example highlighted by our research participants was AHS's implementation in March 2023 of improved monitoring and enforcement of a targeted 45-minute hospital offload time where hospital EDs were obligated to assume appropriate patient care rapidly so that paramedics could return to the community within the 45-minute timeframe. Early indications from our research suggest that the change has been transformative in improving the availability of EMS resources and in boosting morale (Newton et al. 2024). However, participants were aware of how this then shifts the workload to staff in the ED. Some evidence has shown that this can improve the length of stay and reduce the time to treatment, possibly translating to improved patient-centred outcomes (Crilly et al. 2020).

Further recommended reforms also supported by the Alberta EMS Provincial Advisory Committee include education and resources to reduce low-acuity calls and to find ways to empower paramedics to safely and efficiently connect patients with appropriate alternate venues for more urgent (but not emergent) care (Government of Alberta 2022; Newton et al. 2024; Sporer 2017). Supporting EMS in this manner by providing the capability for operational flexibility improves efficacy and also helps avoid crippling bottlenecks like ED offloads. Solutions like this that integrate with the broader health system require careful investment in staff and resources beyond the most traditional of EMS roles. The expansion of community care paramedics is a crucial option to directly provide urgent care (instead of the emergent care, which EMS is designed to respond to) and has shown to be a cost-effective strategy in Ontario (Xie et al. 2021).

In addition to these operational enhancements, addressing the EMS working environment is also critically important for ensuring a sustainable prehospital health system (Cash et al. 2019). In the context where burnout and attrition are prominent contributors to the staffing issues most EMS systems face (Basnawi 2024), our research participants frequently highlighted how informal expectations of being a touchstone for patients unable to otherwise access community services was a major contributor to increased workload, frustration and stress (Newton et al. 2024). Conversely, properly equipping, supporting and empowering providers promises to be a powerful intervention to counter this burnout that is compromising staffing levels (Ericsson et al. 2022). Supports that can alleviate the workload and concurrently enhance morale for EMS include effective shared 811 response, mobile outreach teams, more innovative and flexible scheduling and utilizing the full scope of practice. If progress can be made in this regard, a virtuous circle may be able to take hold where enhanced staffing supports an arrest in attrition that allows the system to function in the manner intended.

To support and complement this imperative of empowering providers, front-line providers also recommended that mentorship programs and allowing rotation through more diverse EMS positions could further reduce burnout and attrition. With a large and constant influx of young practitioners, mentorship programs are needed to support new hires with clinical knowledge and also to create a supportive, safe environment to ask questions (Burgess et al. 2018). Diversifying positions to incorporate more education, training and (perhaps most critically) consistent alternative daytime clinical work (such as community paramedicine) into regular schedules could dramatically alleviate provider stress. The steps to achieve this involve EMS system administrators, consulting with front-line staff and developing positions that incorporate new roles progressively and effectively into daily operations. Harnessing these existing desires within the profession to provide more diverse and effective care must therefore concurrently use human resource management strategies that explicitly look beyond short-term crises and instead focus on the (more critical) longer-term health of the EMS workforce. Administrators need to be supported in being less reactionary and avoid chasing short-term metrics (or placating political pressure) by placing undue demands on providers (such as not limiting involuntary overtime), especially vulnerable junior paramedics whose retention is essential to the health of the prehospital care system.

System Reform Cannot Happen in Isolation

System-level reforms that fall short in achieving the intended impact is a common experience across many Canadian health systems. Policies aimed at restructuring should be proactive in thinking through unintended consequences. Recent failures to accommodate broader stresses on the emergency response system turned strengths of the streamlined province-wide borderless approach into a weakness – namely, the seemingly obvious benefits of breaking down borders.

This EMS case study highlights that effective change is hard and multiple strategies are needed to address the multifactorial problems plaguing Alberta's and other provinces' EMS systems.

Conclusion

Overall, the current predicament that Alberta's borderless EMS system finds itself in is a strong example of how even advantageous and seemingly common-sense health system reforms can still fail to make more substantial impacts when broader issues remain unaddressed. Effective reforms must always work to identify structural impediments to their intended mechanisms of success and strive to mitigate factors that could attenuate or sabotage hoped-for improvements. For this example, we have discussed the potential efficacy of more ambitious operational and cultural changes in supporting staffing and allowing the implemented borderless system to function as effectively and as intended. In EMS and other health sectors, policy makers in Alberta and across Canada need to demonstrate that they can learn from similar experiences with past reforms and address such complexities. Albertans and Canadians do not have the time to wait.

Declaration of Interest

Janna Newton is employed by Alberta Health Services as a primary care paramedic.

Source of Funding

Janna Newton was financially supported by the Carpenter Medical Corporation's Consulting Health Policy: Studentship.

Correspondence may be directed to Janna Newton by e-mail at janna.newton@ucalgary.ca.

References

Alberta Health Services (AHS). 2009, March 20. EMS Transition on Track for April 1. Retrieved June 1, 2024. <https://www.albertahealthservices.ca/news/releases/2009/Page496.aspx>.

Basnawi, A. 2024. Addressing Challenges in EMS Department Operations: A Comprehensive Analysis of Key Issues and Solution. *Emergency Care and Medicine* 1(1): 11–23. doi:10.3390/ecm1010003.

Bellefontaine, M. 2023, January 22. High EMS Workloads Creating Problems for Paramedic Students Seeking Work Placements. *CBC News*. Retrieved June 1, 2024. <https://www.cbc.ca/news/canada/edmonton/high-ems-workloads-creating-problems-for-paramedic-students-seeking-work-placements-1.6721689>.

Burgess, A., C. van Diggele and C. Mellis. 2018. Mentorship in the Health Professions: A Review. *The Clinical Teacher* 15(3): 197–202. doi:10.1111/tct.12756.

Cash, R.E., K. White-Mills, R.P. Crowe, M.K. Rivard and A.R. Panchal. 2019. Workplace Incivility Among Nationally Certified EMS Professionals and Associations With Workforce-Reducing Factors and Organizational Culture. *Prehospital Emergency Care* 23(3): 346–55. doi:10.1080/10903127.2018.1502383.

Crilly, J., A.N.B. Johnston, M. Wallis, J. O'Dwyer, J. Byrnes, P. Scuffham et al. 2020. Improving Emergency Department Transfer for Patients Arriving by Ambulance: A Retrospective Observational Study. *Emergency Medicine Australasia* 32(2): 271–80. doi:10.1111/1742-6723.13407.

Easton, R. 2022, February 28. Alberta's Ambulance Response Times Have Worsened From the Start of the Pandemic, Data Shows. *CBC News*. Retrieved June 6, 2024 <https://www.cbc.ca/news/canada/calgary/ems-dispatch-red-alert-disconnect-foip-data-1.6365457>.

Ericsson, C.R., V. Lindström, A. Rudman and H. Nordquist. 2022. Paramedics' Perceptions of Job Demands and Resources in Finnish Emergency Medical Services: A Qualitative Study. *BMC Health Services Research* 22(1): 1469. doi:10.1186/s12913-022-08856-9.

Government of Alberta. 2022. *Alberta EMS Provincial Advisory Committee: Final Report*. Retrieved July 20, 2023. <https://open.alberta.ca/dataset/662927da-9567-4b38-8dd5-6f57636ec5ec/resource/0325bbde-b0c1-47ab-8a5a-90b509da86bc/download/hlth-alberta-emergency-medical-services-provincial-advisory-committee-final-report.pdf>.

Jones, A.M. 2022, November 18. Health-Care Workers Logged More Hours of Overtime in 2021 Than in a Decade: Report. *CTVNews*. Retrieved July 20, 2023. <https://www.ctvnews.ca/health/health-care-workers-logged-more-hours-of-overtime-in-2021-than-in-a-decade-report-1.6158482>.

Kreindler, S., Z. Aboud, S. Hastings, S. Winters, K. Johnson, S. Mallinson et al. 2022. How Do Health Systems Address Patient Flow When Services Are Misaligned With Population Needs? A Qualitative Study. *International Journal of Health Policy and Management* 11(8): 1362–72. doi:10.34172/ijhpm.2021.36.

Newton, J., T. Carpenter and J. Zwicker. 2024. Exploring Paramedic Perspectives on Emergency Medical Service (EMS) Delivery in Alberta: A Qualitative Study. *BMC Emergency Medicine* 24: 66. doi:10.1186/s12873-024-00986-z.

Offin, S. 2024, March 4. Are Rural Communities Suffering From a Paramedic Shortage in Calgary? *Global News*. Retrieved June 1, 2024. <https://globalnews.ca/video/10335225/are-rural-communities-suffering-from-a-paramedic-shortage-in-calgary/>.

PricewaterhouseCoopers LLP (PWC). 2022, October. *Alberta Emergency Medical Services Dispatch Review*. Retrieved June 1, 2024. <https://open.alberta.ca/dataset/959c7d28-3748-4835-91a8-07891ced6d37/resource/df22e579-62aa-4577-8bd0-31b9cebae44b/download/hlth-pwc-alberta-medical-emergency-services-dispatch-review.pdf>.

Raymond, T. 2024, June 18. City of Ottawa Calling on Province to Help Deal With Paramedic Offload Delays at Local Hospitals. *CTV News Ottawa*. Retrieved July 20, 2024. <https://ottawa.ctvnews.ca/city-of-ottawa-calling-on-province-to-help-deal-with-paramedic-offload-delays-at-local-hospitals-1.6930237>.

Rumbolt, R. 2018, October 5. EMS Workers Spend Many Unproductive Hours Waiting in Hospital Hallways: Survey. *Calgary Herald*. Retrieved June 18, 2023. <https://calgaryherald.com/news/local-news/ems-workers-spend-many-unproductive-hours-waiting-in-hospital-hallways-survey>.

Rusjan, B. and M. Kiauta. 2019. Improving Healthcare Through Process Standardization: A General Hospital Case Study. *International Journal of Health Care Quality Assurance* 32(2): 459–69. doi:10.1108/IJHCQA-06-2018-0142.

Ryan, S. 2021, August 2. Alberta Paramedics Overworked and Exhausted: Union. *Global News*. Retrieved July 20, 2023. <https://globalnews.ca/news/8071718/alberta-paramedics-ems-emt-overworked-exhausted-union/>.

Sporer, K.A. 2017. 911 Patient Redirection. *Prehospital and Disaster Medicine* 32(6): 589–92. doi:10.1017/S1049023X17006999.

Toloo, G.S., G. Fitzgerald, P. Aitken, K. Chu, J. Ting and V. Tippett. 2011. *Emergency Health Services: Demand & Service Delivery Models – Monograph 1: Literature Review and Activity Trends*. Queensland University of Technology.

Villani, M. 2024, January 4. Calgary Paramedics Experiencing Burnout as Shifts Go Unfilled. *Calgary CTV News*. Retrieved July 20, 2024. <https://calgary.ctvnews.ca/calgary-paramedics-experiencing-burnout-as-shifts-go-unfilled-1.6709531>.

Xie, F., J. Yan, G. Agarwal and R. Ferron. 2021. Economic Analysis of Mobile Integrated Health Care Delivered by Emergency Medical Services Paramedic Teams. *JAMA Network Open* 4(2): e210055. doi:10.1001/jamanetworkopen.2021.0055.

Commentary: The Canadian Healthcare Crisis and the Emerging Role of Paramedicine

Commentaire : La crise des soins de santé au Canada et le rôle émergent du personnel paramédical

MICHAEL FELDMAN, MD, PhD, FRCPC
Assistant Professor
Department of Medicine
University of Toronto
Medical Director
Sunnybrook Centre for Prehospital Medicine
Toronto, ON

DONALD L. PIERCE
Senior Field Manager
Ontario Ministry of Health
Emergency Health Program Management and Delivery Branch
Toronto, ON

Abstract

Canada's healthcare system is struggling to provide primary care and acute care for ever-increasing numbers of patients, who are turning to emergency medical services (EMS) agencies to obtain timely care when in need. Paramedics are experiencing the downstream effects of these challenges, leading to a diversion of ambulances away from the communities they serve, increased call volumes and staff burnout. Well-intended policies, such as a borderless EMS system, should not be used as a stopgap measure to service non-emergency calls, and there should be a defined and enforceable process for returning ambulances to their home communities. Community paramedic and alternative treatment destinations represent an evolving area of paramedic practice that could offer solutions to some of the challenges faced by the healthcare system and relieve some of the occupational issues faced by paramedics. However, to fully realize the benefits offered by some of these changes in paramedic practice, they must adopt evidence-based best practices and be accompanied by relevant changes in paramedic education and supportive government policy.

Résumé

Le système de santé du Canada a du mal à fournir des soins primaires et des soins de courte durée à un nombre toujours croissant de patients qui se tournent vers les services médicaux d'urgence (SMU) pour obtenir des soins en temps opportun lorsqu'ils en ont besoin. Les ambulanciers paramédicaux subissent les effets de ces défis, ce qui entraîne un détournement des ambulances loin des collectivités qu'ils desservent, une augmentation du volume d'appels et l'épuisement du personnel. Les politiques bien intentionnées, comme le système de SMU sans frontière, ne devraient pas être utilisées comme solution de rechange pour répondre aux appels non urgents, et il devrait y avoir un processus défini et exécutoire pour le retour des ambulanciers dans leurs collectivités d'origine. Les services paramédicaux communautaires et le choix d'autres établissements pour le traitement sont des domaines en évolution dans la pratique des ambulanciers paramédicaux. Ces domaines pourraient apporter des solutions à certains défis auxquels le système de santé est confronté et pourraient soulager certains problèmes professionnels auxquels sont confrontés les ambulanciers paramédicaux. Toutefois, pour tirer pleinement parti des avantages offerts par ces changements dans la pratique paramédicale, ils doivent adopter des pratiques exemplaires fondées sur les données probantes et s'accompagner de changements pertinents dans la formation du personnel paramédical et dans les politiques gouvernementales de soutien.

The Impact of Canada's Healthcare Crisis on Access to Emergency Medical Services Care

Canada's healthcare system is in crisis, with ever-increasing numbers of patients turning to emergency medical services (EMS) and emergency departments to obtain needed care. None of the issues identified in the accompanying paper by Newton et al. (2024) have to do with the clinical practice of paramedics, but the problems affecting paramedics arise because of issues in the healthcare system. A borderless EMS system ensures that a patient suffering an emergency has a likelihood of getting an ambulance predicated solely on the whereabouts of all available paramedic resources, not just those associated with a specific municipality. The borderless system in Alberta is but one example of how EMS policies were created to address healthcare resources made increasingly scarce by the widespread and systemic deficiencies in our healthcare system. Ontario has a similar borderless system that is ensured through legislation and where the minister of health is responsible for maintaining a balanced and integrated system of paramedic services, coordinated through Ontario's centralized ambulance communication centres. However, the borderless system policy should not result in the *poaching* of ambulances to service non-emergency transfers in the larger cities. This use of the borderless system policy is not acceptable and may even be unethical when it deprives rural

and First Nations communities of paramedic resources, exacerbating the existing disparities that these communities face in access to healthcare. An equitable borderless system policy should have metrics in place to monitor its performance in responding to emergency calls, where timely response has proven beneficial in improving health outcomes for a number of clinical conditions, including trauma, stroke, heart attacks, mental health and addictions and out-of-hospital cardiac arrest. There should also be a defined and enforceable process for returning ambulances to their home communities in a timely manner as soon as there are no remaining emergency calls that require a response.

Community Paramedicine's Evolving Role

One central concept the authors were able to highlight in their article (Newton et al. 2024) is the diversity of front-line EMS providers that now exist in many paramedic services, including community paramedics who are empowered to look beyond acute healthcare crises and manage people in their homes. These paramedics may serve increasing roles in healthcare education and promotion, diverting care away from overcrowded, understaffed hospitals, provide access to alternative destinations and enable virtual access to physicians for service and care. Community paramedic programs are an area of evolving but as yet incompletely developed practice that have the potential to contribute solutions to some of the problems in the broader healthcare system.

Although this was not addressed by Newton et al. (2024), the extent to which the public will tolerate adverse clinical outcomes that take place in the community setting is yet to be defined. For example, a patient with a benign-sounding complaint, such as fatigue, who later is found to have had sepsis or a myocardial infarction, may result in some taking a dim view of non-transport or alternative destinations. Perhaps, a safe middle ground might be to offer a clinical online consult with a dedicated EMS physician for certain clinical presentations before deciding on treatment courses at home or at alternative, non-hospital sites. We agree that innovative programs in community paramedicine not only have promise for their patients but may also have benefits by decreasing occupational stress injury for the responders, increase their sense of purpose and increase morale, thereby making a difference in long-term retention of the paramedic workforce. For these changes to successfully take hold, paramedic education at the college or university level needs to include training in all these aspects of paramedic practice. In addition, governments could play a role by supporting the development of community paramedic programs and alternative destination and care practices that incorporate performance metrics and adopt evidence-based best practices.

Conclusion

Partnering with paramedics to develop a healthcare safety net to manage structural challenges in the Canadian healthcare system is a Sisyphean task, one that cannot be borne by EMS agencies and their governing policies alone. Paramedics are suffering the effects of Canada's

healthcare crisis, just like the other sectors of our healthcare system. Failing to consider and study the potential roles of paramedics in the broader healthcare system, beyond just their responses to emergency calls, risks undermining the very things they have been doing well and are striving for. In the end, the solution to some of the challenges in EMS brought about by the crisis in Canadian healthcare may be addressed by including paramedics in the broader healthcare discussion, examining proposed solutions they bring to the table, ensuring that there is a supportive government and educational system in place and applying similar metrics for measuring outcomes they might be able to offer.

Correspondence may be directed to Michael Feldman by e-mail at michael.feldman@sunnybrook.ca.

Reference

Newton, J., T. Carpenter and J. Zwicker. 2024. How Good Reforms Fail: The Warning Example of Alberta's Borderless EMS System. *Healthcare Policy* 20(1): 47–54. doi:10.12927/hcpol.2024.27476.

DATA MATTERS

Are Small Teams a Viable Strategy to Deliver Early Psychosis Intervention Services in Rural Areas? An Ontario Fidelity Study

Les petites équipes constituent-elles une stratégie viable pour offrir des services d'intervention précoce contre la psychose dans les régions rurales? Une étude ontarienne sur la fidélité

AVRA SELICK, PhD
Project Scientist
Provincial System Support Program
Centre for Addiction and Mental Health
Toronto, ON

GORDON LANGILL, MSW, RSW
Executive Director
Peterborough Youth Services
Peterborough, ON

SANDY BROOKS, MED
Evaluator
Provincial System Support Program
Centre for Addiction and Mental Health
Toronto, ON

JANET DURBIN, PhD
Scientist
Provincial System Support Program
Centre for Addiction and Mental Health
Associate Professor
Department of Psychiatry
University of Toronto
Toronto, ON

Abstract

Early psychosis intervention (EPI) is a complex model of care designed to be delivered by a large multidisciplinary team. However, in practice, it is often delivered by very small teams, particularly in rural areas. This study analyzed fidelity data from over half of Ontario EPI programs (n = 24) to compare model fidelity in programs with smaller (≤2.1 staff) and larger (≥4.3 staff) teams. Few differences were identified, suggesting that small teams may be a viable option to deliver the EPI model, although both large and small teams were challenged to deliver almost a third of the elements of care.

Résumé

L'intervention précoce en cas de psychose (IPE) est un modèle complexe de soins conçus pour être prodigués par une grande équipe multidisciplinaire. Cependant, dans la pratique, ces soins sont souvent fournis par de très petites équipes, en particulier dans les zones rurales. Cette étude analyse les données sur la fidélité de plus de la moitié des programmes d'IPE en Ontario (n = 24) afin de comparer les modèles de fidélité entre les équipes plus petites (≤2,1 employés) et plus grandes (≥4,3 employés). Peu de différences ont été relevées, ce qui laisse entendre que les petites équipes peuvent constituer une bonne solution de rechange pour offrir le modèle d'IPE, bien que les grandes et les petites équipes aient rencontré des défis pour offrir près du tiers des éléments de soins dudit modèle.

Background

Early psychosis intervention (EPI) is internationally recognized as a best practice to treat young people experiencing their first episode of psychosis (Bertolote and McGorry 2005). EPI is a comprehensive model of care that integrates multiple evidence-based practices and is designed to be delivered by a multidisciplinary team (Bennett and RAISE Connection Program Investigators 2018; Mueser et al. 2015; NHS England 2016). EPI programs have been implemented across Canada, and several provinces, including Ontario, Quebec, Nova Scotia and British Colombia, have prioritized EPI as a core component of their mental health services (Bertulies-Esposito et al. 2022; Durbin et al. 2016; Iyer et al. 2015).

Canada, similar to many jurisdictions, has large sparsely populated regions (Statistics Canada 2022). Supporting equitable healthcare delivery in these rural and remote regions is an ongoing challenge (Weinhold and Gurtner 2014; Whaley 2020). For a specialized program like EPI, the lower population density in rural and remote regions may mean insufficient cases to justify a large multidisciplinary team and difficulty recruiting professionals to fill all team roles (Cheng et al. 2014; Pipkin 2021). Similar challenges have been raised for other team-based mental health treatment models (Luciano et al. 2014; Meyer and

Morrissey 2007). As a result, smaller teams than the model specifies may be tasked with treatment delivery, with less certain results. In Ontario, there are currently 45 EPI programs and, according to a 2014 survey, almost half had two or fewer full-time equivalent (FTE) staff (Standards Implementation Steering Committee 2015).

Limited prior research in Canada or elsewhere has examined whether small teams are able to deliver the full EPI model. One US study of 36 EPI teams reported a positive but non-significant correlation between team FTEs and fidelity to the model (Addington et al. 2020). A 2004 Australian study found that fidelity was variable for three EPI teams that consisted of two EPI providers embedded in general mental health teams (O'Kearney et al. 2004). Finally, a 2012 survey of Ontario programs found that programs serving catchment areas with lower population density, all of which had two or fewer FTEs, were more challenged to deliver some elements of care but more likely to deliver others (Durbin et al. 2016). This research, however, is now over a decade old and was based on a key informant survey rather than more rigorous fidelity assessments.

Fidelity assessments are a strategy to measure whether the delivery of an intervention adheres to the intended practice model. In Ontario, the Early Psychosis Intervention Ontario Network (EPION) and the Centre for Addiction and Mental Health partnered to assess EPI program fidelity to the model to support quality improvement. In the present study, we utilized these data to compare fidelity for large and small EPI teams.

Methods

Fidelity assessment scale and process

Fidelity assessments were conducted using the First Episode Psychosis Services Fidelity Scale (Addington et al. 2016, 2020). The scale includes 31 items, with each item rated between 1 (not implemented) and 5 (fully implemented). A rating of 4 is considered satisfactory. Fidelity assessments were conducted by teams of two to three trained independent assessors. Fidelity ratings were assigned based on interviews with staff, clients and family members, an audit of 10 randomly selected client health records and program administrative data. Prior to the COVID-19 pandemic, data were collected through a two-day site visit. During the pandemic, interviews were conducted remotely and chart audits were conducted by local staff, trained and supervised remotely. More detail on the fidelity model has been published previously (Selick et al. 2021). Data on program characteristics were obtained through the fidelity assessment or existing administrative data collected by EPION.

Sample

Between 2017 and 2022, all Ontario EPI programs were invited to receive an assessment. Participation was voluntary and programs were included annually on a first come, first served basis until capacity was reached based on the available budget to support assessments. Twenty-four of Ontario's 45 EPI programs received at least one fidelity assessment. If programs received more than one assessment, only the most recent was included in this study.

Analysis

Given that a mix of small and large teams were assessed each year, we did not expect time-based differences to impact results. Therefore, data for the 24 programs were combined and a mean fidelity rating was calculated per item. Over time, a small number of items were modified by the scale developer to increase clarity, rating reliability and alignment with the most recent evidence (Addington et al. 2020), with additional minor modifications made by the study team for the Ontario context. Of the 31 items, rating criteria for 19 items were unchanged and could be calculated for all 24 programs; criteria for 12 items that had changed could be calculated for 16 programs.

While specific guidance on the minimum FTEs necessary for EPI delivery is lacking, it seemed likely that delivering the model with two or fewer FTEs would pose a challenge. In our study sample, nine programs reported 2.1 or fewer clinical FTEs and 15 reported 4.3 or more clinical FTEs, excluding psychiatry (Table 1). Programs were therefore grouped as larger (≥4.3 clinical FTEs) and smaller (≤2.1 clinical FTEs). Mann-Whitney *U* tests were used to compare the mean item ratings between groups, and the percentage of item mean scores that met adherence (≥4) was calculated per group. Analyses were conducted using IBM SPSS Statistics 27 (2020). Ratings are presented in a heat map to visually show patterns in the findings. Ethics approval was obtained from the Centre for Addiction and Mental Health research ethics board.

Results

Sample

Of the 24 participating programs, nine were categorized as small teams and 15 as large teams (Table 1). Programs were located across Ontario. Although large teams had much larger overall caseloads (mean = 146 vs. 20), large and small teams had similar caseloads per clinical FTE. Compared with large teams, small teams were more likely to operate in rural areas and serve smaller catchment area populations.

Fidelity scores

Large teams had a mean fidelity score of 4 or greater for 19 items (63%); small teams had a mean fidelity score of 4 or greater for 17 items (55%) (Table 2). There were three items where large teams met the target rating of 4 but small teams did not: *psychiatrist role on team*, *multidisciplinary team* and *practicing team lead*. There was one item where small teams met the target rating of 4 but large teams did not: *timely contact with referred individual*. Mean item fidelity ratings were significantly different ($p < 0.05$) for only one item: *practicing team lead* (small = 3.4 vs. large = 4.5). For both large and small teams, there were 11 items with mean scores below 4.

TABLE 1. Sample description

Program	Clinical FTEs*	Total caseload	Caseload per FTE	Ontario region	Urban/rural	Catchment area population
Large (*n* = 15)						
Program 1	22.1	502	22.7	Central	Mainly urban	>500,000
Program 2	15.4	281	18.2	East	Mixed	>500,000
Program 3	14	90	6.4	Central	Mixed	200,000–500,000
Program 4	13	101	7.8	Central	Mixed	>500,000
Program 5	11	151	13.7	Central	Mainly urban	>500,000
Program 6	10.7	208	19.4	East	Mixed	200,000–500,000
Program 7	10.7	70	6.5	West	Mixed	>500,000
Program 8	10.4	177	17.0	West	Mainly urban	>500,000
Program 9	9.5	118	12.4	West	Mixed	200,000–500,000
Program 10	9	83	9.2	North	Mixed	200,000–500,000
Program 11	6.8	130	19.1	Central	Mainly urban	>500,000
Program 12	6	104	17.3	East	Mainly urban	100,000–200,000
Program 13	5	106	21.2	West	Mainly urban	200,000–500,000
Program 14	5	36	7.2	West	Mixed	100,000–200,000
Program 15	4.3	39	9.1	Central	Mainly urban	>500,000
Mean	10.2	146.4	13.8	N/A	N/A	N/A
Small (*n* = 9)						
Program 16	2.1	21	10.0	East	Mainly rural	20,000–100,000
Program 17	2	15	7.5	West	Mixed	20,000–100,000
Program 18	1.8	27	15.0	East	Mixed	20,000–100,000
Program 19	1.5	29	19.3	West	Mixed	100,000–200,000
Program 20	1.5	29	19.3	East	Mixed	20,000–100,000
Program 21	1.4	16	11.4	East	Mainly rural	<20,000
Program 22	1	10	10.0	North	Mixed	20,000–100,000
Program 23	1	13	13.0	East	Mixed	20,000–100,000
Program 24	1	23	23.0	East	Mixed	20,000–100,000
Mean	1.5	20.3	14.3	N/A	N/A	N/A

*Excluding psychiatry.
FTE = full-time equivalent.

TABLE 2. Fidelity ratings for large and small programs

Items	Small (*n* = 9) Mean (range)	Large (*n* = 15) Mean (range)	Total (*n* = 24) Mean (range)	*p*-value
Assignment of case manager	5.0 (5–5)	5.0 (5–5)	5.0 (5–5)	1.00
Antipsychotic medication prescription	4.9 (4–5)	5.0 (5–5)	5.0 (4–5)	0.68
Crisis intervention services§	5.0 (5–5)	4.9 (4–5)	4.9 (4–5)	0.76
Participant/provider ratio	4.9 (4–5)	4.9 (4–5)	4.9 (2–4)	0.93
Comprehensive psychosocial needs assessment§	4.6 (3–5)	5.0 (5–5)	4.8 (3–5)	0.35
Timely contact after discharge from hospital	5.0 (5–5)	4.7 (2–5)	4.8 (2–5)	0.45
Explicit diagnostic admission criteria	4.4 (3–5)	4.7 (3–5)	4.6 (3–5)	0.35
Patient retention§	4.7 (4–5)	4.6 (4–5)	4.6 (4–5)	0.61
Antipsychotic dosing within recommendations	4.3 (3–5)	4.7 (4–5)	4.6 (3–5)	0.35
Annual formal comprehensive assessment§	4.1 (1–5)	4.8 (3–5)	4.5 (1–5)	0.54
Program duration	4.3 (3–5)	4.5 (4–5)	4.5 (3–5)	0.60
Comprehensive clinical assessment	4.2 (2–5)	4.5 (1–5)	4.4 (1–5)	0.60
Patient psychoeducation	4.2 (1–5)	4.4 (1–5)	4.3 (1–5)	0.82
Psychiatrist role on team	3.8 (1–5)	4.6 (3–5)	4.3 (1–5)	0.29
Services for patients with substance use disorders§	4.0 (2–5)	4.3 (3–5)	4.2 (2–5)	0.54
Communication with in-patient services§	4.4 (3–5)	4.0 (2–5)	4.2 (2–5)	0.54
Multidisciplinary team	3.9 (1–5)	4.3 (2–5)	4.2 (1–5)	0.29
Family involvement in assessments	4.1 (2–5)	4.1 (2–5)	4.1 (2–5)	0.95
Practicing team leader	3.4 (1–4)	4.5 (4–5)	4.1 (1–5)	0.01*
Timely contact with referred individual	4.3 (1–5)	3.5 (1–5)	3.8 (1–5)	0.12
Family education and support§	3.4 (1–5)	3.9 (1–5)	3.7 (1–5)	0.92
Treatment/care plan after initial assessment§	3.1 (1–5)	3.7 (1–5)	3.4 (1–5)	0.47
Active engagement and retention	3.8 (1–5)	3.2 (1–5)	3.4 (1–5)	0.48
Supporting health management§	3.0 (1–5)	3.6 (1–5)	3.3 (1–5)	0.54
Weekly multidisciplinary meetings	2.4 (1–5)	3.8 (1–5)	3.3 (1–5)	0.07
Psychiatrist caseload	2.3 (1–5)	2.9 (1–5)	2.7 (1–5)	0.56
Targeted public education	2.2 (1–5)	2.8 (1–5)	2.6 (1–5)	0.26
Early intervention§	2.3 (1–4)	1.9 (1–3)	2.1 (1–4)	0.54
Cognitive behavioural therapy	1.9 (1–5)	1.5 (1–5)	1.7 (1–5)	0.52
Supported employment§	1.0 (1–1)	1.3 (1–4)	1.2 (1–4)	0.76
Supported education§	1.0 (1–1)	1.0 (1-1)	1.0 (1-1)	1.00

Note: Heat map represents higher fidelity scores in green and lower fidelity scores in red.
§*n* = 16 (small = 6; large = 10).
*Significant ($p < 0.05$).

Discussion

The present study compared model fidelity in large and small Ontario EPI programs. Our data showed that small teams delivered similar care to large teams in most areas of practice. The main differences identified pertained to team structure and how team members worked together, elements intended to support high-quality service delivery. Small teams were significantly less likely to have a practicing team lead. Although not significant, small teams were also less likely to achieve high fidelity for psychiatrist integration into the team and weekly team meetings. From the study data, it is unclear whether lower fidelity in team practices affected care delivery as few additional areas were identified where large teams performed better.

In addition, there were a number of items for which both large and small teams did not achieve satisfactory fidelity scores, especially related to psychosocial treatment delivery. Manualized models of EPI such as NAVIGATE and OnTrack may help strengthen consistency and quality of care (George et al. 2022). These models, however, expect that EPI is delivered by larger multidisciplinary teams with specialized skills. In Ontario, the feasibility of implementing these manualized models in smaller EPI teams and possible need for adaptations is currently being investigated (Kozloff et al. 2020). It is also possible that some low-performing items (e.g., *active engagement and retention*, which focuses on community visits) were impacted by the COVID-19 pandemic and will improve without system intervention.

Implications for research

An important next step is to examine the strategies used by small teams to support fidelity in order to identify effective strategies that could be implemented more widely. Small programs in Ontario historically operated as part of networks (Standards Implementation Steering Committee 2015), although current data are lacking. Network structures varied, but, similar to other jurisdictions (Behan et al. 2017; Pipkin 2021), they typically included a larger *hub* team supporting multiple smaller *spokes* or multiple small teams that partnered to support each other. Some networks were formalized and some were informal. Levels and types of support received from network partners ranged widely, including staff training, standardized tools, supervision and specialist consultation. Some small teams were also embedded within a general mental health team and leveraged supports from the broader team. For small teams, it is likely that an ability to leverage supports from partners, both EPI and non-EPI, is key to supporting fidelity.

It is also important to compare small teams to other strategies for rural delivery. Specialist outreach or multi-site programs are another potential approach to serving rural areas. In these models, a large central team delivers treatment to surrounding rural areas through telemedicine, travelling clinics, operating multiple sites and/or consultation to local providers. Currently, there is limited evidence on the relative effectiveness of these different models, and it has been suggested that different models may be necessary in different contexts (Behan et al. 2017; Cheng et al. 2014; Pipkin 2021).

Implications for policy and practice

The present study suggests that small teams may be a viable model for delivering EPI in regions that cannot support a full team. Formalizing and systematically implementing networks, particularly with the expansion in telemedicine use during the COVID-19 pandemic, may help support small team fidelity. Ongoing quality monitoring, including fidelity and outcome measurement, can help identify successful practices for serving rural and remote areas. There were also a number of items for which both large and small teams did not achieve satisfactory fidelity scores, suggesting that all programs require additional support to deliver the full model. Improving practice in these areas may require centralized intervention to provide clear guidance on expected practice, training, monitoring and coaching. In many jurisdictions, this role is performed by intermediary organizations, which work with programs and funders to support system implementation of evidence-based practices (Durbin et al. 2021; Proctor et al. 2019).

Limitations

A limitation of applied system evaluation is that measures must evolve in response to system needs and emerging evidence on best practices. In the present study, changes to the fidelity scale over time reduced the sample for some items. Participation in fidelity assessments was voluntary and it is possible that the study sample included higher-performing programs. That said, extensive efforts were used to encourage participation and the study sample included diverse programs from across the province. It is also possible that there are elements of practice where large and small programs differed that were not captured in the fidelity scale. The scale can only capture quality of delivery in a limited way and it does not include some elements of care (e.g., peer support), which are receiving increasing recognition as important components of EPI. The study does not allow us to reach conclusions on the minimum number of staff necessary to delivery EPI with fidelity; however, it provides some preliminary evidence on the feasibility of delivering the model with very small teams.

Conclusion

This study found that EPI programs with very small teams had similar fidelity scores to programs with larger teams for most elements of practice, suggesting that small teams may be a viable way to support equitable access to EPI services across the province. However, both large and small programs struggled to deliver almost a third of the elements of care. All programs may need centralized support to deliver the full model.

Correspondence may be directed to Avra Selick by e-mail at avra.selick@camh.ca.

References

Addington, D.E., R. Norman, G.R. Bond, T. Sale, R. Melton, E. McKenzie et al. 2016. Development and Testing of the First-Episode Psychosis Services Fidelity Scale. *Psychiatric Services* 67(9): 1023–25. doi:10.1176/appi.ps.201500398.

Addington, D., V. Noel, M. Landers and G.R. Bond. 2020. Reliability and Feasibility of the First-Episode Psychosis Services Fidelity Scale–Revised for Remote Assessment. *Psychiatric Services* 71(12): 1245–51. doi:10.1176/appi.ps.202000072.

Behan, C., S. Masterson and M. Clarke. 2017. Systematic Review of the Evidence for Service Models Delivering Early Intervention in Psychosis Outside the Stand-Alone Centre. *Early Intervention in Psychiatry* 11(1): 3–13. doi:10.1111/EIP.12334.

Bennett, M. and RAISE Connection Program Investigators. 2018. *On Track NY Team Manual*. Retrieved January 16, 2025. Centre for Practice Innovations and Office of Mental Health. <https://ontrackny.org/Portals/1/Files/Resources/Team%20Manual%207-2018%20Revision.pdf?ver=2018-08-03-125125-913>.

Bertolote, J. and P. McGorry. 2005. Early Intervention and Recovery for Young People With Early Psychosis: Consensus Statement. *The British Journal of Psychiatry* 187(S48): S116–19. doi:10.1192/bjp.187.48.s116.

Bertulies-Esposito, B., S. Iyer and A. Abdel-Baki. 2022. The Impact of Policy Changes, Dedicated Funding and Implementation Support on Early Intervention Programs for Psychosis. *The Canadian Journal of Psychiatry* 67(8): 585–97. doi:10.1177/07067437211065726.

Cheng, C., C.S. Dewa, G. Langill, M. Fata and D. Loong. 2014. Rural and Remote Early Psychosis Intervention Services: The Gordian Knot of Early Intervention. *Early Intervention in Psychiatry* 8(4): 396–405. doi:10.1111/eip.12076.

Durbin, J., A. Selick, D. Hierlihy, S. Moss and C. Cheng. 2016. A First Step in System Improvement: A Survey of Early Psychosis Intervention Programmes in Ontario. *Early Intervention in Psychiatry* 10(6): 485–93. doi:10.1111/eip.12201.

Durbin, J., A. Selick, R. Coriandoli, M. Roebuck and G. Langill. 2021, September 21. *Building a High Quality Mental Health and Addictions System: Learning From Four Intermediary Organizations*. Centre for Addiction and Mental Health. Retrieved January 16, 2025. <https://help4psychosis.ca/wp-content/uploads/2022/05/Intermediary_Pofiles__FINAL_Report_Sept_21_2021.pdf>.

George, P., S.S. Ghose, H.H. Goldman, J. O'Brien, T.C. Daley, L.B. Dixon et al. 2022. Growth of Coordinated Specialty Care in the United States With Changes in Federal Funding Policies: 2014–2018. *Psychiatric Services* 73(12): 1346–51. doi:10.1176/appi.ps.202100600.

Iyer, S., G. Jordan, K. Macdonald, R. Joober and A. Malla. 2015. Early Intervention for Psychosis: A Canadian Perspective. *The Journal of Nervous and Mental Disease* 203(5): 356–64. doi:10.1097/NMD.0000000000000288.

Kozloff, N., G. Foussias, J. Durbin, S. Sockalingam, J. Addington, D. Addington et al. 2020. Early Psychosis Intervention-Spreading Evidence-Based Treatment (EPI-SET): Protocol for an Effectiveness-Implementation Study of a Structured Model of Care for Psychosis in Youth and Emerging Adults. *BMJ Open* 10(6): e34280. doi:10.1136/bmjopen-2019-034280.

Luciano, A., G.R. Bond, R.E. Drake and D.R. Becker. 2014. Is High Fidelity to Supported Employment Equally Attainable in Small and Large Communities? *Community Mental Health Journal* 50(1): 46–50. doi:10.1007/s10597-013-9687-2.

Meyer, P.S. and J.P. Morrissey. 2007. A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. *Psychiatric Services* 58(1): 121–27. doi:10.1176/ps.2007.58.1.121.

Mueser, K.T., D.L. Penn, J. Addington, M.F. Brunette, S. Gingerich, S.M. Glynn et al. 2015. The NAVIGATE Program for First-Episode Psychosis: Rationale, Overview, and Description of Psychosocial Components. *Psychiatric Services* 66(7): 680–90. doi:10.1176/APPI.PS.201400413.

NHS England. 2016, April. *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance*. Retrieved January 16, 2025. <https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/early-intervention-in-psychosis/nccmh-eip-guidance.pdf?sfvrsn=ae517db4_4>.

O'Kearney, R., G. Garland, M. Welch, L. Kanowski and S. Fitzgerald. 2004. Factors Predicting Program Fidelity and Delivery of an Early Intervention Program for First Episode Psychosis in Rural Australia. *Australian e-Journal for the Advancement of Mental Health* 3(2): 75–83. doi:10.5172/jamh.3.2.75.

Pipkin, A. 2021. Evidence Base for Early Intervention in Psychosis Services in Rural Areas: A Critical Review. *Early Intervention in Psychiatry* 15(4): 762–74. doi:10.1111/EIP.13019.

Proctor, E., C. Hooley, A. Morse, S. McCrary, H. Kim and P.L. Kohl. 2019. Intermediary/Purveyor Organizations for Evidence-Based Interventions in the US Child Mental Health: Characteristics and Implementation Strategies. *Implementation Science* 14(1): 1–14. doi:10.1186/s13012-018-0845-3.

Selick, A., G. Langil, C. Cheng. D. Addington, S. Archie, S. Butt et al. 2021. Feasibility and Acceptability of a Volunteer Peer Fidelity Assessment Model in Early Psychosis Intervention Programmes in Ontario: Results From a Pilot Study. *Early Intervention in Psychiatry* 15(3): 480–85. doi:10.1111/eip.12961.

Standards Implementation Steering Committee. 2015, July. *After Release of the Ontario Early Psychosis Intervention (EPI) Program Standards: Results of the 2014 EPI Program Survey of Current Practices in Relation to the Standards: Executive Summary*. Centre for Addiction and Mental Health and the Early Psychosis Intervention Ontario Network. Retrieved January 16, 2025. <https://kmb.camh.ca/uploads/5ce5d2e6-99a8-4c0d-ad82-2e3465ddaf84>.

Statistics Canada. 2022, February 9. Population Growth in Canada's Rural Areas, 2016 to 2021. Retrieved January 16, 2025. <https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm>.

Weinhold, I. and S. Gurtner. 2014. Understanding Shortages of Sufficient Health Care in Rural Areas. *Health Policy* 118(2): 201–14. doi:10.1016/J.HEALTHPOL.2014.07.018.

Whaley, J. 2020. A Longitudinal Review of Rural Health Policy in Ontario. *Healthcare Management Forum* 33(2): 53–56. doi:10.1177/0840470419886617.

RESEARCH PAPER

Implementing Active Offer of Services in Both Official Languages in a Hospital Setting in Ontario

Mise en œuvre de l'offre active de services dans les deux langues officielles dans un milieu hospitalier en Ontario

KATRINE SAUVÉ-SCHENK, PhD, OT REG (ONT)
Assistant Professor
School of Rehabilitation Sciences
University of Ottawa
Scientist
Institut du Savoir Montfort
Ottawa, ON

JACINTHE SAVARD, PhD, OT REG (ONT)
Professor Emeritus
School of Rehabilitation Sciences
University of Ottawa
Scientist
Institut du Savoir Montfort
Ottawa, ON

FRANÇOIS DURAND, PhD
Professor
Telfer School of Management
University of Ottawa
Scientist
Institut du Savoir Montfort
Ottawa, ON

Abstract

Providing services in a patient's preferred language is linked to safe and quality care. This paper presents the process and outcomes of implementing practices of active offer (AO) of French-language services in a hospital setting in a region of Ontario with a low density of francophones. Participating unit managers and site coordinators selected AO practices and carried out an implementation plan. The implementation's success was linked to the support

received from higher management and site coordinators. Challenges included the managers' rival priorities and perceived language priorities. This process could be applied to meet the needs of other language communities.

Résumé

La prestation de services dans la langue préférée du patient est liée à des soins sécuritaires et de qualité. Ce document présente le processus et les résultats de la mise en œuvre des pratiques d'offre active de services en français dans un milieu hospitalier situé dans une région ontarienne à faible densité de francophones. Les gestionnaires d'unité et les coordonnateurs locaux participants ont choisi les pratiques d'offre active et ont déployé un plan de mise en œuvre. Le succès de la mise en œuvre était lié au soutien reçu de la part des cadres supérieurs et des coordonnateurs locaux. Les défis rencontrés comprenaient les priorités concurrentes des gestionnaires et les priorités linguistiques perçues. Ce processus pourrait être appliqué pour répondre aux besoins d'autres communautés linguistiques.

Introduction

Language discordance, which occurs when healthcare professionals and patients are not proficient in the same language, is linked to decreased quality of care and patient safety (Bowen 2015; Reaume et al. 2024). Canada has two official languages, and the impact of language discordance has been observed for people whose main language is neither of the official languages and for members of the official language minority communities (OLMCs). OLMCs are groups of people whose preferred language is French but live in English majority-language regions outside the province of Quebec or whose preferred language is English but live in the French-majority province of Quebec (de Moissac and Bowen 2018; Seale et al. 2022).

Many francophones, defined as individuals who have French as their mother tongue or first official language, especially those living in OLMCs, have indicated that they would prefer receiving their health services in French; however, only a smaller percentage will ask for French-language services (FLS) and an even smaller percentage will receive them (Léger 2020). There are several reasons for the low number of FLS requests, including a concern that waitlists are longer (de Moissac and Bowen 2017; Savard et al. 2020) or that services will be of lower quality (Léger 2020). Some francophones may not request FLS as they consider themselves capable in both official languages or more proficient in English. Thus, bilingual francophones may often accept health services in English. Importantly, second-language proficiency at home or at work does not mean that patients are equally proficient in a healthcare context (Itzhak et al. 2017). The resulting language discordance can create challenges. For example, patients may ask healthcare providers fewer questions, have difficulties understanding medical details (Sauvé-Schenk et al. 2024) or experience issues with consent

(Peled 2018). There are many reported situations of francophones being unable to effectively use English in a highly emotional or stressful health situation, for example, when presenting to the emergency room for mental health assistance (Vandyk et al. 2022).

Studies have shown that actively offering services in both official languages can increase the request and use of FLS (Bélanger et al. 2018). Increasing active offer (AO) shows the potential to reduce events of language discordance in a healthcare encounter and increase quality and safety of care. AO is defined as "an invitation, verbal or written, to speak in the official language of one's choice. The offer to speak in the official language of choice must precede the request for services" (translated from Bouchard et al. 2012: 46).

Canadian provinces have different laws and policies mandating the provision of services in French and English. For example, bilingual services are provided in all publicly funded healthcare organizations in New Brunswick and only in some organizations that are identified or designated by the provincial government in Ontario and Manitoba (Foucher 2017). In Ontario, fully or partially publicly funded health organizations are not automatically designated to offer services in French; rather, an organization can self-identify or be identified by the Local Health Integration Network (LHIN) to receive a designation. Having a designation means that the organization must provide services in both official languages, and being identified implies that the organization is working toward an official designation (Government of Ontario 2023).

Over the past 20 years, there have been governmental efforts to increase access to health services in the official languages, both from the provincial government (e.g., the introduction of prescribed principles of AO under the *French Language Services Act*, 1990 [O. Reg. 544/22]) and from the federal government (e.g., Health Canada's financial support resulting from the action plans and roadmaps for the official languages [Bouchard et al. 2024]). Société Santé en français (SSF) is one such funded national organization with a mandate to improve access to French-language health services for OLMCs (SSF 2021). Importantly, the SSF was instrumental in collaborating with the national health services accreditation organization to set a new voluntary norm that recognizes access to services in both official languages (Accreditation Canada n.d.).

Several factors can influence the implementation of an innovation, such as the implementation of AO practices in a healthcare site. The Consolidated Framework for Implementation Research (CFIR) presents five domains with constructs that can be used to guide the implementation process as well as understand implementation outcomes (Damschroder et al. 2022a). According to the CFIR, the implementation process can be affected by the innovation itself as well as the determinants, including those related to the inner setting domain where implementation is taking place (e.g., workplace culture); the individuals working in this setting (e.g., motivation); and the outer domain in which the implementation setting exists (e.g., provincial laws) (Damschroder et al. 2022a). This framework also clarifies anticipated versus actual implementation outcomes. Actual implementation outcomes are the adoption of the

innovation, the success or failure of the implementation of the innovation and the sustainment of the innovation over the longer term (Damschroder et al. 2022b).

In English majority-speaking settings, the implementation of FLS is subject to a particular set of contextual factors or determinants (Forgues et al. 2017). For example, determinants from the inner setting include administrative will, human resource availability and organizational policies on language of services, as well as individual factors such as employee perceptions about the importance of providing FLS in their communities. Outer setting determinants include the provincial language policies and the local language needs (Forgues et al. 2017).

Our understanding of how to successfully implement AO practices in healthcare settings continues to be limited, especially in OLMCs where there is a low density of FLS users and low number of French-speaking staff. The objectives of the study were to understand how an organization, via unit managers, can initiate and conduct the implementation of AO practices and to identify the factors that influenced the implementation outcomes.

This paper reports on the implementation process and outcomes of introducing AO of FLS practices in one acute healthcare setting with a low density of FLS users and low number of French-speaking staff.

Methods

Site selection and participant recruitment

To participate in the study, a healthcare site needed to express an interest in improving health services for their francophone patients. Potential hospital sites were approached by the SSF via a general e-mail invitation. Five sites, from communities with a variety of densities of French-language speakers, responded. Three sites initially accepted to participate in the project. Of these, two sites later declined. Reasons were a lack of human resources and a major provincial healthcare restructuring. Hence, this project was carried out in only one hospital located in Ontario.

From this participating site, the research team sought the assistance of local hospital members to act as site coordinators by liaising with the higher administration, unit managers and the researchers. Study participants were the site coordinators and unit managers who were recruited from the units where AO practices could be introduced.

Innovation and implementation process

The first phase of the study served to set up implementation. The managers and site coordinators attended a three-hour workshop, led by the researchers, that focused on language discordance in healthcare, national and provincial language laws and principles of AO of services in both official languages.

The researchers guided the unit managers and the site coordinators to work together to enumerate current AO practices in their hospital and to identify potential additional practices that could be implemented (innovation). They used a list of research-based practices,

derived by the researchers from a literature review, to help conceptualize AO using small manageable practices to choose from. They chose four practices and then created an implementation process plan.

In the second phase, the site coordinators and unit managers began introducing these AO practices in the selected units. A research assistant was available to them at each step to support implementation.

Ethical consideration

Participating hospital's research ethics board approval was obtained (certificate #2017101). Approval was also obtained from the researchers' institutions (certificates # FC-30-11-16 and A04-17-05). All study participants provided written consent.

Data collection

The managers and site coordinators were invited to participate in two semi-structured interviews. The first focused on the workshop's effectiveness, the process for choosing the innovation and the implementation process plan, with a focus on anticipated implementation outcomes (e.g., "What do you foresee will be the challenges or difficulties in implementing your action plan?"). The second interview took place approximately eight months later following implementation of the actions and focused on the perceived outcomes (e.g., "What do you see as the main results of the implementation of this action plan on your unit [impact on the organization, the unit, the personnel, the patients]?").

Data analysis

The data stemming from the recorded semi-structured interviews were transcribed and the verbatims were analyzed using a general inductive approach (Thomas 2006). With this approach, meaning was found both inductively and deductively using the project objective and the main domains and constructs of the CFIR (Damschroder et al. 2022a, 2022b). This framework guided the analysis of the implementation process and implementation outcomes. Data were managed using NVivo 12 software (2018) (QSR International, Doncaster, Australia).

Results

Site and participants

The project was carried out in a regional hospital where AO of FLS practices were not common, located in a region of Ontario with a low density of French-speaking individuals. The regional hospital provides services within a large health district, of which approximately 2% identify as francophone (Ontario Health 2025). The LHIN had recently identified this hospital as an organization that should be offering FLS (NWLHIN 2013).

Three site coordinators supported this study: two upper-level managers and one administrative assistant who was the new FLS officer. These leaders assisted with tasks

such as research ethics board applications, site/researcher communication and participant recruitment.

Managers from the four following units participated in the study: in-patient unit, outpatient clinic, admitting service and staff management office. One manager left their unit (interview UM002) and the incoming unit manager agreed to participate in the study (interview UM006); they reviewed the workshop content with the research assistant. As this is a small hospital and there is a risk of reidentification of the participants, units are not linked to the interviews (Table 1).

TABLE 1. Participants and interview identifiers

Participants	Participant identifier		Participant preferred language of communication
	Participants Interview 1	Interview 2	
Unit managers	UM001 UM002 UM003 UM004	UM005 UM006 UM007 UM008	English unilingual English unilingual/English unilingual English unilingual English preference, also speaks French
Site coordinator	–	SC009	English preference, also speaks French

The process and outcomes of implementation are described in the following section, guided by the CFIR and focusing on the innovation domain, setting domains (outer, inner and individual), implementation process constructs and indicators of implementation outcomes (Damschroder et al. 2022a, 2022b).

Innovation domain

In collaboration with the participants, the scope of AO was defined. Using the evidence-based list of possible AO practices provided by the research team during the workshop, the managers, with the support of the site coordinators, followed a process to choose practices for implementation. They considered innovation constructs, including adaptability of the practices to their context, complexity and cost.

> Are we doing this? Can we do this? Is this doable for us? And we kind of went through [the practices on the list] and then decided which ones we thought we could get done quickly, some things would take a little more time to get implemented, and then [there were] other things that may never, might not be possible. (UM004)

The site coordinator reported that this list of research-based practices prepared by the researchers helped to better understand the concept of AO.

> I think that the most valuable piece was the list of suggestions [on] how to make an active offer of French language services and how very easy most of them would be

> for managers to implement. […] Things like identify the people in your unit who speak French, and here's a pin for them. Think about your signage. Very simple and effective. (SC009)

The managers chose to introduce four practices that could be adapted to their individual units and that they thought were relatively low cost and low complexity. These practices were to (1) add French/English bilingual telephone messages; (2) add bilingual signage on the units (large hospital directional signs were already in both official languages); (3) add bilingual educational/informational resources on the units; and (4) have French-speaking unit staff wear lapel pins indicating that they can provide their services in both languages.

Implementation process

The unit managers were initially responsible for leading the implementation of the AO practices; however, the site coordinators took a larger responsibility in guiding implementation because of the managers' pressing administrative challenges and competing priorities from the acute care hospital setting. For example, the timing of the flu season bed-capacity crisis coincided with the implementation. The unit managers stated that this assistance from the site coordinators was an important facilitator for the success of the implementation. "[It was] helpful getting reminders from [site coordinators] because sometimes we get overwhelmed with other tasks …" (UM008).

> The signs [were] easy […] what I ended up doing was taking pictures of all the signs I had on my unit and sending them to [the site coordinator]. And then she just made arrangements to get them all done bilingual[ly] … . (UM007)

The site coordinators recognized their role in supporting managers with implementation, especially in the context of rival priorities.

> [The managers] also knew that, you know, some of those decisions [related to the choice of active offer practices] were made because those were the things that we could provide them the most support in implementing … I think they just looked at us and said, "Okay, you're going to get our signs translated? Great. Tell me when they're done." (SC009)

A manager recognized additional determinants from the inner, outer and individual domains (CFIR) that facilitated implementation. They stated that higher hospital management supported implementation of AO practices because their organization was identified for designation by the provincial government. This facilitated access to external support services, such as translators, information technology technicians and facility management,

to carry out implementation. Additional costs were also incurred, and delays occurred in the implementation calendar because of these external services.

Implementation outcomes

The unit managers and site coordinators identified that their implementation was successful and that there was concrete evidence from the implementation of the four practices, for example, translated education materials on their units.

While the unit managers adopted the innovation and played a key role in the successful implementation of outcomes, several of them reported having doubts about the importance of the implemented practices for OLMCs in relation to other hospital priorities and questioning their impact.

> To be 100 per cent honest, here at the [hospital], in my nineteen years of working for this organization, I have never really come across a French-speaking patient [who] was unable to communicate in English. So, it hasn't been, like, I haven't really necessarily seen a benefit. (UM002)

> You know, we've made those changes, but did it have any effect on anybody [who] is a French-speaking person? I don't know. Because ... did we ask any of our patients when they were discharged, "Did you notice our signage is now in English and French? [D]id it enhance your experience? [W]as it something that you found helpful?" (UM007)

Nevertheless, the site coordinators championed the project and reported feeling motivated to implement additional AO practices. "… we've [site coordinators] gone beyond the parameters of the research project to actively offer French. And we're motivated. I think […] the primary piece for me is [that] I want to keep going". (SC009)

The site coordinators self-initiated the implementation of two additional AO practices. The first was "Welcome/Bienvenue" signs at all patient contact points with instructions guiding clerks on how to obtain French-interpretation services for the patients. The second was the addition of, in English-language pre-operative letters sent to patients, a French sentence informing patients that they can contact the FLS officer for clarifications or a French version of the letter. The site coordinator explained the positive impact of the addition of this sentence in the letters for a particular patient for whom they were able to organize interpretation services.

> So, had we not included that information [to call the FLS officer] and had [the patient] not called, he would have shown up for his appointment. […] He would have not been prepared for the procedure. He would have been on the medications [he was instructed to cease one week prior to the appointment]. He would have been

> sent home. He would have been extremely frustrated. The hospital resources would have been wasted. (SC009)

The coordinators also began transferring lessons learned to other minority-language groups. For example, they set up a centralized list of francophone staff who could provide services in French and added workers who could provide services in other languages spoken in that region.

> So, in addition to a list of staff who speak French and English, we have a list of staff who speak Finn[ish] and Italian and Ukrainian, etc. So, that information is housed in the same place, on the Intranet, as the list of francophones or French-speaking staff. So, if you know the process to have somebody attend and provide service to a patient in French, you know the process for Italian or whatever [language]. (SC009)

Managers reported being concerned about the sustainment of AO practices that were linked to their limited number of French-speaking staff in the organization. "… We don't have any French-speaking staff in this department" (UM008). Even with established language priorities, they were unable to fill their French-language positions. "[French speaking] Clerical [staff]? I have none. And that's not for lack of, you know, I know every posting that we put up, you know, French language is one of the criteria" (UM004).

Sustainment was also at risk because of the managers' general lack of conviction that the francophone population had priority needs to be addressed compared with the region's other language groups.

> We have a large Indigenous population in [this region]. There's a lot of Indigenous people [who] do not speak any English. We have a large Italian population, a large Finnish population … But I haven't come across a French family or a French patient [who] doesn't speak English. (UM008)

The site coordinator reported that three of the practices would be sustainable: the bilingual signs, educational materials as well as the telephone messaging system, because these practices were now integrated into formal hospital processes and did not rely on French-speaking staff. "Every single new and newly revised patient education material [now] goes through the translation process, and it's not approved until it is bilingual" (SC009).

Discussion

Respecting language of preference is a key tenet of providing health services in an officially bilingual country such as Canada, a central concept of patient-centred care (Picker Institute 2024) and a recognized element of quality of care (Accreditation Canada n.d.). Actively

offering services in both official languages is therefore an important step toward meeting the needs of the OLMCs.

This project served to improve our understanding of the key factors that influenced the implementation of AO of FLS practices in an Anglo-dominant regional hospital in a low-density francophone region of Canada. The main factor influencing the successful implementation process and its outcomes, specifically the sustainment of the AO practices, was support from higher administration and site coordinators.

We originally planned to have the acute care unit managers lead the implementation process. Since they were closest to those patients who would benefit from AO, we believed that they would be best to spearhead the process. The managers were fully engaged in identifying needs and priorities and determining the chosen practices for implementation, which likely increased the acceptability and adoption of the practices in their units (Damschroder et al. 2022a, 2022b). However, as the process of implementation progressed, roles needed to be redefined to adapt to the setting's rival priorities and limited resources, and the site coordinators took charge of concrete tasks and directed the implementation process to completion.

The project seemed to have minimal influence on the managers' beliefs about the importance of AO of services in both official languages. Vézina (2017) suggests that the best way to encourage such a change in attitudes toward FLS is to link the importance of the change to quality and safety, which are values of patient-centred care common in most healthcare organizations. This minimal conviction on the part of the managers was offset by the support of higher hospital administration (Forgues et al. 2017; Sawang and Unsworth 2011), who, during the study, created an FLS officer position and met with the research team to discuss implementation and offer additional resources. The site coordinators also acted as internal champions of AO and FLS and had a positive influence on effectiveness of the implementation (Greenhalgh et al. 2004; Miech et al. 2018). While healthcare professionals need to be aware of the importance of the principles of AO of services in both official languages and be willing to adopt such behaviours, this type of high-level managerial support has been shown to be critical in inciting employees to enact AO (Savard et al. 2017).

Sustainment of FLS innovations can be influenced by factors such as lack of staff buy-in and resource challenges, specifically limited bilingual staff (Drolet et al. 2014). Sustainment, which is an implementation outcome that refers to the innovation being delivered over the long term (Damschroder et al. 2022b), was also supported by higher administration as they allowed the official integration of several of the AO practices into the hospital processes.

While this project reinforced the participants' understanding of official language laws and policies and understanding of the role of language in patient-centred care, it also encouraged them to recognize that similar practices and strategies could be applied to support the language needs of other minority-language groups receiving services in their hospital (e.g., asking language of preference at the admission, suggesting translation/interpretation services).

This project's approach to implementation of AO practices was used in a region with low density of francophones, but could be applied in other OLMCs, with possible increased success in areas with higher density of francophones. More specifically, in such high-density areas, units would be more likely to admit French-speaking patients and have less difficulty hiring a minimal number of bilingual staff, which in turn may increase unit managers' ownership of practices needed to meet the needs of this population. This should be confirmed in future studies.

While the CFIR highlights the importance of gathering outcome data from innovation deliverers and key decision makers, as they have the most influence on success of the implementation, the voices of innovation receivers should be collected when possible (Damschroder et al. 2022b). An important limitation of this study was this lack of data from francophone patients. A future study could focus on their experience of AO practices and on their perception of the benefit and importance of AO practices.

Based on our experiences, the following are the recommendations to facilitate implementation processes and outcomes:

1. At project onset, secure buy-in from higher administration and site coordinators.
2. Support innovation deliverers, such as the unit managers, to have a good understanding of local language laws and policies and of the link between language and patient-centred care. Adding examples taken from their own setting of local francophone patients' communication barriers in the initial workshop may be helpful to positively change their beliefs about the importance of the implementation in their region.
3. Encourage the transfer of AO practices designed for OLMCs to help meet the needs of other language minority groups.
4. Support the organization to define their needs: Where will actions have the most impact? Which actions are more feasible to implement (e.g., choosing practices at the level of the healthcare professionals or more centralized actions such as signage)? Provide a list of tangible research-based AO practices that can be adapted to the local context. Considering current limitations in the healthcare setting, ensure that suggested actions have varying resource requirements.

Conclusion

Ensuring that healthcare services are actively offered in the patient's preferred language is a basic tenet of patient-centred care. Anglo-dominant health organizations in low-density francophone regions who are mandated to provide FLS may benefit from support to implement practices of AO of services in both official languages. This project outlined a process for implementation and served to improve our understanding of the key determinants that influence the success of this type of implementation, particularly the significance of support from higher administration and site coordinators.

Funding

This research was funded by the *Société Santé en français*.

Correspondence may be directed to Katrine Sauvé-Schenk by e-mail at ksauvesc@uottawa.ca.

References

Accreditation Canada. n.d. Official Languages Recognition Program. Retrieved May 8, 2024. <https://accreditation.ca/assessment-programs/official-languages-recognition-program/>.

Bélanger, R., C. Mayer-Crittenden, J. Mainguy and A. Coutu. 2018. Enquête sur l'offre active pour les services auxiliaires de santé du Nord-Est de l'Ontario. *Reflets : Revue d'intervention sociale et communautaire* 24(2): 212–47. doi:10.7202/1053869ar.

Bouchard, L., M. Beaulieu and M. Desmeules. 2012. L'offre active de services de santé en français en Ontario : une mesure d'équité. *Reflets : Revue d'intervention sociale et communautaire* 18(2): 38–65. doi:10.7202/1013173ar.

Bouchard, L., J. Savard and M. Dumond. 2024. La santé en contexte francophone minoritaire au Canada : 20 ans de recherche: Introduction. *Minorités linguistiques et société* 22: 1–9. doi:10.7202/1110619ar.

Bowen, S. 2015, August. *Impact des barrières linguistiques sur la sécurité des patients et la qualité des soins*. Société Santé en français. Retrieved January 16, 2025. <https://www.reseausantene.ca/wp-content/uploads/2018/05/impacts-barrieres-linguistiques.pdf>.

Damschroder, L.J., C.M. Reardon, M.A.O. Widerquist and J. Lowery. 2022a. Conceptualizing Outcomes for Use With the Consolidated Framework for Implementation Research (CFIR): The CFIR Outcomes Addendum. *Implementation Science* 17(1): 7. doi:10.1186/s13012-021-01181-5.

Damschroder, L.J., C.M. Reardon, M.A.O. Widerquist and J. Lowery. 2022b. The Updated Consolidated Framework for Implementation Research Based on User Feedback. *Implementation Science* 17(1): 75. doi:10.1186/s13012-022-01245-0.

de Moissac, D. and S. Bowen. 2017. Impact of Language Barriers on Access to Healthcare for Official Language Minority Francophones in Canada. *Healthcare Management Forum* 30(4): 207–12. doi:10.1177/0840470417706378.

de Moissac, D. and S. Bowen. 2018. Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience* 6(1): 24–32. doi:10.1177/2374373518769008.

Drolet, M., J. Savard, J. Benoît, I. Arcand, S. Savard, J. Lagacé et al. 2014. Health Services for Linguistic Minorities in a Bilingual Setting: Challenges for Bilingual Professionals. *Qualitative Health Research* 24(3): 295–305. doi:10.1177/1049732314523503.

Forgues, E., B. Bahi and J. Michaud. 2017. Offering Health Services in French: Between Obstacles and Favourable Factors in Anglophone Hospital Settings. In M. Drolet, P. Bouchard and J. Savard, eds., *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities* (pp. 149–186). University of Ottawa Press.

Foucher, P. 2017. Services de santé en français au Canada : l'état du droit. In M. Drolet, P. Bouchard and J. Savard, eds., *Accessibilité et offre active : Santé et services sociaux en contexte linguistique minoritaire* (pp. 77–98). University of Ottawa Press.

French Language Services Act, R.S.O. 1990, c. F.32. Government of Ontario. Retrieved January 17, 2025. <https://www.ontario.ca/laws/regulation/220544>.

Government of Ontario. 2023, September 7. User Guide – Designation of Organizations Under the *French Language Services Act*. Retrieved October 27, 2024. <https://www.ontario.ca/page/user-guide-designation-organizations-under-french-language-services-act>.

Greenhalgh, T., G. Robert, F. Macfarlane, P. Bate and O. Kyriakidou. 2004. Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. *Milbank Quarterly* 82(4): 581–629. doi:10.1111/j.0887-378X.2004.00325.x.

Itzhak, I., N. Vingron, S.R. Baum and D. Titone. 2017. Bilingualism in the Real World: How Proficiency, Emotion, and Personality in a Second Language Impact Communication in Clinical and Legal Settings. *Translational Issues in Psychological Science* 3(1): 48–65. doi:10.1037/tps0000103.

Léger. 2020. *Rapport final – Perceptions des communautés de langue officielle en situation minoritaire ; accès aux services de santé dans la langue officielle de son choix*. Santé Canada.

Miech, E.J., N.A. Rattray, M.E. Flanagan, L. Damschroder, A.A. Schmid and T.M. Damush. 2018. Inside Help: An Integrative Review of Champions in Healthcare-Related Implementation. *SAGE Open Medicine* 6: 1-11. doi:10.1177/2050312118773261.

North West LHIN (NWLHIN). 2013. *Local Environmental Scan: Adapted from the Common Environmental Scan: A Review of Selected Information about Ontario's Local Health Integration Networks*. Retrieved February 4, 2025. <https://tbrhsc.net/wp-content/uploads/2018/05/2013-Spring-North-West-LHIN-Common-Environmental-Scan.pdf>.

O. Reg. 544/22: ACTIVE OFFER OF SERVICES IN FRENCH - PRESCRIBED MEASURES. Under: French Language Services Act, R.S.O. 1990, c. F.32. Government of Ontario. Retrieved January 17, 2025. <https://www.ontario.ca/laws/regulation/220544>.

Ontario Health. 2025. North West Region. Government of Ontario. Retrieved February 3, 2025. <https://www.ontariohealth.ca/about-us/our-programs/ontario-health-regions/north-west-region>.

Peled, Y. 2018. Language Barriers and Epistemic Injustice in Healthcare Settings. *Bioethics* 32(6): 360–67. doi:10.1111/bioe.12435.

Picker Institute. 2024. The Picker Principles of Person Centred Care. Retrieved May 8, 2024. <https://picker.org/who-we-are/the-picker-principles-of-person-centred-care/>.

Reaume, M., R. Batista, D. Prud'homme and P. Tanuseputro. 2024. Qualité et sécurité des services de santé offerts en situation linguistique minoritaire en Ontario : investigations des données administratives de santé. *Minorités linguistiques et société* 22: 1–19. doi:10.7202/1110631ar.

Sauvé-Schenk, K., J. Savard, J.-C. Miljours and L. Bouchard. 2024. L'expérience des francophones des soins et des services en contexte linguistique minoritaire : bilan et perspectives. *Minorités linguistiques et société* 22: 1–18. doi:10.7202/1110633ar.

Savard, J., K. Bigney, L.-A. Kubina, S. Savard and M. Drolet. 2020. Structural Facilitators and Barriers to Access to and Continuity of French-Language Healthcare and Social Services in Ontario's Champlain Region. *Healthcare Policy* 16(1): 78–94. doi:10.12927/hcpol.2020.26289.

Savard, J., L. Casimiro, P. Bouchard and J. Benoît. 2017. Les comportements favorables à l'offre active, leur mesure et leurs déterminants. In M. Drolet, P. Bouchard and J. Savard, eds., *Accessibilité et offre active : Santé et services sociaux en contexte linguistique minoritaire* (pp. 303–42). University of Ottawa Press.

Sawang, S. and K.L. Unsworth. 2011. A Model of Organizational Innovation Implementation Effectiveness in Small to Medium Firms. *International Journal of Innovation Management* 15(5): 989–1011. doi:10.1142/S1363919611003398.

Seale, E., M. Reaume, R. Batista, A.B. Eddeen, R. Roberts, E. Rhodes et al. 2022. Patient-Physician Language Concordance and Quality and Safety Outcomes Among Frail Home Care Recipients Admitted to Hospital in Ontario, Canada. *CMAJ* 194(26): E899–908. doi:10.1503/*CMAJ*.212155.

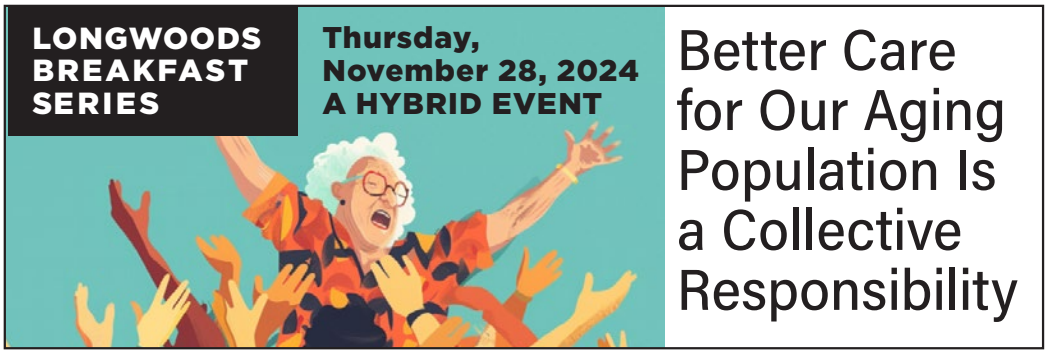
Société Santé en français (SSF). 2021. Un réseau de partenaires. Retrieved October 27, 2024. <www.santefrancais.ca>.

Thomas, D.R. 2006. A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation* 27(2): 237–46. doi:10.1177/1098214005283748.

Vandyk, A., S. Lightfoot, K. Levesque, M.-C. Domecq and J.D. Jacob. 2022. Les expériences de patients francophones qui se présentent fréquemment à l'urgence pour des raisons de santé mentale. *Recherche en soins infirmiers* 150(3): 79–88. doi:10.3917/rsi.150.0079.

Vézina, S. 2017. Active Offer, Bilingualism, and Organizational Culture. In M. Drolet, P. Bouchard and J. Savard, eds., *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities* (pp. 233–58). University of Ottawa Press.

RECENT EVENTS



longwoods.com/events

Policy is always in the making. This journal is designed to serve readers from diverse backgrounds including health system managers, practitioners, politicians and their administrators, educators and academics. Our authors come from a broad range of disciplines including social sciences, humanities, ethics, law, management sciences and knowledge translation. They want good policy – a foundation for best practices.

www.healthcarepolicy.net