WOODGREEN

NOVEMBER 2021

Resettling health and wellness

THE VALUE OF INTEGRATED NEWCOMER CARE

Contents

Holistic Care

Newcomers

> “When I joined an integrated care team, I was able to deliver the holistic care my patients needed and the results have been amazing.”
>
> – Primary Care Physician

Acknowledgements

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About WoodGreen Community Services

A United Way Anchor Agency, WoodGreen combines significant scale and a proven track record with an entrepreneurial mindset, continuously seeking and developing innovative solutions to critical social needs. With a rich history spanning more than 80 years, WoodGreen is one of the largest social service agencies in Toronto, serving 37,000 people each year from 36 locations. Together we help people find safe, affordable housing, seniors live independently, internationally-trained professionals enter the job market, parents access childcare, children and youth access after-school programs, newcomers settle in to Canadian life, homeless and marginalized people get off the streets, youth find meaningful employment and training and provide a wide range of mental health supports.

Advisory panel members

Dr. Alnoor Aziz, Crescent Town Health Centre

Dr. Catherine Yu, East Toronto Family Practice Network and Health Access Thorncliffe Park

Dr. Deborah Kopansky-Giles, St. Michael's Hospital and Canadian Memorial Chiropractic College

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Introduction

COVID-19 has disrupted immigration. Canada has welcomed fewer people than planned, leaving families separated and humanitarian obligations unmet. The federal government has responded by increasing admissions targets, with plans to accept 45,000 protected persons this year and 1,233,000 permanent residents over the next three years.[1]

We at WoodGreen Community Services welcome this news. As one of the largest social services agencies in Toronto, we help over 7,000 immigrants and their families settle into their new lives in Canada each year through WoodGreen's Newcomer Programs and Services. We have witnessed the invaluable and essential contributions newcomers make to their neighbourhoods, communities, and society. We know that when more people decide to call Canada home, we all benefit—economically, socially, and culturally.

But Canada's social safety net isn't doing enough to promote newcomer well-being. While newcomers often cite the desire for a better quality of life as their motivation for migrating,[2] their health and wellness outcomes paint a troubling picture. On average, newcomers arrive to Canada in better health than the general population.[3] But their health and wellness tend to rapidly decline during and after settlement.

Researchers, providers, and newcomers have pointed to the social determinants of health to explain this trend.[4] Social determinants of health are societal factors that influence health and wellness. They are the conditions in which people are born, live, work, and age and the broader economic, social, and political forces that shape these conditions of daily life – from immigration status to income security to social connection.[5] Newcomers facing adverse conditions experience avoidable and inequitable deterioration of health. We've seen it first hand. Many of WoodGreen's newcomer clients face food insecurity, crowded housing, poor access to health care, and racism and discrimination, which negatively impact their well-being.

Newcomer health and social supports aren't typically structured or funded to address the complexity or interrelatedness of these challenges. Part of the reason for this is due to the public policy that shapes how services are provided. Although health impacts settlement and integration, and settlement and integration impact health, the two are often treated as separate, rather than interrelated, policy issues. At the service level, this means that newcomer supports are deeply fragmented.

That's why at WoodGreen Community Services, we've been partnering with other organizations to close these gaps through integrated care programs for newcomers that bridge health, settlement, and other social services. WoodGreen's Interprofessional Care (IPC) program was built specifically to provide wrap-around care for newcomer clients by strengthening collaboration and coordination between settlement and primary health care providers. This work is just one part of WoodGreen's broader commitment to integrated care. We also joined with five other anchor partners across the continuum of care to form the East Toronto Health Partners (ETHP), an integrated care network and one of the first Ontario Health Teams.

While organizations like WoodGreen are working to develop and deliver integrated care for newcomers, these programs are still the exception, not the norm. And existing initiatives like ours continue to face barriers to realizing their full potential—from inadequate funding, to limited information-sharing infrastructure, to insufficient support services. For integrated newcomer care to scale up and succeed, we need government to collaborate with settlement providers, community agencies, health care organizations, and other stakeholders across the continuum of care to co-create and implement solutions that address these challenges.

Now is the time to take collective action to strengthen existing initiatives and to make integrated care for newcomers the standard approach. The COVID-19 pandemic has had dire, unequal impacts on newcomers, laying bare the need to integrate health and settlement services.[6] Integrated care will only become more important as Canada implements its plans to increase the number of newcomers it will welcome over the next few years.

We've created this report to contribute to the conversation, encourage discussion, and prompt urgent action. We aim to share our insights and experiences to make the case for integrated newcomer care and to provide direction on potential policy responses that will help ensure initiatives work for newcomers, frontline workers, and organizations alike. To inform this work, we've conducted an extensive review of the literature and consulted with practitioners delivering integrated care for newcomers. We conducted in-depth interviews with frontline workers, including primary care physicians, and settlement case counsellors associated with WoodGreen Community Services and peer organizations. We've also learned from the lived experiences of WoodGreen's clients under the IPC program and have included their stories throughout the report. With their consent, we have changed the names of these individuals and some details about their experiences to ensure their privacy. This report has also benefited from the input and advice of an advisory panel made up of local practitioners and experts working to implement integrated care and promote newcomer health and wellness.

At WoodGreen Community Services, we envision a Toronto, an Ontario, a Canada, where everyone has the opportunity to thrive. To realize this vision, we need to integrate health and settlement services. We need integrated care for newcomers.

The COVID-19 pandemic has had dire, unequal impacts on newcomers, laying bare the need to integrate health and settlement services.

Who are Newcomers?

The term "newcomer" has many definitions. These definitions have significant impacts, shaping who can access services and the types of services offered. Some funders and programs define newcomers very narrowly. For instance, settlement services funded by Immigration, Refugees and Citizenship Canada (IRCC) are restricted to individuals who are not yet Canadian citizens and have select immigration statuses, including permanent residents, refugees and protected persons, and some temporary foreign workers.[7]

But we've found that defining newcomers in this limited way doesn't reflect the realities that frontline workers see on the ground. WoodGreen's work with clients has shown that:

- **Many people who are new to Canada and would most benefit from services, don't meet the immigration status criteria.** Temporary residents, asylum seekers, and individuals without status are generally excluded. Some of these people may eventually become eligible, after years of delayed access to services. Others may never be eligible to receive help.
- **Settlement and integration are not uniform processes that end at the moment of citizenship or after a specific amount of time.** For instance, not all newcomers obtain Canadian citizenship. And the many who do may not always be able to benefit from resettlement support, while eligible, due to barriers like care-giving responsibilities, etc. Some newcomers may still need support over the long-term, well after they have become citizens. And other newcomers may have been born in Canada, but grew up in other countries, and still require assistance resettling.
- **Newcomers are diverse and seeing them through the lens of their immigration status alone can fail to account for their multiple and intersecting identities.** Status intersects with racialization, gender, sexual orientation, class, religion, age, ability, and other identities to shape individual needs, challenges, and experiences.

That's why WoodGreen Community Services uses a broad and inclusive definition. **We use the term "newcomer" to refer to any individual who has moved to Canada from another country with the intention to reside here to live, work, and/or study.** Newcomers have multiple and intersecting identities that shape their unique needs and the challenges they may face as they navigate settlement over the course of their lives.

FIGURE 1
COMPARISON OF FUNDED SERVICES TO WOODGREEN'S NEWCOMER SERVICES

Funded services	WoodGreen newcomer services
How long are services offered?	**How long are services offered?**
Pre-arrival — Arrival — Citizenship	Pre-arrival — Arrival — →
What statuses are included?	**What statuses are included?**
✓ Permanent residents ✓ Refugees and protected persons ✓ Some temporary foreign workers	✓ Permanent residents ✓ Refugees and protected persons ✓ Asylum seekers ✓ Temporary foreign workers ✓ International students ✓ Canadian citizens ✓ Individuals without status

The Challenge: Newcomers are Falling Through the Cracks

When we talk about health, we immediately think about medical interventions: diagnoses, prescriptions, and surgeries. But well-being is influenced by so much more than just medical factors. It's also determined by the economic, social, and political conditions of our daily lives.

Newcomers regularly face social determinants of health that negatively impact their well-being. Individuals and their families often experience barriers to finding suitable and stable employment[8]; securing safe and affordable housing[9], and accessing timely and quality care services[10], which undermines their health and wellness. Many people also belong to racialized groups, encountering interpersonal and structural forms of racism and discrimination that contribute to health inequities.[11] We've seen the impact of these health-reducing conditions become even more pronounced during the COVID-19 pandemic. Many newcomer and racialized populations have encountered greater risk of contracting the virus where they live and work—in overcrowded housing, and health care and services sector jobs.[12] While newcomers make up just over 25% of the population in Ontario, they have accounted for 43.5% of all COVID-19 cases in the province.[13]

To address these systemic health inequities and enable newcomers to thrive in Canada, we need policies that recognize how social factors can determine and interact with health and wellness outcomes. For instance, income insecurity can cause stress and poor mental health, making it more difficult to look for work. In turn, lack of work contributes to income insecurity and the cycle continues. But as it currently stands, newcomer supports are not holistic or comprehensive enough to address this interplay. Newcomers, their needs, and in some cases their families, are falling through the cracks.

Health and settlement services are fragmented

Part of the challenge is that health and settlement services in Canada are fragmented, with the social and medical aspects of challenges addressed separately from each other. On the one hand, settlement services, which include supports like language training and employment assistance, are predominately funded by the federal government and provided through local non-profit agencies.[14] These social supports are specifically designed to assist newcomers but stop short at health care. On the other hand, health care services are administered by provincial and territorial governments and can be accessed

ALEX'S EXPERIENCE

Alex is a recent newcomer to Canada. He is having difficulty accessing stable employment, leaving him in a precarious housing situation and without enough income to meet his basic needs.

Alex is also experiencing post-traumatic stress disorder (PTSD) and the added strain of his living situation has been negatively impacting his mental health. Alex has been in and out of the hospital for acute mental health care. But he sees a different practitioner each time he receives emergency services and has not been receiving culturally competent care. Alex has also had very little follow up when he leaves the hospital. He feels alone and doesn't know what services are available to him or how to access them. This lack of support is negatively impacting his mental health. He isn't receiving any baseline mental health care and is having trouble keeping up with the activities of his daily life.

Please note that all client stories, names and images featured in this report have been anonymized to protect the identities of our clients.

MARIA'S EXPERIENCE

> Maria recently immigrated to Canada with her two children. Her son has severe medical issues and sometimes has to miss school.

She does not speak English or French well and is unable to explain his condition to his teachers. Maria is very anxious about her son's health and school absences. She is nervous about leaving him at home with a caregiver, when she can find one, and has trouble sleeping. Maria regularly feels unwell from stress. Maria has finally been referred to a pediatrician to address her son's concerns. But she also faces a language barrier with the pediatrician's office. When she called to reschedule her son's appointment, the office misunderstood and cancelled it instead. Maria didn't know this. She was left expecting a call back with a new time and date.

through different entry points—from emergency rooms to walk-in clinics to family doctors.[15] These supports stop short of providing social services and are not usually designed with newcomers in mind.

Yet the health and wellness challenges facing newcomers don't recognize these silos: for example, a social condition like food insecurity can affect a medical condition like diabetes and vice versa. Furthermore, newcomers must navigate a complex maze of different providers focused on different issues, in different locations, and with different eligibility criteria. Many newcomers are unsure of what's available, where to turn, or in what order. Finding and accessing the right care in this context is difficult, resource intensive, and stressful. We heard in interviews that this high burden of system navigation can lead newcomers to delay or forgo seeking help for serious issues and can lead to individuals ending up in emergency care.

Not only does this negatively impact newcomer health and wellness outcomes, but also the quality and experience of care. Interviewees explained that the siloed ways in which services operate means that newcomers have to constantly repeat their stories to each provider and experience support as a series of disjointed, convoluted, and one-off events. This is especially challenging for people who face language and cultural barriers. We heard that this lack of coordination and collaboration across services also means that frontline workers often have to deliver assistance without complete information on their newcomer clients' needs and without clear accountability for ongoing case management and follow-up help.

This is particularly problematic given that newcomers face greater barriers accessing and remaining connected to support than the Canadian-born population.[16] We heard from interviewees that many newcomers have to delay seeking help to take care of their immediate survival needs. Other individuals may not be able to access support at all as eligibility for different services is often dependant on immigration status.[17] Even when newcomers do manage to connect with services, care itself can be inappropriate. Interviewees described how health care services are often not responsive to newcomers' language, cultural, and health literacy needs.

Newcomers are being left in the space between health and settlement, with poorer health outcomes than Canadian-born populations.[18] This inequality contradicts Canada's commitment to universal health care and undermines successful settlement and integration.

The Opportunity: Integrated Care for Newcomers

We need to integrate health and settlement services to close the health and wellness gap and enable newcomers to thrive in Canada. Integrated care is a leading approach that can provide newcomer populations and their local communities with more seamless, comprehensive, and connected services across the continuum of care.

What is integrated care?

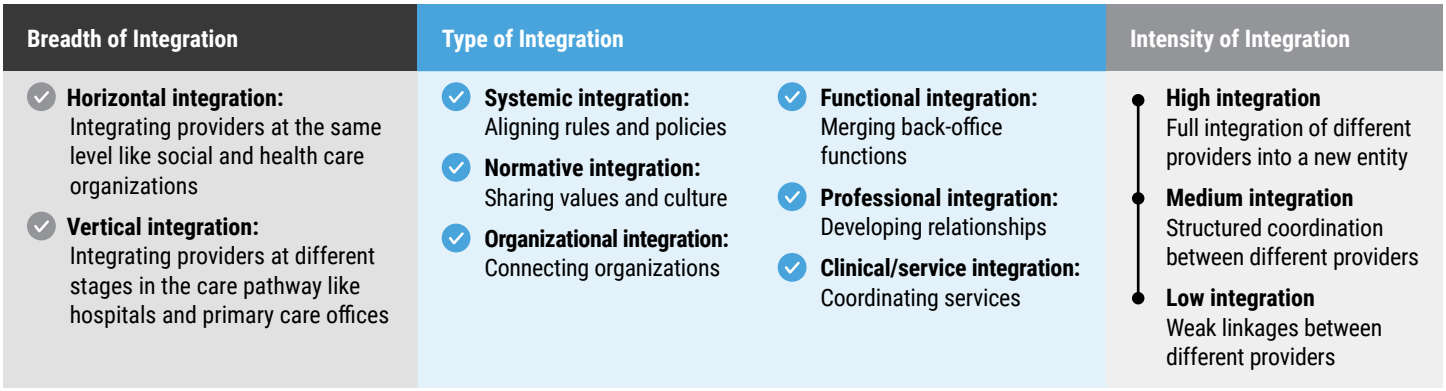
Integrated care is a collaborative approach that places the user and their family at the centre of care and organizes a complement of services according to their needs and perspectives.[19] It is an umbrella term used to refer to initiatives that reduce fragmentation between services, enabling more coordinated, cohesive, and continuous care for people facing complex challenges that cut across multiple issue areas, providers, and settings.[20] In health care, and for newcomers specifically, it often includes a focus on connecting health care with other human service systems, like settlement and social services.[21]

What does integrated care look like in action?

We've seen many different models of integrated care for newcomers—each with unique benefits and potential challenges. Some, like community hubs, house separate health and social service providers in the same location.[22] Others, like care networks, focus on improving coordination and facilitating referrals between different service providers. There are also interprofessional team models like WoodGreen's, which bring health, settlement, and other social service professionals onto the same team, in the same location, to work together directly.

Ultimately, there is no one right way to do integrated care—it is an evolving goal, not a single method.[23] The best approach will be context-specific and depend on the specific needs of the newcomer community being served. Policymakers, practitioners, and community members have the opportunity to co-design initiatives and decide how to best integrate, including which service providers to include, what kinds of integration to pursue, and to what extent.[24]

FIGURE 2
DIFFERENT METHODS OF INTEGRATION



Source: Kodner, 2009.

Integrated care in action: WoodGreen's Interprofessional Care (IPC) program

WoodGreen's Interprofessional Care (IPC) program is an integrated care initiative for newcomers that is targeted at bridging the gap between health care, settlement, and other social services. Together with our partners, WoodGreen launched the IPC program in 2017. Through this initiative, WoodGreen's settlement professionals partner with primary care practices in the Taylor Massey community to better support newcomer clients with complex and interrelated social and medical needs.

REVISITING ALEX: THE IMPACT OF INTEGRATED CARE

On page 7, we told the story of Alex, a newcomer who had been experiencing complex and compounding challenges, including mental illness, income instability, and precarious housing. Despite regular visits to the hospital, Alex wasn't receiving any follow-up or connection to additional supports. By enrolling in WoodGreen's IPC program. Alex was able to get help that addressed the causes, rather than simply the consequences, of his health difficulties. His family physician connected him with an IPC case counsellor specialist, located just down the hall in the same office. The counsellor talked to Alex in his first language to learn more about how he was feeling and sought to understand his immediate needs. Together, Alex and the counselor developed a plan of action. The counsellor introduced Alex to a mental health worker in the neighbourhood and helped him schedule his appointments. They enrolled him in a free tax clinic too, where he learned he was eligible for $8,000 he had not previously known about. The case counsellor also worked with Alex to find him stable housing close to the clinic. Alex now has regular supports for his mental health and his financial and housing situations have stabilized. He feels comfortable visiting the doctors and counsellors on the IPC team, and hasn't had to use urgent care for some months. The IPC program not only improved Alex's individual well-being but has prevented expensive and ineffective emergency visits that did little to improve his health and well-being in the long term.

Alex now has regular supports for his mental health and his financial and housing situations have stabilized.

How does the IPC program work?

Who is involved?

The IPC program consists of three case counsellor specialists from WoodGreen who specialize in settlement and integration. They work directly with local primary care teams that include family physicians, physician assistants, and a registered nurse community case specialist. The program runs out of Crescent Town Health Centre and Comprehensive Healthcare Network clinics. It is available to any newcomer in the community, no matter their immigration status.

How does the process unfold?

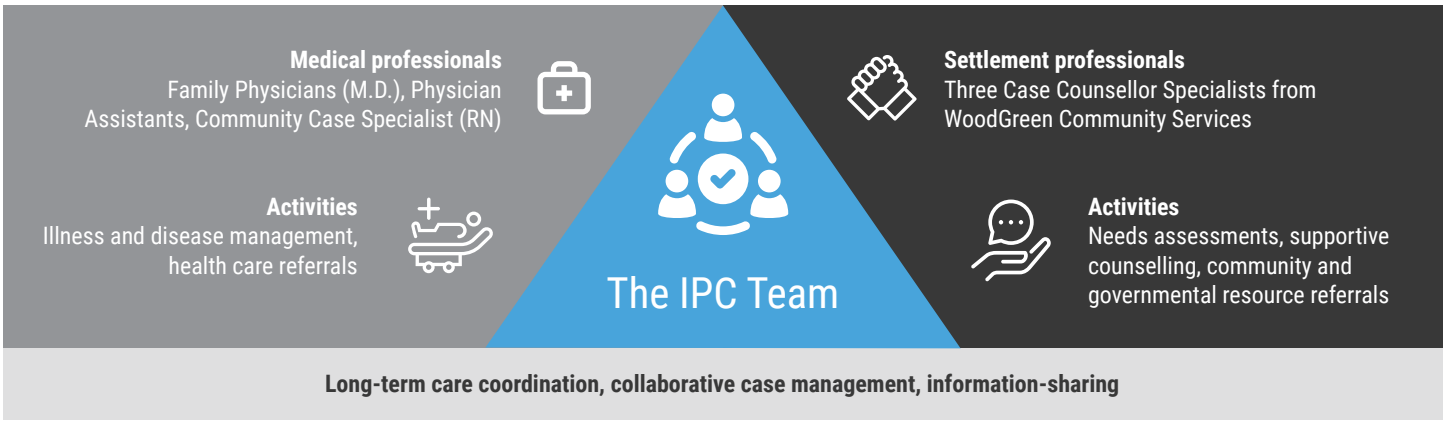
Newcomer clients usually enter the IPC program through the medical system. When a client attends an appointment with a medical professional on the team, they are referred to a WoodGreen case counsellor specialist to address any social determinant needs they have. The case counsellor specialists are directly embedded within the primary health care clinics and can drop by to be introduced to newcomer clients in-person. This level of integration makes the referral process a more seamless experience for clients and helps to build familiarity and trust.

Once connected, newcomer clients sit down with their case counsellor specialist. The counsellor conducts a comprehensive needs assessment and offers supportive counselling to the client as they discuss their experiences, concerns, and needs. Critically, WoodGreen's counsellors are trained in anti-oppressive practices and culturally competent care. This helps to increase mutual respect with clients and builds positive engagement within the health care system. The counsellors also have access to interpretation services, ensuring clients can fully express themselves and that information is presented clearly to support informed decision-making.

Newcomer clients collaborate with their counsellor to create a care plan based on their particular needs and goals, which is shared with the medical team members. The counsellors reduce the administrative burden of system navigation by connecting clients with other services they need to address any social determinants of health. They provide connections to other programs like WoodGreen's Housing Help Centre, information and assistance with applications to government programs, and patient referrals to other relevant organizations in the community. At the same time, the counsellor continually collaborates with the medical team who work to address any interrelated or other medical challenges that the client is facing.

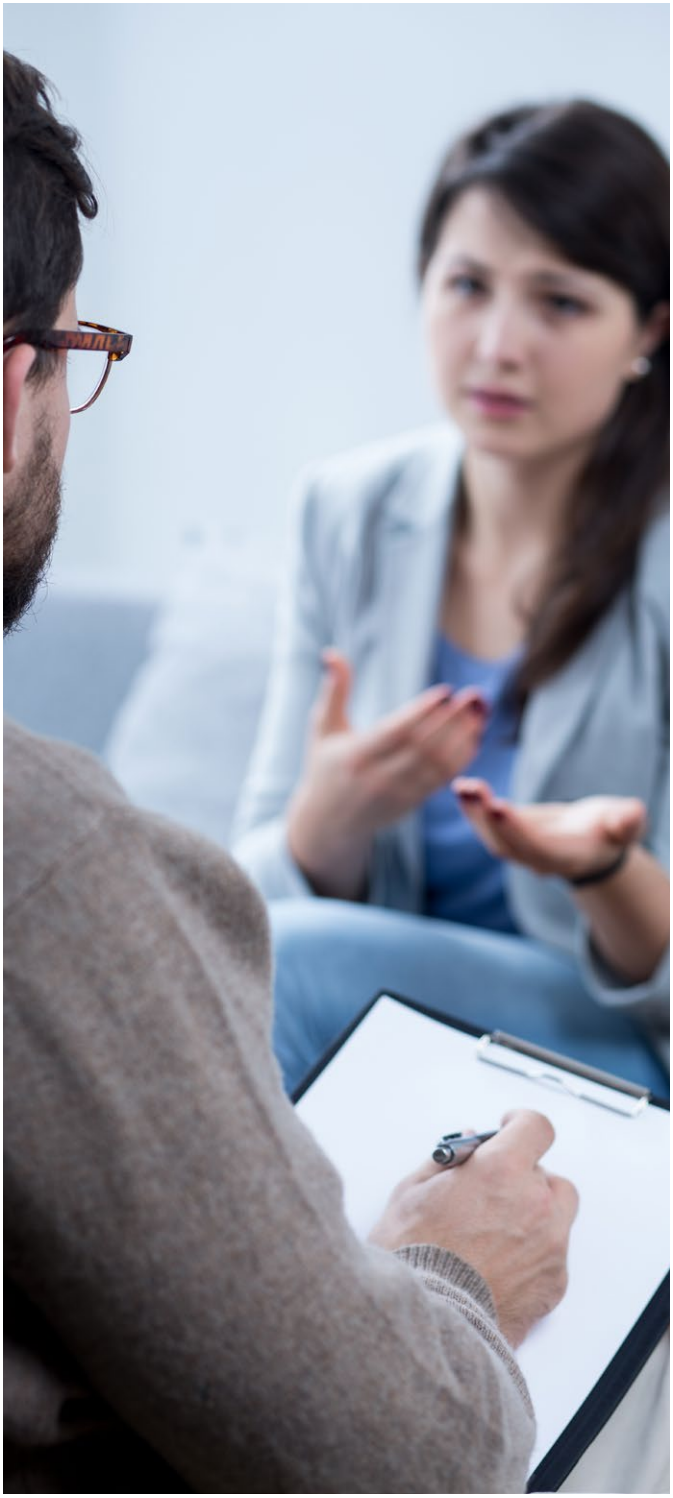
Over time, the counsellors conduct ongoing case management with clients. Critically, both the medical and non-medical IPC team members share the same electronic medical record (EMR). This allows IPC team members to easily communicate with each other, have complete information, and jointly monitor an individual's care journey. The whole team is made aware if a referral falls through or an intervention does not achieve the desired outcome. Through a process of elimination, the team can then collaboratively determine why certain client issues may still be persisting and work with clients accordingly make adjustments to care plans.

FIGURE 3
STRUCTURE OF WOODGREEN'S IPC TEAM



What is the impact?

The IPC program addresses newcomer needs in a way that is holistic and pragmatic: providing service that is easy to access, linguistically appropriate, culturally sensitive, and trauma-informed. By taking this approach, the program actively reduces the burden of system navigation for clients and promotes accountability and long-term support across the continuum of care. In 2020 – 2021 alone, the IPC program served over 350 clients and provided over 2330 interactions. During the second and third quarters of 2021, we helped create over 570 attachments to the critical health and social services WoodGreen's newcomer clients needed.



> "Hearing from and seeing our clients transform their lives through this model is so rewarding. Clients have told me that they've been in spaces where they don't feel heard.
>
> But in the IPC program they feel empowered. We listen to our clients and deliver care that works for them. Many clients have said that this kind of support alone helps their well-being."

– IPC case counsellor specialist

Implications for Policymakers

Integrated care for newcomers has the potential to realize the Government of Ontario's vision for health care by advancing the quadruple aim, an internationally-recognized and World Health Organization recommended best practice framework for health care systems that highlights four objectives: improved care experiences, improved population health, improved provider well-being, and lower costs.[25] As an organization, we've seen integrated care for newcomers deliver on all these goals. It can enhance newcomer care experiences, improve their health and wellness outcomes, and facilitate settlement and integration. It can also reduce burnout amongst providers and generate system efficiencies.

Here are four reasons why integrated care should be an essential feature of our settlement and health care systems.

Integrated care enhances newcomer care experiences

Integrated care has the potential to improve the quality and experience of care for newcomers. As a people-centred approach, it organizes services around their needs and perspectives, rather than artificial administrative boundaries.[26] This improves care continuity, allowing newcomers to gain timely access to the services they need through any door, without the burden of system navigation.[27]

Integrated care improves outcomes for newcomer populations

Integrated care has the potential to improve newcomer health and wellness outcomes. It encourages holistic attention to the complexity of newcomer needs, including the social determinants of health.[28] Care is coordinated across time and services when needed, heightening accountability for long-term support and preventing the avoidable deterioration of newcomer health and wellness.

Integrated care promotes well-being amongst care professionals

Integrated care has the potential to enhance the well-being of health and settlement workers. Burnout is prevalent amongst care professionals and can cause reduced patient satisfaction and health outcomes.[29] By building and coordinating relationships and support between providers, integrated care has been found to combat burnout and improve job satisfaction and well-being.[30]

Integrated care generates efficiencies for health and settlement systems

Integrated care has the potential to improve the efficiency, cost-effectiveness, and sustainability of care systems.[31] It helps break down silos between health and social care services. It also reduces the risk for duplication of work and may minimize high-cost services such as hospital admissions by diverting cases to lower service levels and encouraging a shift to preventative care.[32]

> "A lot of my newcomer patients' health issues were being caused by things like poverty. But as a physician, I only had the resources to treat the symptoms instead of these root causes.
>
> When I joined an integrated care team I was able to deliver the holistic care my patients needed and the results have been amazing. My patients are thriving. They've been coming in less often and feel more settled in their lives."

– IPC case counsellor specialist

Enabling Integrated Newcomer Care to Work in Practice

Integrated care for newcomers doesn't just happen by itself. It requires breaking down silos between, and even within, health and settlement.

We know from first-hand experience that this is no easy task. Policymakers and stakeholders from across the continuum of care will need to come together in partnership to address existing barriers to integration and to create the conditions needed for initiatives to promote newcomer health and wellness. We all have a role to play in realizing integrated care for newcomers as the standard approach moving forward.

In the following section, we investigate some of the most pressing challenges to integrated newcomer care and consider potential action areas to respond to these issues. We explore the need to recognize settlement as a health and wellness issue and ways to make sure integrated care works for newcomers, for frontline workers, and for organizations alike.

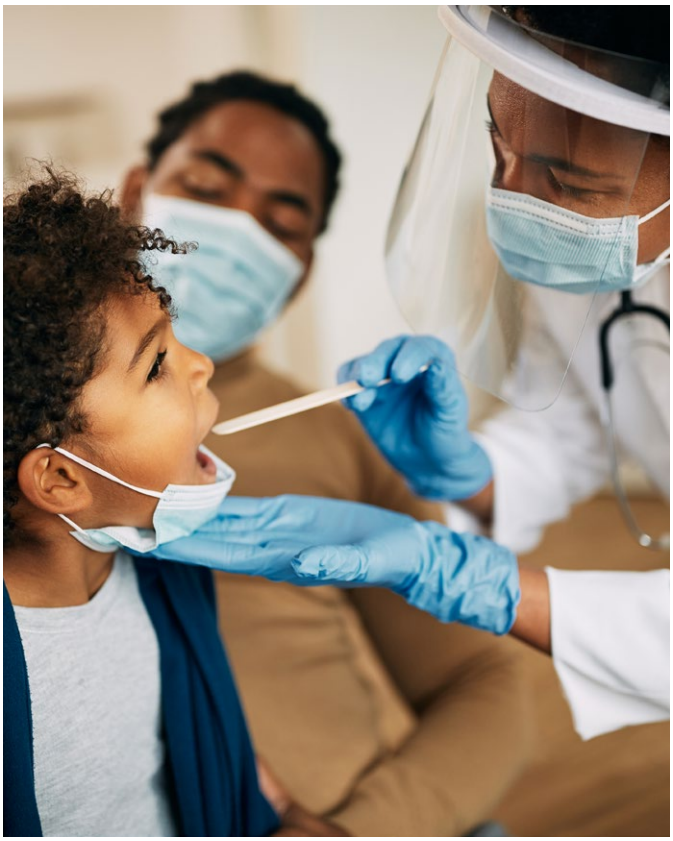


FIGURE 4

POLICY RECOMMENDATIONS TO ENABLE INTEGRATED CARE FOR NEWCOMERS

Recognize settlement as a health and wellness issue

Make integrated care work for newcomers	Make integrated care work for frontline workers	Make integrated care work for organizations
✓ Include newcomers of all statuses	✓ Provide integration incentives and resources	✓ Align incentives across organizations
✓ Expand support services and locations	✓ Develop information-sharing systems and guidance	✓ Provide change management support
✓ Support robust community engagement	✓ Implement training and education programs	✓ Require race-based and sociodemographic data collection

Recognize settlement as a health and wellness issue

Health and settlement are typically treated as separate policy issues, falling under different orders and ministries of government. This siloed approach has been a critical barrier to integration at the service level, leaving newcomers with fragmented health and social supports. Some decision-makers have taken steps to respond to calls for integration. For instance, the City of Toronto named "promoting and supporting good health" as a strategic priority in its 2013 Toronto Newcomer Strategy.[33] Community Health Centres have also long been providing coordinated health and social services.[34] More recently, the Ontario Ministry of Health and Long-Term Care has started integrating care through the new Ontario Health Teams (OHTs), which are groups of providers responsible for delivering services across the care continuum for a geographic population.[35] But more can and needs be done to ensure that efforts to integrate care consider settlement and newcomers' specific health and wellness challenges.

To realize integrated care for newcomers, we need to first take action to recognize settlement as a health and wellness issue. Policymakers, settlement service providers, and health care organizations should:

- **Make newcomer health and wellness a strategic priority.** Government should begin to break down policy silos by prioritizing newcomer well-being across both health and settlement ministries and departments, setting the stage for further coordinated efforts. Collaboration on issues facing newcomers has been done before (e.g. the Canada-Ontario Immigration Agreement[36]), but more sustained partnership across orders of government is needed for integrated newcomer care to scale and thrive. Service providers need to take similar action too, mirroring the shift at the policy level. Organizations across the continuum of care should include and provide for newcomer health and wellness in their strategic plans and coordinate across traditional service silos. For instance, OHTs could include newcomers as a priority population, setting the stage for a collaborative plan of action that addresses settlement as a health and wellness issue.
- **Allocate funding to newcomer health and wellness supports** in both health and settlement budgets. Provincial health systems need to carve out resources to enable health care organizations to dedicate resources to holistically addressing newcomer health specifically. At the same time, governments that fund settlement services need to allocate resources for service providers to be able to invest in newcomer health and wellness programs. While the federal government, the largest funder of settlement services, has largely stayed away from newcomer health, the reality on the ground shows that this needs to change. It's clear that settlement and health are intertwined.

Make integrated care work for newcomers

Newcomers need to be at the heart of integrated care. Any effort to reduce fragmentation between health and settlement must centre their diverse needs first and foremost. Policymakers need to engage newcomer populations and remove obstacles to care that impact individuals on the basis of racialization, gender, age, language, socioeconomic background, and immigration status. Integrated care alone will be ineffective at improving access to care for newcomers if these barriers to accessing integrated care itself remain unaddressed. **The following recommendations are aimed at ensuring integrated care initiatives provide support in a way that promotes health equity and resonates with newcomers and their communities.**

A INCLUDE NEWCOMERS OF ALL STATUSES

Frontline staff working on WoodGreen's IPC team point to the program's broad eligibility requirements as a critical success factor. We heard from interviews that many newcomers who would benefit from the integration of health and settlement services lack secure legal status in Canada. At the same time, we heard that integrated care would also benefit people who are not new to Canada per se, but are new to care services and face barriers like language and information gaps. For instance, WoodGreen's IPC team has served newcomers who have been in Canada for many years but have previously been unable to access language training and other settlement supports.

Still, narrow and disparate inclusion criteria across other services leave many newcomers without help and increases the burden of system navigation. On the settlement side, services funded federally are restricted to individuals who are not yet Canadian citizens and have select immigration statuses.[37] While provincially and municipally-funded programs tend to have broader criteria, many temporary residents, refugee claimants, individuals without status, and naturalized citizens remain unable to access settlement support.[38] On the health side, many newcomers are ineligible for provincial health insurance or have their coverage delayed, leaving them to pay for expensive care out-of-pocket. For instance, permanent residents in Ontario are typically required to wait three months before they are eligible for the Ontario Health Insurance Program (OHIP).[39] Even when select groups of newcomers are eligible for temporary support under the Interim Federal Health Program (IFHP), some providers are unaware or unwilling to serve newcomers under this coverage.[40] This means that needed care is often delayed, forgone, or inadequate, contributing to stress and poor health outcomes.[41]

To make sure help can be accessed by people who need it most, integrated care for newcomers needs to include individuals of all statuses. Policymakers should:

Enable integrated care initiatives to have broad, inclusive eligibility criteria. This means including newcomers who are uninsured and individuals who don't have secure legal status, or are undocumented. It also means serving newcomers who have been in Canada for a long time or who have obtained Canadian citizenship. We've seen the benefits of such inclusive eligibility throughout the COVID-19 pandemic. For instance, Ontario's move to waive the three-month OHIP waiting period, cover the cost of COVID-19 services, and fund hospital and physician services for medically necessary health care for individuals without insurance, has removed eligibility barriers to screening and treatment for the virus.[42] Not only has this benefited newcomer health, but also wider population health, as it helps to reduce potential community transmission.

B EXPAND SUPPORT SERVICES AND LOCATIONS

Integrated care needs to be designed to meet newcomers where they are — in languages, at locations, and with supports that meet their needs. This means providing services that promote equitable access and delivering care within the communities where newcomers live — backed up with language services, childcare, and transportation supports.

Language services

A key success factor for the WoodGreen IPC model has been access to language and cultural interpretation support. Newcomers to Canada come from diverse linguistic and cultural backgrounds.[43] We heard in interviews that many newcomers have trouble communicating their health, wellness, and cultural needs in English or French. At the same time, we heard that health care providers are often unable to deliver support in other languages, and can be unaware of or insensitive to cultural factors. These language and cultural gaps can be a large obstacle to care and contribute to health inequities.[44] We heard that misunderstandings between newcomer clients and service providers occur frequently, resulting in misdiagnoses, inappropriate interventions, and delayed care. Language barriers have been associated with increased risk of medical errors, adverse treatment reactions, and hospital admissions.[45]

But while language services are funded through Immigration, Refugees and Citizenship Canada (IRCC) for settlement programs, language and cultural supports are not widely available in health care settings.[46] Health care providers are given little guidance or financial support for interpretation and translation services.[47] To fill the gap, many health care professionals turn to untrained interpreters like family members or friends. This can result in critical interpretation errors, undermines privacy and informed consent, and prevents newcomers from fully and directly participating in their own care.[48]

> "I'm baffled why doctors don't have more access to interpretation services. I've had clients come to me with depression symptoms. But since they couldn't clearly communicate this to their doctors, they weren't receiving the right treatment."
>
> – IPC case counselor specialist

Integrated care initiatives need to break down language and cultural barriers to improve equitable access to care for diverse newcomer communities. Policymakers should collaborate with health care, settlement, and other social service organizations to:

- Develop and implement coordinated language services at scale. This would enable widespread and seamless language and cultural interpretation support, providing newcomers and frontline workers with immediate access to face-to-face or telephone-based assistance during and across service interactions.[49] We've seen the benefits of this type of support through initiatives like Language Services Toronto, an over-the-phone interpretation service created by the Toronto Central Local Health Integration Network.[50] Programs like this need to be more widely adopted, with service provider organizations providing continuous onboarding and training to ensure that newcomers and frontline workers are aware of and know how to use available support.

Child care services

Poor access to child care can also serve as a barrier to health and settlement services. Many newcomer families cannot afford to pay for formal child care services and have to turn to their own informal supports instead.[51] We heard from interviewees that when newcomers with caregiving responsibilities don't have family or friends able to look after their children, they end up missing or delaying critical appointments. We've seen how this lack of consistent, quality, and affordable child care restricts access to health and settlement services for newcomer women in particular, who more often take on caregiver roles within their families.[52] For instance, one of WoodGreen's newcomer clients had to delay receiving her COVID-19 vaccine for months due to a lack of child care support. As a single mother with two autistic children, she was unable to leave her kids at home by themselves to attend a vaccination clinic.

Existing child care supports for newcomers are insufficient. The federal government funds some limited on-site child care.[53] But this support is restricted to only some services, mainly language programs, and available supports have long waiting lists. The House of Commons Standing Committee on Citizenship and Immigration has recommended that more child care services need to be available to improve access to services.[54] At the same time, health policy does not generally provide for this type of support for newcomers and it's left up to individual providers.

More child care supports are needed for integrated care initiatives to be accessible for newcomers and to ensure equitable service provision across genders. Policymakers should:

- **Develop and scale child care across services, or increase funding avenues for organizations to provide this support** so that newcomer parents and guardians have easy and flexible access to integrated care. This could include expanding the settlement sector's on-site child care services to health care settings or adopting a similar provincial model across integrated health and settlement services. Alternatively, child care funds or subsidies could be provided to newcomers to help them pay for offsite support.

Location and transportation

Where you live has a big impact on the health and social care you receive. We heard in interviews that newcomers often live in areas with less access to health and social supports. They tend to be overrepresented in lower-income neighbourhoods at the periphery of cities, while health and settlement services have traditionally been concentrated in central areas.[55] We heard that this historic and present under-resourcing of newcomer neighbourhoods means many individuals have to seek care far outside their communities. This poses an additional challenge, however: newcomers often do not have private vehicles and the neighbourhoods they tend to live in lack rapid public transit.[56] The transit available is expensive and is an additional cost barrier to care.[57] This need to travel for care presents particular added challenges for newcomers with children, newcomers who are seniors, and newcomers who have disabilities.[58]

There has been a lack of investment in services in newcomer communities. While government funds some limited transportation services for its programs, this support is mainly provided for participation in language programs and is not readily available in the health care system. But even with transportation assistance, many newcomers are precariously employed and lack the flexibility and financial security to take on the opportunity cost of missing work to travel far for care. And while virtual solutions may work well for other populations, newcomers often state a preference for interpersonal interaction and face barriers to accessing needed technology.[59]

To be successful, integrated care initiatives need to connect services to the neighbourhoods where newcomers live and work. Policymakers should:

- **Invest in permanent locations in newcomer communities** to address the inequitable distribution of care services. In the interim, government should collaborate with health care, settlement, and other social service organizations to support the development and delivery of outreach services where newcomers live and work, such as regular mobile clinics, which could help to facilitate access to integrated care.
- **Provide vouchers or reimbursement for transportation to services, or increase funding avenues for organizations to provide this support** in order to alleviate financial barriers that newcomers face when accessing care outside of their communities when needed.

MEETING NEWCOMERS WHERE THEY ARE: CRESCENT TOWN COMMUNITY ASSESSMENT CENTRE

Crescent Town is a densely-populated neighbourhood in East Toronto. Many residents who live there are low-income, racialized, recent newcomers who often perform essential work and live in crowded housing, making the area a high risk for COVID-19 outbreaks.[60] As provincial assessment criteria opened up in May 2020, our IPC team jumped into action to assist Michael Garron Hospital and our primary care partners in creating the Crescent Town Community Assessment Centre. By bringing COVID-19 testing services to the community, the team was able to test 410 people in only 8 days, finding 7 positive cases that would have otherwise gone undetected and spread throughout the community.[61] The Crescent Town Community Assessment Centre was the first community-based testing service in the province and has served as a key model for bringing critical COVID-19 services to newcomers. It's been replicated in other neighbourhoods and has also been adapted to support community-based vaccination efforts.

A SUPPORT ROBUST COMMUNITY ENGAGEMENT

Finally, WoodGreen's IPC work has shown that integrated care initiatives work best when newcomer communities play an active role. We heard from interviewees that engaging newcomers and their communities in initial planning through to active service delivery helps to ensure that integrated care initiatives are targeted to local needs, are representative of diverse interests, and are adaptable to changing priorities. By partnering with community members, care providers benefit from being able to quickly identify emerging issues and rapidly mobilize interventions from the ground up, like volunteer networks to check-in with community elders.[62] We also heard that ongoing and meaningful community engagement is essential for developing trust and accountability between service providers and newcomer populations.

To gain these benefits, integrated care initiatives need to be guided by systematic and sustained engagement with newcomers and their communities. Policymakers, health care organizations, settlement providers, and other social service agencies should:

Mandate and fund robust community engagement efforts as central components of their integrated newcomer care strategy. For instance, the Government of Ontario already requires OHTs to engage with local communities in development of their collaborative decision-making arrangements and to provide for direct participation of patients, families, and caregivers in decision-making.[63] The inclusion of leaders from newcomer communities in the governance of integrated care programs would be a natural extension of this policy. Another promising approach is for provider organizations to create formal community outreach roles on integrated care teams. Community health workers, multicultural health brokers, and settlement workers who are members of the communities they serve or trained volunteers are ideal candidates to serve as liaisons and cultural brokers.[64]

ENGAGING NEWCOMER COMMUNITIES: CRESCENT TOWN COMMUNITY RESPONSE TEAM

WoodGreen's IPC team also collaborated with Michael Garron Hospital, TNO - The Neighborhood Organization, South Riverdale Community Health Centre, and other partners to form the Crescent Town Community Response Team during the COVID-19 pandemic.[65] Residents from the community were eager to volunteer for the initiative. In addition to checking in with their neighbours, volunteers helped connect residents with available resources, distributed over 6,000 face masks, and shared posters with critical COVID-19 information in multiple languages. The volunteers also met with staff from our IPC team every week to discuss community concerns, providing key information and guidance that helped target our efforts to reduce community transmission. The initiative has since grown into a community ambassador program that works closely with the community to address health inequity.

Engaging newcomers helps to ensure that integrated care initiatives are targeted to local needs, are representative of diverse interests, and are adaptable to changing priorities.

Make integrated care work for frontline workers

Frontline workers make up the backbone of integrated care. They are a central point of coordination, interacting directly with newcomers, other providers, and management. Their success is crucial to any program's success. **The following recommendations are aimed at ensuring frontline workers have the resources, information, training and support they need to deliver support in integrated newcomer care initiatives.**

A PROVIDE INTEGRATION INCENTIVES AND RESOURCES

Integrated newcomer care requires frontline workers to engage in large amounts of non-service work such as meetings with other providers, community engagement, and client advocacy. It requires significant administrative and management support to help coordinate care across services. Interviewees told us that programs are often not funded in a way that provides resources for these activities and support staff. We heard that this leaves frontline workers unable to fully engage or forces them to work on critical integration activities unpaid and off-the-side of their desks.

> Frontline workers make up the backbone of integrated care.

Across health and settlement, payment models undermine efforts to integrate frontline work. On the settlement side, service provider organizations are mostly funded under Contribution Agreements for five-year periods or less.[66] These program contracts provide minimal funding for key integrated care activities like coordinating services and managing partnerships.[67] They also leave settlement agencies without the sufficient and stable funding needed to build capacity and ensure stability for their frontline workers.[68] On the health care side, payment models for health professionals also predominately focus on service delivery, rather than care coordination activities. For instance, many family physicians are paid directly under a fee-for-service model, which rewards volume and provides little incentive for engaging with non-medical service providers in ongoing collaborative care.[69] There has been movement away from these types of activity-based payments, however, towards blended capitation (i.e. per patient) payments in some provinces like Ontario.[70] For instance, Family Health Network and Family Health Organization models are now primarily compensated through capitation payments.[71]

To enable full and fair participation of frontline workers and the development of collaborative teams across providers, we need to have sufficient resources and the right incentives for key activities and supports in place. Policymakers should:

- **Increase core funding for settlement service provider organizations.** Providing these agencies with larger and more flexible allotments for coordination and other non-service activities associated with integrated care will enable frontline workers to more effectively and sustainably participate in initiatives.
- **Partner with physicians to continue payment model reform and evaluation to improve their ability to engage in integrated care activities**, by developing alternatives that are informed by their frontline experiences, and client preferences and needs. Payment model options that support physician participation in integrated care is essential to wholistic, effective care delivery, and access to services for newcomer families, who often resort to walk-in clinics or the ER to obtain immediate care would benefit from coordinated care that includes services aimed at their medical and social wellness.

B DEVELOP INFORMATION-SHARING SYSTEMS AND GUIDANCE

Information-sharing between professionals is a key enabler of integrated care.[72] It allows frontline workers to understand newcomer needs, monitor outcomes and interventions, and better coordinate services. But interviewees told us that frontline workers often aren't able to access key information about newcomer clients from other providers. Instead, they are forced to develop creative workarounds. We heard that accessing just one piece of data such as a patient's COVID-19 vaccination status can take a series of email chains or multiple phone calls—wasting time and resources better spent interacting with newcomers and serving their needs.

Across health and settlement, frontline workers face barriers to sharing information. There is a lack of integrated information and communication technology (ICT) systems. Care records and other documentation are often kept on inoperable digital systems and, in some cases, physical records are still used.[73] Information-sharing between frontline workers is also inhibited by differences in data governance policies across professions, providers, and sectors. For instance, while Ontario health care providers must comply with the Personal Health Information Protection Act (PHIPA), this legislation does not normally apply to settlement organizations.[74] Instead, settlement agencies must comply with the Personal Information Protection and Electronic Documents Act (PIPEDA), which is not specifically targeted at health information. Different providers are often risk averse to sharing in this context, leaving frontline workers without the information they need to deliver integrated care.

Information-sharing between health and settlement providers needs to be enabled for integrated newcomer care initiatives to succeed. Policymakers should:

- **Invest in integrated ICT systems** for both health and settlement services. This could include the development of a single shared electronic health record that is accessible across the continuum of care, no matter the service provider, in real time. Such a system would help improve care coordination, communication, and decision-making.
- **Provide guidance on information-sharing rules** across health and settlement. This would help to create certainty and reduce the operational risks of sharing information across providers. For instance, government could develop regulations that impose PHIPA-equivalent obligations on settlement agencies in integrated care or create standard terms for information sharing across sectors to reduce the burden on organizations.[75]

REVISITING MARIA: THE IMPACT OF INTEGRATED CARE

On page 8, we told the story of Maria, a newcomer facing language barriers while trying to access care for her son. Maria received the pediatrician referral via WoodGreen's IPC team. Her counsellor was following her case, and because they had access to her electronic medical record (EMR), they could see that the appointment for Maria's child had been cancelled. The counsellor called Maria and was able to have an interpreter on the phone with them. Maria was surprised that the appointment had been cancelled: she had been waiting anxiously for a follow up from the doctor's office. The counsellor connected with the pediatrician's office and rescheduled the appointment for Maria's son. Maria and her son are seeing the pediatrician regularly. They're working through a diagnosis and care plan, and her son's health is slowly improving. Maria has also been connected to language classes and has already improved her English skills. She is still anxious sometimes, but she feels more in control of this part of her life.

C IMPLEMENT TRAINING AND EDUCATION PROGRAMS

Integrated care for newcomers requires frontline workers to work differently together and in a multidisciplinary context that they may not have been traditionally trained for. As such, systems thinking and collaboration across traditional disciplinary boundaries can be challenging for many professionals.[76] We heard in interviews that frontline workers from different service providers can have conflicting views about newcomer priorities and sometimes don't have deep knowledge about each other's roles. Though the province is moving toward a health teams model, training in integrated care is not widely available to help practitioners manage these differences and adopt new ways of collaborating.[77] Instead, health workers are typically educated in professional training silos, which negatively impacts their ability to work on integrated care teams.

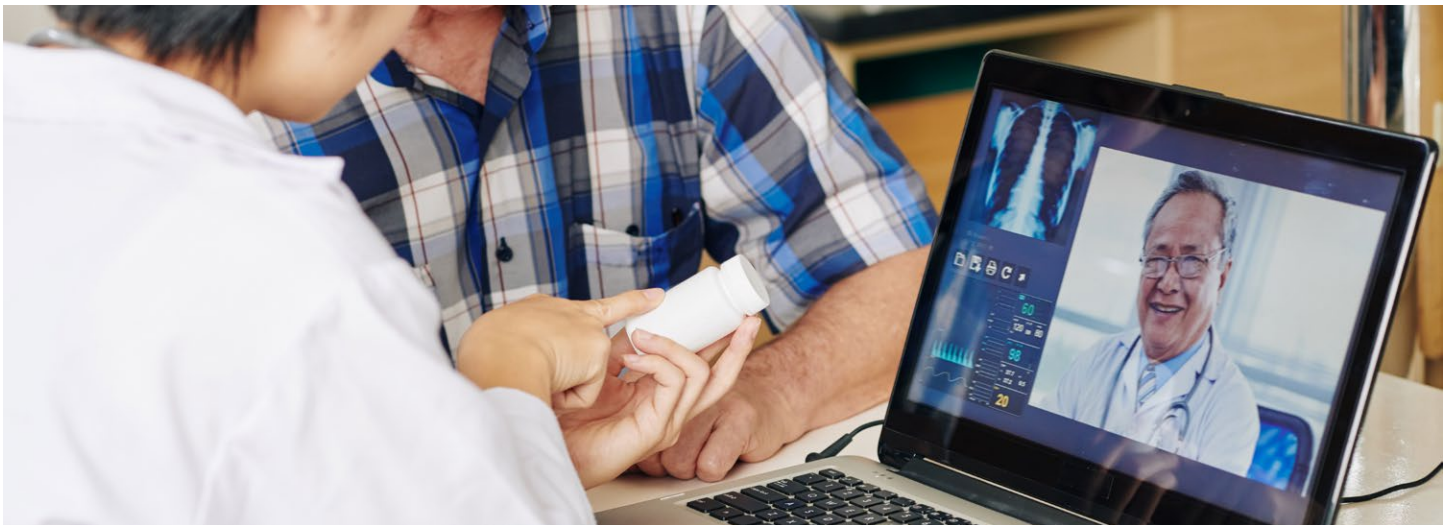
At the same time, integrated care for newcomers also means working with diverse and vulnerable populations. Some newcomers have experienced trauma before and throughout the settlement process. Other people with precarious immigration statuses may fear being reported to immigration authorities while accessing care services.[78] Many newcomers also belong to racialized groups and have experienced racism, bias, and discrimination, including in the health care system.[79] But we heard from interviewees that providers are often not prepared to deliver care that is responsive to these experiences. Many professionals have not been trained in anti-oppression and anti-racism frameworks, undermining their ability to create an environment where newcomers feel safe, included, and empowered while accessing care.[80]

The development and implementation of training programs for professionals engaging in integrated newcomer care initiatives is needed. Policymakers should encourage and provide resources for academic institutions and service providers to:

- **Develop and deliver team-based and interprofessional training** in educational and professional contexts to prepare practitioners to collaborate across traditional service boundaries. This will enable professionals to develop core competencies in integrated care, including advocacy, communication, teamwork, people-centred care, and continuous learning.[81] Interprofessional education in pre- and post-licensure training has been shown to set health professionals up for success in collaborative practice, helping them improve the efficiency and quality of their work and gain a better understanding of the roles of other professionals on joint care teams.[82]
- **Develop and deliver anti-oppression and anti-racism training** in educational and professional contexts to prepare practitioners to deliver care that is responsive to the diverse needs and experiences of newcomers. This will enable professionals to understand how their own privilege and biases inform their work, engage in actions that reduce power imbalances and promote equity, and empower newcomer clients.[83]

TRAINING FOR INTEGRATED CARE: ST. MICHAEL'S HOSPITAL ACADEMIC FAMILY HEALTH TEAM

St. Michael's Hospital Academic Family Health Team (SMHAFHT) is a primary care teaching clinic affiliated with the University of Toronto.[84] It operates at six clinical sites and serves patients facing many social determinants of health. SMHAFHT delivers an interprofessional education (IPE) program to train upcoming health professionals to work collaboratively in care teams.[85] The IPE program has been a large success, with a member of the Academic Family Health Team noting that over 15 years of evaluation data has demonstrated that students improved their collaborative practice competency through the initiative.



Make integrated care work for organizations

Organizations across health and settlement sectors have typically operated in silos. For integrated newcomer care to succeed, organizations need to come together in partnership. **The following recommendations are aimed at ensuring organizations have the aligned incentives, change management, and monitoring and evaluation support that they need to develop, put into action, and achieve integrated care for newcomer populations. This includes aligning incentives across organizations, providing support for change management, and moving to collect the right demographic data needed to evaluate success.**

A ALIGN INCENTIVES ACROSS ORGANIZATIONS

Health and settlement providers still face fragmented incentives that reward organizations for individual, rather than collective, action and outcomes. We heard from interviewees that this can be a challenge to achieving shared goals for newcomer health and wellness. Each organization is responsible to their own boards, strategic plans, and funders with individual accountability requirements that can come into tension with the shared objectives of integrated care.[86] Since health and settlement services are funded by and accountable to different bodies, there are few incentives for collaboration and care coordination between and even within the two sectors.[87] Organizations might actually be in competition with each other for the same resources or care market share, leading to a scarcity mindset.

To enable organizations to collaborate and focus on shared goals, government needs to consult with service providers to design and implement aligned incentives that meet organizational needs and facilitate participation in integrated care initiatives. Policymakers should:

- **Implement shared accountability frameworks** to incentivize attention to the needs of newcomers within the context of the whole care system, rather than the needs of individual organizations. This will help to align priorities across partners in integrated care and provide a common basis for joint decision-making.
- **Integrate program financing** to promote inter-organizational collaboration, rather than competition. While traditional reforms have typically focused on single sectors, integrated financing would align incentives across health and settlement organizations. For instance, participating organizations could operate using pooled funds, where each partner contributes to a common fund.[88] Alternatively, organizations could receive population-based integrated funding, where the group of providers would collectively receive funding for a defined population.[89] These models would need to be implemented in a way that distributes funding equitably to each partner organization.

B PROVIDE CHANGE MANAGEMENT SUPPORT

Adopting methods of cross-organizational working, creating shared program objectives, and establishing joint procedures will require more than just incentives. Given the long siloed history between health and settlement organizations, organizations will also need sufficient time and dedicated resources to implement transformational changes to the way they work together to deliver newcomer care.[90]

While many organizations stand ready and willing to pursue the path towards integration, they often don't have the capacity, resources, or supports to do this kind of work. We heard in interviews that outside of their integrated care efforts, health and settlement organizations already have slim operating budgets and are being tasked with doing more with less. Despite increased operating costs and heightened demand, settlement organizations have faced budget cuts in recent years and lack stable, multi-year funding for engaging in long-term transformational change.[91] Similarly, health organizations have also faced fiscal restraint.[92]

Government has taken some steps to acknowledge this situation and provide more resources to support organizations in the development and implementation of integrated care initiatives. For instance, the Government of Ontario has developed the OHT Central Program of Supports. It includes guidance documents on issues like collaborative decision-making arrangements, with a checklist of minimum requirements, and the Rapid-Improvement Support and Exchange (RISE), a website with access to resources and experts on OHTs.[93] After further consultation, OHTS are also now eligible to receive one-time funding to support capacity and generate momentum.[94] We heard in interviews that organizations appreciate the autonomy and flexibility provided under the government's current light-touch approach.

But we also heard that greater and sustained support for organizational change management is needed to enable initiatives to scale-up and reach maturity. Policymakers should:

Fund and provide supports for change management to help organizations make the transition to integrated care for newcomers. In practice this could look like resource allocations for key transformation activities. For example, funds for joint working groups to align goals across health and settlement, funds for community needs assessments to ensure initiatives are responsive to local contexts, and funds for greater evaluation efforts to track progress and enable innovation. It could also look like providing guidance on beneficial governance structures and dedicated change management experts for each integrated care initiative.

C REQUIRE RACE-BASED AND SOCIODEMOGRAPHIC DATA COLLECTION

Organizations looking to improve newcomer health access and outcomes through integrated care need to monitor and evaluate their initiatives using a health equity lens. Race-based and sociodemographic data collection and analysis is an essential part of that work. This information is critical to ensuring that integrated care eliminates, rather than produces, health inequalities. It enables organizations to see if services are being provided equitably across newcomer populations and if there are needed adjustments to address any gaps in care.[95]

But while race-based and sociodemographic data collection is a standard health practice globally, Canada has fallen behind.[96] Governments and health providers have often failed to track this critical information, including during the COVID-19 pandemic[97], which has had disproportionate impacts on Black, Indigenous, and newcomer populations. There are some entities that have been measuring data for health equity and to assist in health planning for the past few years, like hospitals and Community Health Centres within the Toronto Central Local Health Integration Network.[98] But this has been the exception, not the norm.

Organizations need to collect this data if their integrated care initiatives are to promote health equity for newcomer populations. Policymakers and service providers should:

Conduct race-based and sociodemographic data collection, analysis, and reporting to see if there are any inequalities, illuminate any needed adjustments to integrated care, and promote accountability for equitable and inclusive service provision.

Conclusion

Most people who come to Canada cite the desire for a better quality of life as their main motivation for migrating. But when we look at the poor health and wellness outcomes of many newcomers, it's clear that this goal is not being achieved. From inadequate housing, food insecurity, through to racism and discrimination, we've seen how the conditions in which newcomers live, work, and age are negatively impacting their health and well-being.

Current avenues for newcomer care are not set up to address these complex challenges. We have settlement services focused on social issues and health services focused on medical issues, but lack the holistic perspective needed to address the challenges facing newcomers that bridge these two spheres. Newcomers are falling through the space in-between health and settlement silos. Their needs are being left unmet and they are forced to navigate a complex maze of different providers focused on different issues.

We need to integrate health and settlement services to close the gap. By reducing fragmentation, integrated care for newcomers stands to improve health and wellness outcomes and deliver a more seamless experience of accessing help. But for integrated newcomer care initiatives to succeed and scale, time and support are needed. We need to recognize settlement as a health and wellness issue and implement interventions that make integrated care work for newcomers, for frontline workers, and for organizations alike.

Integrated care for newcomers is needed now more than ever before. We've witnessed the disproportionate impact COVID-19 has had on newcomers, exacerbating many of the conditions that have already undermined their health and wellness. At the same time, Canada is planning on increasing the number of newcomers it will welcome over the next few years to make up for shortfalls in admissions caused by the pandemic. To promote well-being and health equity for present and future newcomers, the right supports have to be in place.

An immediate and collaborative effort is needed. Government needs to partner with stakeholders across the continuum of care to address existing challenges to implementing integrated care and to promote the right conditions for adoption at scale. Now is the time for Canadian policymakers, health care organizations, settlement service providers, and local community agencies to take collective action and integrate health and settlement services.

Now is the time for integrated newcomer care.

Endnotes

1 Immigration, Refugees and Citizenship Canada, "Canada Announces 3 New Initiatives to Welcome and Support More Refugees," Government of Canada, June 18, 2021, https://www.canada.ca/en/immigration-refugees-citizenship/news/2021/06/canada-announces-3-new-initiatives-to-welcome-and-support-more-refugees.html; Immigration, Refugees and Citizenship Canada, "Government of Canada Announces Plan to Support Economic Recovery Through Immigration," Government of Canada, October 30, 2020, https://www.canada.ca/en/immigration-refugees-citizenship/news/2020/10/government-of-canada-announces-plan-to-support-economic-recovery-through-immigration.html

2 Grant Schellenberg and Hélène Maheux, "Immigrants' Perspectives on Their First Four Years in Canada: Highlights From Three Waves of the Longitudinal Survey of Immigrants to Canada," Statistics Canada, November 21, 2008, https://www150.statcan.gc.ca/n1/en/catalogue/11-008-X20070009627.

3 Edward Ng, *The Healthy Immigrant Effect and Mortality Rates* (Ottawa: Statistics Canada, November 2011), https://www150.statcan.gc.ca/n1/pub/82-003-x/2011004/article/11588-eng.pdf.

4 Faraz Vahid Shahidi, *Community-Based Perspectives on the Political Economy of Immigrant Health: A Qualitative Study* (Toronto: Wellesley Institute, December 2011), https://www.wellesleyinstitute.com/wp-content/uploads/2012/05/Political-Economy-of-Immigrant-Health.pdf.

5 World Health Organization, "Social Determinants of Health," WHO, accessed July 7, 2021, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1; Samantha Artiga and Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (San Francisco: Kaiser Family Foundation, May 2018), https://files.kff.org/attachment/issue-brief-beyond-health-care.

6 John Shields and Zainab Abu Alrob, COVID-19, *Migration and the Canadian Immigration System: Dimensions, Impact and Resilience* (Toronto: BMRC-IRMU, July 2020), https://bmrc-irmu.info.yorku.ca/files/2020/07/COVID-19-and-Migration-Paper-Final-Edit-JS-July-24-1.pdf?x82641.

7 Immigration, Refugees and Citizenship Canada, "Service Delivery Improvements Funding Process: Funding Guidelines," Government of Canada, April 20, 2021, https://www.canada.ca/en/immigration-refugees-citizenship/corporate/partners-service-providers/funding/guidelines-service-delivery-improvements.html#clients.

8 Stephanie Premji, "'It's Totally Destroyed Our Life': Exploring the Pathways and Mechanisms Between Precarious Employment and Health and Well-Being Among Immigrant Men and Women in Toronto," *International Journal of Health Services* 48, no. 1 (2018): 106–27, https://doi.org/10.1177/0020731417730011; Stephanie Premji and Yogendra Shakya, "Pathways Between Under/Unemployment and Health Among Racialized Immigrant Women in Toronto," *Ethnicity and Health* 22, no. 1 (2017): 17–35, https://doi.org/10.1080/13557858.2016.1180347.

9 Valerie Preston et al., "Precarious Housing and Hidden Homelessness Among Refugees, Asylum Seekers, and Immigrants in the Toronto Metropolitan Area," *CERIS Working Paper Series* (Toronto, December 2011), https://ighhub.org/resource/precarious-housing-and-hidden-homelessness-among-refugees-asylum-seekers-and-immigrants.

10 Anjana Aery and Kwame McKenzie, *Primary Care Utilization Trajectories for Immigrants and Refugees in Ontario Compared with Long-Term Residents* (Toronto: Wellesley Institute, November 2018), https://www.wellesleyinstitute.com/wp-content/uploads/2018/11/Primary-care-utilization-trajectories-for-immigrants-and-refugees-in-Ontario-compared-with-long-term-residents.pdf.

11 Sheryl Nestel, *Colour Coded Health Care: The Impact of Race and Racism on Canadians' Health* (Toronto: Wellesley Institute, 2012), https://www.wellesleyinstitute.com/health/colour-coded-health-care-the-impact-of-race-and-racism-on-canadians-health/; Ilene Hyman, *Racism as a Determinant of Immigrant Health* (Ottawa: Public Health Agency of Canada, 2009), https://www.researchgate.net/publication/255654375_Racism_as_a_determinant_of_immigrant_health.

12 Shields and Alrob, *COVID-19, Migration and the Canadian Immigration System: Dimensions, Impact and Resilience*.

13 Astrid Guttmann et al., *COVID-19 in Immigrants, Refugees and Other Newcomers in Ontario: Characteristics of Those Tested and Those Confirmed Positive*, as of June 13, 2020 (Toronto: ICES, September 2020), https://www.ices.on.ca/Publications/Atlases-and-Reports/2020/COVID-19-in-Immigrants-Refugees-and-Other-Newcomers-in-Ontario.

14 Jessica Praznik and John Shields, *An Anatomy of Settlement Services in Canada: A Guide* (Toronto: BMRC-IRMU, July 2018), https://bmrc-irmu.info.yorku.ca/files/2018/07/An-Anatomy-of-Settlement-Services-in-Canada_BMRCIRMU.pdf.

15 Gregory P. Marchildon, Sara Allin, and Sherry Merkur, "Canada: Health System Review," *Health Systems in Transition* 22, no. 3 (2020): 1–194, https://eurohealthobservatory.who.int/publications/i/canada-health-system-review-2020.

16 Tanvir C. Turin et al., "Overcoming the Challenges Faced by Immigrant Populations While Accessing Primary Care: Potential Solution-Oriented Actions Advocated by the Bangladeshi-Canadian Community," *Journal of Primary Care & Community Health* 12 (2021): 1–11, https://doi.org/10.1177/21501327211010165.

17 Praznik and Shields, *An Anatomy of Settlement Services in Canada: A Guide.*

18 Ng, *The Healthy Immigrant Effect and Mortality Rates*.

19 World Health Organization Regional Office for Europe, *Integrated Care Models: An Overview* (Copenhagen: WHO Regional Office for Europe, October 2016), https://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf.

20 Sara Shaw, Rebecca Rosen, and Benedict Rumbold, *What Is Integrated Care? Research Report* (London: Nuffield Trust, June 2011), https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-report-web-final.pdf; Dennis L. Kodner and Cor Spreeuwenberg, "Integrated Care: Meaning, Logic, Applications, and Implications – A Discussion Paper," *International Journal of Integrated Care* 2, no. 4 (2002): 1–6, https://doi.org/10.5334/ijic.67.

21 Dennis Kodner, "All Together Now: A Conceptual Exploration of Integrated Care," *Healthcare Quarterly* 13 (2009): 6–15, https://doi.org/10.12927/hcq.2009.21091.

22 Peter Clutterbuck et al., *Towards an Integrated Immigrant Services Delivery System in Durham Region: Research and Considerations for Moving Forward* (Ajax: Community Development Council Durham, August 2010), https://www.cdcd.org/wp-content/uploads/2015/06/CDCD-Aug-2010.pdf.
Please also find an alternative link for the Clutterbuck et. al source (end note #22) below:
https://www.cdcd.org/wp-content/uploads/2021/06/CDCD-Aug-2010.pdf

23 Brigid Pike and Deirdre Mongan, *The Integration of Health and Social Care Services* (Dublin: Health Research Board, February 2014), https://www.hrb.ie/fileadmin/publications_files/The_integration_of_health_and_social_care_services_2014.pdf.

24 Kodner, "All Together Now: A Conceptual Exploration of Integrated Care"; Shaw, Rosen, and Rumbold, *What Is Integrated Care? Research Report*.

25 Premier's Council on Improving Healthcare and Ending Hallway Medicine, *A Healthy Ontario: Building a Sustainable Health Care System* (Toronto: Government of Ontario, June 2019), https://files.ontario.ca/moh-healthy-ontario-building-sustainable-health-care-en-2019-06-25.pdf; Rishi Sikka, Julianne M. Morath, and Lucian Leape, "The Quadruple Aim: Care, Health, Cost and Meaning in Work," *BMJ Quality & Safety* 24 (2015): 608–10, https://doi.org/10.1136/BMJQS-2015-004160; World Health Organization, *WHO Global Strategy on Integrated People-Centred Health Services 2016 – 2026: Executive Summary* (Geneva: WHO, July 2015), https://interprofessional.global/wp-content/uploads/2019/11/WHO-2015-Global-strategy-on-integrated-people-centred-health-services-2016-2026.pdf.

26 Rishi Hazarika and Sarah Purdy, "Integrated Care: Demonstrating Value and Valuing Patients," *Future Hospital Journal* 2, no. 2 (2015): 132–36, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6460198/.

27 Josephine McMurray et al., "Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada," *Journal of Immigrant and Minority Health* 16 (2014): 576–85, https://doi.org/10.1007/s10903-013-9954-x.

28 Leo Lewis and Nieves Ehrenberg, *Realising the True Value of Integrated Care: Beyond COVID-19* (Oxford: International Foundation for Integrated Care, May 2020), https://integratedcarefoundation.org/publications/realising-the-true-value-of-integrated-care-beyond-covid-19-2; Mahiben Maruthappu, Ali Hasan, and Thomas Zeltner, "Enablers and Barriers in Implementing Integrated Care," *Health Systems & Reform* 1, no. 4 (2015): 250–56, https://doi.org/10.1080/23288604.2015.1077301.

29 Thomas Bodenheimer and Christine Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *The Annals of Family Medicine* 12, no. 6 (2014): 573–76, https://doi.org/10.1370/afm.1713.

30 Donna Sullivan Havens, Jody Hoffer Gittell, and Joseph Vasey, "Impact of Relational Coordination on Nurse Job Satisfaction, Work Engagement and Burnout: Achieving the Quadruple Aim," *The Journal of Nursing Administration* 48, no. 3 (2018): 132–40, https://doi.org/10.1097/NNA.0000000000000587.

31 Ellen Nolte and Emma Pitchforth, *What Is the Evidence on the Economic Impacts of Integrated Care?* (Copenhagen: WHO Regional Office for Europe, 2014), https://www.euro.who.int/__data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf.

32 Hazarika and Purdy, "Integrated Care: Demonstrating Value and Valuing Patients."

33 City of Toronto, "Toronto Newcomer Strategy: Helping Newcomers Thrive and Prosper" (Toronto: City of Toronto, January 2013), https://www.toronto.ca/legdocs/mmis/2013/cd/bgrd/backgroundfile-55333.pdf.

34 Aunima R. Bhuiya et al., Rapid Synthesis: Identifying the Features and Impacts of Community Health Centres (Hamilton: McMaster Health Forum, October 2020), https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/identifying-the-features-and-impacts-of-community-health-centres.pdf?sfvrsn=234559d5_2; Ministry of Health and Long-term Care, "Community Health Centres," Government of Ontario, accessed July 2, 2021, https://www.health.gov.on.ca/en/common/system/services/chc/.

35 Ontario Ministry of Health and Long-Term Care, "Ontario Health Teams: Introduction and Overview" (Toronto: Government of Ontario, April 2019), https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/oht_intro_webinar_en.pdf.

36 "Canada-Ontario Immigration Agreement – General Provisions 2017," Government of Canada, November 24, 2017, https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/agreements/federal-provincial-territorial/ontario/immigration-agreement-2017.html.

37 Immigration, Refugees and Citizenship Canada, "Service Delivery Improvements Funding Process: Funding Guidelines."

38 Praznik and Shields, *An Anatomy of Settlement Services in Canada: A Guide; Standing Committee on Citizenship and Immigration, Improving Settlement Services Across Canada* (Ottawa: House of Commons Canada, June 2019), https://www.ourcommons.ca/Content/Committee/421/CIMM/Reports/RP10577155/cimmrp26/cimmrp26-e.pdf.

39 Juan Sanchez et al., *Part One: Examining the Health Status & Health Care Experiences of New Permanent Residents in the Three-Month OHIP Wait: A Scoping Review of the Peer-Reviewed Literature* (Toronto: Wellesley Institute, July 2016), https://www.wellesleyinstitute.com/wp-content/uploads/2016/07/Examining-Health-in-the-Three-Month-Wait-Part-One.pdf.

40 Grace Pollock et al., "Discrimination in the Doctor's Office: Immigrants and Refugee Experiences," *Critical Social Work* 13, no. 2 (2019): 61-79, https://doi.org/10.22329/csw.v13i2.5866.

41 Ritika Goel, Gary Bloch, and Paul Caulford, "Waiting for Care: Effects of Ontario's 3-Month Waiting Period for OHIP on Landed Immigrants," *Canadian Family Physician* 59, no. 6 (2013): 269–75, https://pubmed.ncbi.nlm.nih.gov/23766065/; Sanchez et al., *Part One: Examining the Health Status & Health Care Experiences of New Permanent Residents*.

42 Ministry of Health and Long-term Care, "Ontario Expands Coverage for Care: Enhanced Health Care Coverage Critical to Support Efforts to Contain COVID-19," Government of Ontario, March 20, 2020, https://news.ontario.ca/en/release/56401/ontario-expands-coverage-for-care; Ministry of Health and Long-term Care, "COVID-19 Expanding Access to OHIP Coverage and Funding Physician and Hospital Services for Uninsured Patients," Government of Ontario, March 25, 2020, https://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4749.pdf.

43 Nishi Kumar et al., "The Right to Language Accessibility in Ontario's Health Care System," Wellesley Institute, June 21, 2017, https://www.wellesleyinstitute.com/health/the-right-to-language-accessibility-in-ontarios-health-care-system/.

44 Nazeefah Laher et al., *Access to Language Interpretation Services and Its Impact on Clinical and Patient Outcomes: A Scoping Review* (Toronto: Wellesley Institute, April 2018), http://www.wellesleyinstitute.com/wp-content/uploads/2018/04/Language-Interpretation-Services-Scoping-Review.pdf.

45 Nazeefah Laher et al., *Access to Language Interpretation Services and Its Impact on Clinical and Patient Outcomes: A Scoping Review*.

46 Salim Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review," *Journal of Immigrant and Minority Health* 18, no. 6 (2016): 1522–40, https://doi.org/10.1007/s10903-015-0276-z; Vivian Tam, Francine Buchanan, and Claude Lurette, "How Do We Ensure That Patients Receive Care in Their Own Languages?," *Healthy Debate*, December 13, 2018, https://healthydebate.ca/2018/12/topic/language-interpretation-in-health-care/.

47 Kumar et al., "The Right to Language Accessibility in Ontario's Health Care System."

48 Nazeefah Laher and Anjum Sultana, "Advancing Health Equity Through Language Interpretation Services," Wellesley Institute, August 2, 2017, https://www.wellesleyinstitute.com/health/advancing-health-equity-through-language-interpretation-services/?highlight=languageinterpretation; Kumar et al., "The Right to Language Accessibility in Ontario's Health Care System."

49 Anjana Aery and Anjum Sultana, *Expanding Language Interpretation Services in Health Care: Policy Brief* (Toronto: Wellesley Institute, April 2018), http://www.wellesleyinstitute.com/wp-content/uploads/2018/04/Language-Interpretation-Services-Policy-Brief.pdf.

50 Patricia O'Campo et al., *Reducing the Language Accessibility Gap: Language Services Toronto Program Evaluation Report* (Toronto: St. Michael's Hospital, July 2014), http://stmichaelshospitalresearch.ca/wp-content/uploads/2016/12/LST_Program_Evaluation_Report_July31_one-up.pdf.

51 Ahmed et al., "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review."

52 Immigration, Refugees and Citizenship Canada, Evaluation of the Settlement Program (Ottawa: Government of Canada, November 2017), https://www.canada.ca/content/dam/ircc/documents/pdf/english/evaluation/e2-2016-settlement-en.pdf.

53 Immigration, Refugees and Citizenship Canada, "Settlement Program Support Services Provisions for Care for Newcomer Children," Government of Canada, March 14, 2013, https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/bulletins-2013/508-march-14-2013.html; CMAS, "Care For Newcomer Children (CNC): Highlights," CMAS, accessed July 5, 2021, https://cmascanada.ca/2012/08/02/care-for-newcomer-children-cnc-highlights/.

54 Standing Committee on Citizenship and Immigration, Improving Settlement Services Across Canada.

55 Toronto Public Health and and Access Alliance Multicultural Health and Community Services, *The Global City: Newcomer Health in Toronto* (Toronto: City of Toronto, November 2011), https://www.toronto.ca/legdocs/mmis/2011/hl/bgrd/backgroundfile-42361.pdf; Robert A. Murdie, *Diversity and Concentration in Canadian Immigration: Trends in Toronto*, *Montreal and Vancouver, 1971 – 2006* (Toronto: Centre for Urban & Community Studies, March 2008), https://tspace.library.utoronto.ca/bitstream/1807/94695/1/Research%20Bulletin%2042_Diversity_and_concentration.pdf.

56 Qaseem Ludin, "Multi-Method Assessment of Newcomer Settlement Experiences in Kitchener-Waterloo," *Theses and Dissertations (Comprehensive)* (Wilfrid Laurier University Follow, 2008), https://scholars.wlu.ca/etd/895.

57 Kesayini Manoharan, Saima Khan, and Thiriah Thangavel, *The Many Challenges Scarborough Immigrants Face with Public Transit* (Toronto: CERIS, 2015), https://www.utsc.utoronto.ca/immigrantscarborough/sites/utsc.utoronto.ca.immigrantscarborough/files/docs/CERIS-Research%20Summary-Transit.pdf.

58 Vivian Runnels, *Understanding Immigrant Seniors' Needs and Priorities for Health Care: A Community Engagement Research Project in the Champlain Local Health Integration Network (LHIN) Region of Ontario* (Ottawa: Ottawa Local Immigration Partnership, August 2017), http://olip-plio.ca/wp-content/uploads/2018/05/Senors-Report-Final-English-Low-Res.pdf; Toronto Public Health and and Access Alliance Multicultural Health and Community Services, *The Global City: Newcomer Health in Toronto*.

59 Shields and Alrob, *COVID-19, Migration and the Canadian Immigration System: Dimensions, Impact and Resilience*; Ontario Council of Agencies Serving Immigrants, *Making Ontario Home 2012: A Study of Settlement and Integration Services for Immigrants and Refugees* (Toronto: OCASI, 2012), http://www.ocasi.org/downloads/OCASI_MOH_ENGLISH.pdf.

60 WoodGreen Community Services, "Working Together to Prevent the Spread of the COVID-19 Virus in the Crescent Town Neighbourhood," WoodGreen Community Services, May 26, 2020, https://www.woodgreen.org/working-together-to-prevent-the-spread-of-the-covid-19-virus-in-the-crescent-town-neighbourhood/.

61 Kelly Grant, "Toronto Doctors Take COVID-19 Testing to the People in Effort to Contain Pandemic," *The Globe and Mail*, June 5, 2020, https://www.theglobeandmail.com/canada/article-toronto-doctors-take-covid-19-testing-to-the-people-in-effort-to/.

62 Nick Goodwin et al., *Co-Ordinated Care for People with Complex Chronic Conditions: Key Lessons and Markers for Success* (London: The King's Fund, October 2013), https://www.kingsfund.org.uk/publications/co-ordinated-care-people-complex-chronic-conditions.

63 Ontario Ministry of Health and Long-Term Care, *Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System* (Toronto: Government of Ontario, July 2020), https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_CDMA_Guidance_Doc.pdf.

64 Sara Torres et al., "Improving Health Equity: The Promising Role of Community Health Workers in Canada," *Healthcare Policy* 10, no. 1 (2014): 73–85, https://doi.org/10.12927/hcpol.2014.23983.

65 WoodGreen Community Services, "Working Together to Prevent the Spread of the COVID-19 Virus in the Crescent Town Neighbourhood."

66 Immigration, Refugees and Citizenship Canada, "Settlement Program: Terms and Conditions," Government of Canada, August 16, 2019, https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/program-terms-conditions/settlement.html.

67 Meyer Burstein, *Reconfiguring Settlement and Integration: A Service Provider Strategy for Innovation and Results* (Burnaby: Canadian Immigrant Settlement Sector Alliance, September 2010), http://p2pcanada.ca/wp-content/uploads/2011/09/Reconfiguring-Settlement-and-Integration.pdf.

68 Ontario Council of Agencies Serving Immigrants, *Telling Our Stories from the Frontline: Adverse Institutional Impacts of Cuts to Immigrant Settlement Funding in Ontario* (Toronto: OCASI, November 2016), https://ocasi.org/sites/default/files/telling-our-stories-from-the-frontline_1.pdf.

69 Jason Sutherland and Erik Hellsten, *Integrated Funding: How and What We Pay For* (Vancouver: UBC Centre for Health Services and Policy Research, May 2015), http://healthcarefunding2.sites.olt.ubc.ca/files/2015/06/White-Paper-Integrated-Funding.pdf.

70 Jason Sutherland and Erik Hellsten, *Integrated Funding: Connecting the Silos for the Healthcare We Need* (Toronto: C.D. Howe Institute, January 2017), https://www.cdhowe.org/public-policy-research/integrated-funding-connecting-silos-healthcare-we-need.

71 Ministry of Health and Long-Term Care, "Primary Care Payment Models in Ontario," Government of Ontario" Government of Ontario, accessed June 30, 2021, https://www.health.gov.on.ca/en/pro/programs/pcpm/.

72 Denis Protti, "Integrated Care Needs Integrated Information Management and Technology," *Healthcare Quarterly* 13 (2009): 24–29, https://doi.org/10.12927/hcq.2009.21093; Goodwin et al., *Co-Ordinated Care for People with Complex Chronic Conditions: Key Lessons and Markers for Success*.

73 Protti, "Integrated Care Needs Integrated Information Management and Technology."

74 Ira Parghi, "Ontario Health Teams: Personal Health Information Sharing, Client Privacy and PHIPA Compliance," BLG, February 28, 2020, https://www.blg.com/en/insights/2020/02/personal-health-information-sharing-client-privacy-and-phipa-compliance.

75 Parghi, "Ontario Health Teams: Personal Health Information Sharing, Client Privacy and PHIPA Compliance."

76 World Health Organization, *People-Centred and Integrated Health Services: An Overview of the Evidence* (Geneva: WHO, 2015), https://apps.who.int/iris/handle/10665/155004.

77 Heather L. Bullock, Kerry Waddell, and Michael G. Wilson, *Knowledge Synthesis: Identifying and Assessing Core Components of Collaborative-Care Models for Treating Mental and Physical Health Conditions* (Hamilton: McMaster Health Forum, March 2017), http://hdl.handle.net/11375/21926.

78 Ruth M. Campbell et al., "A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada," *Journal of Immigrant and Minority Health* 16 (2014): 165–76, https://doi.org/10.1007/s10903-012-9740-1.

79 Nestel, *Colour Coded Health Care: The Impact of Race and Racism on Canadians' Health*.

80 Nadha Hassen et al., "Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review," *International Journal of Enviromental Research and Public Health* 18, no. 6 (2021): 2993, https://doi.org/10.3390/ijerph18062993; Margaret Alexander, *An Integrated Anti-Oppression Framework for Reviewing and Developing Policy: A Toolkit for Community Service Organizations* (Toronto: Springtide Resources Inc., 2008), http://www.oaith.ca/assets/files/Publications/Intersectionality/integrated-tool-for-policy.pdf.

81 Margrieta Langins and Liesbeth Borgermans, *Strengthening a Competent Health Workforce for the Provision of Coordinated/ Integrated Health Services* (Copenhagen: WHO Regional Office for Europe, September 2016), https://www.euro.who.int/__data/assets/pdf_file/0010/288253/HWF-Competencies-Paper-160915-final.pdf.

82 World Health Organization, *Framework for Action on Interprofessional Education & Collaborative Practice* (Geneva: WHO, 2010), https://apps.who.int/iris/handle/10665/70185.

83 Kwame McKenzie et al., *Building Capacity to Support the Mental Health of Immigrants and Refugees: A Toolkit for Settlement, Social and Health Service Providers* (Toronto: Centre for Addiction and Mental Health, June 2020), https://swissask.ca/wp-content/uploads/2020/06/A-toolkit-for-settlement-social-and-health-service-providers.pdf.

84 Deborah Kopansky-Giles, *IntegratedCare4People: Enhancing Primary Healthcare Delivery in the Inner-City Community in Toronto, Canada* (Integrated People-Centred Health Services, May 2016), https://www.integratedcare4people.org/media/files/TorontoSMHFamilyHealthTeam.pdf.

85 Deborah Kopansky-Giles, *IntegratedCare4People: Enhancing Primary Healthcare Delivery in the Inner-City Community in Toronto, Canada*.

86 Anna Charles et al., *A Year of Integrated Care Systems: Reviewing the Journey So Far* (London: The King's Fund, September 2018), https://www.kingsfund.org.uk/sites/default/files/2018-09/Year-of-integrated-care-systems-reviewing-journey-so-far-full-report.pdf.

87 Jonathan Stokes et al., "Towards Incentivising Integration: A Typology of Payments for Integrated Care," *Health Policy* 122, no. 9 (2018): 963–69, https://doi.org/10.1016/j.healthpol.2018.07.003; Charles et al., *A Year of Integrated Care Systems: Reviewing the Journey So Far*.

88 Anne Mason et al., "Integrating Funds for Health and Social Care: An Evidence Review," *Journal of Health Services Research & Policy* 20, no. 3 (2015): 177–88, https://doi.org/10.1177/1355819614566832.

89 Sutherland and Hellsten, "Integrated Funding: Connecting the Silos for the Healthcare We Need."

90 World Health Organization, *People-Centred and Integrated Health Services: An Overview of the Evidence*.

91 Standing Committee on Citizenship and Immigration, *Improving Settlement Services Across Canada; Ontario Council of Agencies Serving Immigrants, Telling Our Stories from the Frontline: Adverse Institutional Impacts of Cuts to Immigrant Settlement Funding in Ontario*.

92 Ontario Hospital Association, *Ontario Hospitals - Leaders in Efficiency* (Toronto: OHA, 2019), https://www.oha.com/Documents/Ontario%20Hospitals%20-%20Leaders%20in%20Efficiency.pdf.

93 Ministry of Health and Long-term Care, "Become an Ontario Health Team," Government of Ontario, accessed May 26, 2021, https://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx; Rapid-Improvement Support and Exchange, "RISE," RISE, accessed May 26, 2021, https://www.mcmasterforum.org/rise.

94 Ministry of Health and Long-term Care, "Ministry of Health Update for Ontario Health Teams" (Toronto, August 2020), https://www.mcmasterforum.org/docs/default-source/rise-docs/rise-presentations/deck_moh-update-for-ontario-health-teams.pdf?sfvrsn=f52a56d5_2; Ministry of Health and Long-term Care, "Ontario Health Teams: Presentation to the Long-Term Care COVID-19 Commission" (Toronto, November 2020), http://ltccommission-commissionsld.ca/presentations/pdf/Ministry_of_Health_Briefing_on_Vision_for_Ontario_Health_Teams_November_16_2020.pdf.

95 Seong-gee Um, "New Data Collection Is Fundamental to Improving Equitable Access to Care ," Wellesley Institute, September 9, 2016, https://www.wellesleyinstitute.com/health/new-data-collection-is-fundamental-to-improving-equitable-access-to-care/?highlight=race-based%20data.

96 Kwame McKenzie, "Race and Ethnicity Data Collection during COVID-19 in Canada: If You Are Not Counted You Cannot Count on the Pandemic Response," The Royal Society of Canada, November 12, 2020, https://rsc-src.ca/en/race-and-ethnicity-data-collection-during-covid-19-in-canada-if-you-are-not-counted-you-cannot-count.

97 Seija Rizvic, "Why Race-Based Data Matters in Health Care," Institute for Canadian Citizenship, July 15, 2020, https://www.inclusion.ca/article/why-race-based-data-matters-in-health-care/.

98 Toronto Central Local Health Integration Network, *Measuring Health Equity Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres* (Toronto: Toronto Central Local Health Integration Network, July 2017), http://torontohealthequity.ca/wp-content/uploads/2013/02/Measuring-Health-Equity-Demographic-Data-Collection-Use-in-TC-LHIN-Hospitals-and-CHCs-2017.pdf.

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